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TITLE 10

Attorney General

JANUARY 1994

STAFF COMMENT: Chapter 10-15-01 contains all new material but is not underscored so as to improve readability.

ARTICLE 10-15

DECEPTIVE ACTS OR PRACTICES

CHAPTER 10-15-01
DECEPTIVE PRICING

10-15-01-01. Definitions. All words used in this chapter which are defined in North Dakota Century Code chapter 51-15 have the meanings given in that chapter. As used in this chapter:

1. "Advertisement" includes statements and representations contained on any label, tag, or sign attached to, printed on, or accompanying merchandise offered for sale or printed in a catalog or any other sales literature.

2. "Clearly and conspicuously" means that the statement, representation, or term being disclosed is reasonably understandable, is in such size, color contrast, or audibility, and is so placed and presented as to be readily noticeable, and is in close proximity to the information it modifies.

3. "Comparable merchandise" means merchandise that is substantially similar in composition, style, design, model, kind, variety, service, or performance characteristics to the merchandise to which it is compared in any advertisement.

4. "Comparative price" means the price or other description of value of merchandise to which a seller compares its current price in any advertisement.

5. "List price" means a price given to a retailer by a manufacturer or other supplier as a suggested retail price for the merchandise and includes the term "manufacturer's suggested retail price".

6. "Price comparison" means an expressed or implied comparison in any advertisement (whether or not expressed wholly or in part in dollars, cents, fractions, or percentages) of a seller's current price for merchandise with any other price or statement of value, whether or not the price is actually stated in the advertisement.

7. "Seller" means any person who offers any merchandise for sale at any location and who disseminates advertisements for that product in North Dakota. Seller may include any officer, agent, employee, sales person, or representative of the seller, and any advertising agency employed by a seller.

8. "Trade area" means the geographic area where the seller's outlets are located or where the seller's advertisements are disseminated.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-01, 51-12-09, 51-15-02

10-15-01-02. Identifying basis of price comparison. It is a deceptive act or practice for a seller to make a price comparison or claim a savings as to any merchandise offered for sale unless the seller clearly and conspicuously discloses the basis for or source of the price comparison or savings claim. However, a seller may make a price comparison or claim a savings without the required disclosure if the price comparison or savings claim is based on the seller's own former price as described in section 10-15-01-03. Terms such as "regular", "regularly", "formerly", "originally", "was", or words of similar meaning may be used by the seller to identify the seller's own former price.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-03. Comparison to seller's own former price. It is a deceptive act or practice for a seller to compare the seller's current price with the seller's former price for any merchandise unless:

1. The former price is a price at which a substantial number of sales were made by the seller during the three months immediately preceding the price comparison;

2. The former price is a price at which a substantial number of sales were made by the seller and the seller clearly and conspicuously discloses the dates during which a substantial number of sales were made by the seller at the former price; or

3. The former price is a price at which the seller offered the merchandise for a reasonably substantial period of time in the recent, regular course of its business, openly, actively, and in good faith, with an intent to sell the merchandise at that price.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-04. Comparison to seller's future prices. It is a deceptive act or practice for a seller to make an introductory offer or to compare its current price for merchandise with the price at which the merchandise will be offered in the future, unless:

1. The future price takes effect within a reasonable time after the introductory offer or price comparison is published; and

2. The future price of the merchandise is, subsequent to the end of the introductory sale, properly established as the seller's regular and customary price.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-05. Range of savings or price comparison claims. It is a deceptive act or practice for a seller to state or imply that any merchandise is being offered for sale at a range of prices, or at a range of percentage or fractional discounts, unless the highest price or the lowest discount in the range is clearly and conspicuously disclosed in the advertisement and a reasonable number of the items in the advertisement are offered with the largest advertised discount or the lowest advertised price. If at least five percent of the items in the advertisement are offered with the largest advertised discount or the lowest advertised price, a rebuttable presumption exists that a reasonable number were offered with at least the largest advertised discount or the lowest advertised price.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-06. Use of list price or similar comparisons. It is a deceptive act or practice for a seller to make a price comparison or to claim a savings, expressed or implied, from a list price or term of similar meaning, unless:

1. The list price does not exceed the highest price at which substantial sales of the merchandise have been made in the seller's trade area;

2. The list price is the price at which the seller offered the merchandise for a reasonably substantial period of time in the recent, regular course of its business, openly, actively, and in good faith, with an intent to sell the merchandise at that price;

3. The list price does not exceed the highest price at which the product is offered by a reasonable number of sellers in the seller's trade area for a reasonably substantial period of time in the recent, regular course of business; or

4. The list price does not exceed the seller's cost plus the percentage markup regularly used by the seller in the actual sale of such merchandise or merchandise of a similar class or kind, in the seller's recent, regular course of business.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-07. Comparison to competitor's price. It is a deceptive act or practice for a seller to compare the seller's price with a price currently being offered by another seller for merchandise unless the merchandise is comparable merchandise and the comparative price is at or below the price at which the comparable merchandise is currently being offered in the seller's trade area by a reasonable number of other sellers in the same trade area, or another identifiable seller.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-08. Bargain offers based on the purchase of other merchandise and use of the word free. It is a deceptive act or practice to use the word free, or words of similar meaning, or to represent bargain offers, including "buy one - get one free", "buy one - get one at half-price", "two for one", and "one cent sale", when describing merchandise to be given to a customer who purchases other merchandise, if the seller recovers, in whole or in part, the cost of the free or bargain merchandise by marking up the price of the item which must be purchased, by substituting an inferior item or service, or otherwise. It is a deceptive act or practice to represent that other merchandise is being offered free or at a bargain price with the sale if the advertised merchandise can be purchased from the advertiser at a lesser price without the free or bargain merchandise, particularly if the merchandise is usually sold at a price arrived at through bargaining.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-09. Use of sale terminology. It is a deceptive act or practice for a seller to use terms such as "sale", "sales prices", "now only $____", or other words and phrases that imply a price savings unless the price of the merchandise is reduced by a reasonable amount from the former price of the merchandise. If the seller reduces the price by five percent or more from the former price, a rebuttable presumption exists that the price reduction was of a reasonable amount. However, the term "sale" may be used in an advertisement where not all items are offered at a reduction from regular price if the items are clearly and conspicuously identified.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-10. Use of term wholesale. It is a deceptive act or practice for a seller to use the term "wholesale" or words of similar meaning in connection with any merchandise offered for sale at retail.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02

10-15-01-11. Reporting. Within twenty-one days after receipt of a written request from the attorney general, persons making price comparisons shall submit a report in writing setting forth substantiating information upon which the price comparison was based.

The attorney general, for cause shown, may grant additional time to respond upon request.

History: Effective January 1, 1994.
General Authority: NDCC 51-12-09, 51-15-05, 54-12-17
Law Implemented: NDCC 51-12-09, 51-15-01, 51-15-02, 51-15-04

TITLE 13

Banking and Financial Institutions, Department of

February 1994

CHAPTER 13-02-12

13-02-12-09. Undue concentration of resources or substantial lessening of competition. For the purpose of determining whether an undue concentration of resources or substantial lessening of competition will result, the application must disclose how the acquisition will not result in an undue concentration of resources or substantial lessening of competition when the reciprocating bank holding company controls another bank, paying and receiving station, or banking house or office in the acquired bank's trade area. The application must include a map of the acquired bank's trade area and must also include a schedule of total deposits of each commercial bank, thrift institution, or credit union within the acquired bank's trade area.

History: Effective February 1, 1994.
General Authority: NDCC 6-01-04, 6-08.3-03, 6-08.3-07
Law Implemented: NDCC 6-08.3-03, 6-08.3-07

TITLE 27

Job Service North Dakota

APRIL 1994

STAFF COMMENT: Article 27-04 contains all new material but is not underscored so as to improve readability.

ARTICLE 27-04

NORTH DAKOTA NEW JOBS TRAINING PROGRAM

CHAPTER 27-04-01
NORTH DAKOTA NEW JOBS TRAINING PROGRAM

27-04-01-01. Definitions. Terms used in this chapter, unless the context clearly indicates otherwise, have the following meanings:

1. "Act" means chapter 493 of the 1993 Session Laws.

2. "Applicant" means a business submitting a project application for approval by job service North Dakota.

3. "Debt service" means the payment of principal and interest on a repayable loan in accordance with the repayment schedule of the training agreement.

4. "Eligible employee" means a person employed throughout the term of the agreement in a new job position identified in the agreement and who is subject to state income tax withholding for the state of North Dakota.

5. "Full-time job" means a job providing thirty-two hours of work per week for a minimum of nine months each year.

6. "Gross payroll" means the gross wages and salaries for new jobs in the first full year after the date of commencement of the project.

7. "Preliminary agreement" means a written document between a business and job service North Dakota agreeing to pursue the development of a training project to train new employees.

8. "Program funds" means any money loaned to a business as a result of a training agreement being entered into under the Act.

9. "Reimbursable" or "project costs" means all necessary, authorized costs providing program services identified in the agreement.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-02. Project funding. An award to a new or expanding business for the purpose of training current and new employees for new job positions must be made in the form of a loan to that business by the department or a community. Funds received in the form of a loan must be used to train employees hired in new job positions and cover administrative costs identified in the agreement.

Job service North Dakota shall calculate the maximum loan amount allowable for new job training projects. The estimated state income tax withholding credit available to the project must be calculated using "withholding" averages developed by the state tax commissioner based on

the hourly wages that are to be paid to the employees in new job positions covered in the agreement and must cover principal and interest payments for the entire loan repayment period. The repayment period may not exceed ten years. Reserves may be included when determining the total loan amount in order to meet initial interest payments until sufficient state withholding tax credits are collected to make payments on both principal and interest.

Financial assistance awarded to a project must be based on the actual cost of allowable services and administrative costs as identified in the agreement. The interest rate to be paid and repayment schedule on a loan shall be determined by the lending entity. Issuance of the proceeds of a loan to a business must be made on a cost reimbursement basis after the business has incurred the costs. Approval of disbursement of the loan must be made jointly by job service North Dakota and the business. Funds requested must be commensurate with training needs. Program funds may not be used to cash flow a business.

The specific vocational preparation guide of the dictionary of occupational titles must be used for determining the length of allowable on-the-job training periods. When a specific job is not listed, time periods must be based on the specific vocational preparation guide for similar jobs.

On-the-job training may not exceed fifty percent of the individual's gross annual wages during the first full year after the date of commencement of the project.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-03. Application fee. As set forth in the preliminary agreement, job service North Dakota may charge each applicant an application fee to cover part or all administrative and legal costs incurred prior to project funding.

If job service North Dakota elects to charge an application fee, this application fee must be charged at the same or equitable basis for each business that applies.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-04. New or expanding business threshold eligibility criteria. Job positions for which training is planned must be positions intended by the employer to exist on an ongoing basis with no plan termination date.

Training is available only to individuals who are eligible employees of the business and who are subject to state income tax withholding.

Jobs that formerly existed do not qualify for new employee training services under the provision of this program. A job is considered to have "formerly existed" if it was part of the business's payroll within North Dakota at the time of commencement of the project.

The earliest date on which program funds may be used to pay training expenses incurred by the project is the date on which job service North Dakota signs the preliminary agreement.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-05. Application process. Applications for training assistance must be submitted to job service North Dakota on behalf of the business, jointly by the business, and by the department or a community certifying that the employer has qualified for a loan.

Job service North Dakota shall use an application for assistance form designated for this purpose.

Information required on the application must be described in the application instructions.

Applications must be submitted to:

North Dakota New Jobs Creation Program
Job Service North Dakota
Job Training Division
1000 East Divide Avenue
P.O. Box 5507
Bismarck, North Dakota 58502

Required forms and instructions are available at this address.

To be funded, the employer must qualify for a loan from the department of economic development and finance, North Dakota future fund, or a community to cover the cost of the training identified in the project.

Job service North Dakota may approve, reject, defer, or refer an application to another training program.

Job service North Dakota reserves the right to require additional information, including a preaward audit or survey of the business.

Before an application is approved for funding by job service North Dakota, job service North Dakota shall investigate the applicability of

other training programs such as those provided by the Job Training Partnership Act, job opportunities and basic skills program, North Dakota board for vocational and technical education, department of public instruction, and other state and federal agencies. This investigation must be completed within fifteen days or as soon thereafter from the date the application is received and all necessary information has been provided by the employer.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-06. Final agreement. Job service North Dakota shall enter into a final agreement with the business within ninety days of the commencement date of the preliminary agreement. The final agreement must contain the following provisions:

1. The starting date and ending date of the training.
2. The length of time each job category will be provided training.
3. The number of new job slots to be created and the number of new jobs to be trained.
4. A repayment schedule outlining all principal and interest payments to be made during the repayment period.
5. Default provisions that are consistent with these rules.
6. A provision specifying that, upon occurrence of an event of default, the business is ineligible for state income tax withholding credit and shall immediately remit payment in full to satisfy the remaining debt service.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-07. Notification of new jobs training projects. When a final agreement to participate and a new job training project is entered into, job service North Dakota shall provide copies of the agreement to the lending agency, state tax commissioner, local development corporation, and state treasurer within ten days of the date of signing the agreement. If, at any time after submitting the agreement, the estimates are revised or the agreement is modified to the extent that it would affect the reporting requirements, job service North Dakota shall notify the lender, state tax commissioner, and state treasurer within thirty days.

History: Effective April 1, 1994.

General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-08. Events of default. An event of default exists if:

1. The business fails to train at a minimum the number of individuals specified in the final agreement.

2. The business fails to complete the training program.

3. Prior to project completion, the business ceases or announces the cessation of operations at the project site, unless such operations are transferred to another facility in the state of North Dakota and job service North Dakota receives assurances of continued repayment.

4. The business fails to act in accordance with the provisions of the training agreement.

5. The business directly or indirectly makes any false or misleading representations or warranties in the program application or training agreement, reports, financial statements, or any other documents that are provided to job service North Dakota.

6. The business fails to make required payments to job service North Dakota and to service providers as identified in the agreement.

7. The business becomes insolvent or bankrupt or admits in writing its inability to pay its debts as they mature or makes an assignment for the benefit of creditors or the business applies for or consents to the appointment of a trustee or receiver for the business or the major part of the property.

8. The business ceases or announces the cessation of operation at the project site prior to completion date of the term of the agreement, unless such operations are transferred to another facility in the state of North Dakota and job service North Dakota receives assurance of continued employment and repayment.

9. The business takes corporate action to affect any of the preceding conditions of default.

10. The business fails to file and pay any state taxes that may be required to be filed and paid to the state of North Dakota.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-09. Options and procedures on default. The business failing to comply with any requirements other than repayment contained in the training agreement must be sent written notice from job service North Dakota which specifies the issues of noncompliance and must be allowed twenty days from the date the notice is sent to affect and cure. If noncompliance is of such a nature that a cure cannot be reasonably accomplished within twenty days, job service North Dakota may extend the period of corrective action to a maximum of sixty days.

Job service North Dakota shall notify the lending institution, local development corporation, state tax commissioner, and state treasurer within five working days, using a designated notice of possible default form, whenever job service North Dakota determines that an event of default has occurred or is likely to occur.

Job service North Dakota shall document its efforts to reconcile the condition responsible for the default and shall provide the lender, state tax commissioner, and state treasurer with copies of all related correspondence upon request.

If job service North Dakota's efforts to reconcile are successful, job service North Dakota shall notify the lender, local development corporation, state tax commissioner, and state treasurer in writing to continue project operations. Continuation of project operations may be subject to new conditions imposed by job service North Dakota as part of the reconciliation.

When job service North Dakota's efforts to reconcile are unsuccessful, job service North Dakota shall provide a copy of the final determination to the lending institution, local development corporation, state tax commissioner, and state treasurer.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

27-04-01-10. Remedies upon default. The exercise of remedies upon the occurrence of any event of default described above is subject to applicable limitations of federal bankruptcy law.

If job service North Dakota determines that a business is in default and the default has not been cured within the time period stated in the contract, job service North Dakota may notify the state tax commissioner and the state treasurer to withhold state income tax withholding credit payments to the business without notice to the business.

No remedy conferred upon or reserved to job service North Dakota, the state tax commissioner, or the state treasurer by the Act, these rules, or the training agreement is intended to be exclusive of any other current or future remedies existing in law or equity or by statute.

Any delay or omission by job service North Dakota to exercise any right or power of the Act, these rules, or the training agreement does not relinquish or diminish authority to act and does not constitute a waiver of default status. Any such right or power may be exercised at any time required and as often as deemed expedient.

Unless required by these rules, neither job service North Dakota, the state tax commissioner, nor the state treasurer is required to provide written or other notice to the business regarding any circumstances related to and including a declaration of an event of default.

An event of any requirement of the Act, these rules, or the training agreement relating to a default should be reached by either party and then waived by the other party. Such waiver is limited to the specific breach being waived and has no bearing on any subsequent breach.

History: Effective April 1, 1994.
General Authority: S.L. 1993, Ch. 493
Law Implemented: S.L. 1993, Ch. 493, § 2

TITLE 33

Health and Consolidated Laboratories, Department of

FEBRUARY 1994

CHAPTER 33-19-01

33-19-01-01. Responsibility. It is the responsibility of any person or persons operating a water treatment, water distribution and storage, wastewater treatment, or wastewater collection and transfer facility or system to comply with this chapter pursuant to North Dakota Century Code chapter 23-26.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-07

33-19-01-02. Definitions. ~~The definitions set forth in North Dakota Century Code section 23-26-02 shall be considered to be incorporated verbatim in this chapter. In addition, the following words and phrases shall have the meanings ascribed to them in this section~~ As used in this chapter, unless the context or subject matter otherwise requires:

1. "Direct responsible charge" means full and active performance of onsite operation of a water or wastewater treatment facility or a water distribution and storage or wastewater collection and transfer system, where the operator is responsible for technical support of the facility or system and provides direction to other operators, is ~~responsible for~~ onsite or on call during shift operations, is responsible for the operation of a major segment of a facility or system, or is the sole person employed as the facility or system operator.

2. ~~"Municipality" means a city or other public body created by or pursuant to state law.~~

~~3.~~ "Official census" means the census taken each decade or a special census taken by the United States bureau of census.

~~4.~~ 3. "Person" means any individual, corporation, partnership, firm, association, trust, estate, public or private institution, group, agency, political subdivision of this state, any other state or political subdivision or agency thereof and any legal successor, representative agent, or agency of the foregoing.

~~5. "Population equivalent" for a wastewater treatment plant or collection system means the calculated population which would normally contribute the same amount of biochemical oxygen demand (BOD_5) per day computed on the basis of seventeen hundredths of one pound [77.11 grams] of five-day twenty-degree Celsius [68-degree Fahrenheit] biochemical oxygen demand per capita per day.~~

~~6.~~ 4. "Water treatment facility" ~~means that portion of the water supply system which obtains and in some way alters the physical, chemical, or bacteriological quality of the water~~ includes the source or sources of water or the water treatment plant or both.

~~7.~~ 5. "Water distribution and storage system" means that portion of the water supply system which obtains, stores, and conveys water from the treatment facility or other supply point to the premises of the consumer.

~~8.~~ 6. "Wastewater treatment facility" means ~~the system or group~~ those systems using mechanical or nonmechanical or both types of process units ~~used~~ for the treatment of wastewater and for the treatment and disposal of solids removed from such wastes.

~~9.~~ 7. "Wastewater collection and transfer system" means that portion of a wastewater system in which wastewater is conveyed to a treatment facility from the premises of a contributor.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-07

33-19-01-03. General.

1. The official census must be used to determine the population served by a water treatment facility, water distribution and storage system, wastewater treatment facility, or wastewater collection and transfer system if population equivalent data is not available.

2. The total number of people served on an annual average daily basis must be used to determine population served by a water treatment facility ~~or a~~, water distribution and storage system, wastewater treatment facility, or wastewater collection and transfer system if official census data is not available.

3. ~~Population equivalent must be used to determine the population served by a wastewater treatment facility or a wastewater collection system.~~

~~4.~~ Facilities or systems with ~~sufficient population equivalent or~~ sufficiently complicated processes may be raised to a classification higher than that indicated by population equivalent or census ~~alone~~.

~~5.~~ 4. Any facility which may have a combination of treatment processes, some of which may be in different facility classes, must be classified based on the treatment process which requires the highest numerical classification.

~~6.~~ 5. An operator who has direct responsible charge shall hold a certificate that is at least equal to ~~or of the next higher grade numerically than~~ the classification of the facility or system where the operator is employed.

~~7. Certification is available to all facility or system operators. Those operators who are not required to be certified under the mandatory certification law and who can meet the qualifications for certification in a given grade should give serious consideration to applying for certification.~~

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-03, 23-26-05, 23-26-07

33-19-01-04. Application for certification.

~~1.~~ Applications for certification must be filed with the ~~state~~ department ~~of health and consolidated laboratories~~ fifteen days prior to the examination on ~~application~~ appropriate forms ~~supplied by the department. Applications must be filed with the department for review prior to the examination. Separate applications must be submitted for each class of certificates~~ An application remains valid for a period of six months from the date of submission.

~~2. An application for certification remains valid for a period of six months from the date of submission by the applicant. A new application for certification must be submitted following expiration of the six-month period.~~

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-05, 23-26-07

33-19-01-05. Examinations.

1. Written examinations must ~~normally~~ be used in determining knowledge, ability, and judgment of the applicant. Oral examinations may be used in lieu of or in conjunction with the written examinations at the discretion of the department.

2. Examinations must be held at ~~such~~ places and times set by the department. ~~Advance notice must be provided.~~ At least one examination session must be held annually. Additional examination sessions may be held at the discretion of the department.

3. ~~The certification fee is nonrefundable and must be received by the department at the time of application. Applicants will be notified of the results of the examinations. Papers and test material shall remain the property of the department. Applicants may, upon request, review the results with the department.~~

~~4.~~ Separate examinations will be prepared for each facility or system ~~classifications~~ classification.

~~5.~~ 4. All examinations must be graded by personnel designated by the department.

~~6.~~ 5. ~~Applicants who fail to pass an examination may rewrite the examination, in the same category and classification level,~~ An examination may be rewritten once within one year from the date on which the ~~failed~~ original examination was written. A new certification application and the required fee must be submitted to the department to rewrite an examination.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-07

33-19-01-06. Fees for certification.

1. Fees for certification, ~~effective July 1, 1990, are as follows:~~ ten dollars per examination.

~~Grade I~~	~~$10.00~~
~~Grade II~~	~~10.00~~
~~Grade III~~	~~10.00~~
~~Grade IV~~	~~10.00~~

2. Fees for annual ~~certificate~~ renewals~~, effective July 1, 1990,~~ are ~~as follows:~~ five dollars per certificate.

~~Grade I~~	~~$ 5.00~~
~~Grade II~~	~~5.00~~
~~Grade III~~	~~5.00~~
~~Grade IV~~	~~5.00~~

3. ~~The fee schedule for initial certification or for annual renewals may be revised by the department, as authorized by North Dakota Century Code chapter 23-26 as necessary to make the program self-sustaining.~~ The certification fee from a qualified applicant is nonrefundable and must be received by the department prior to the examination. Applicants will be notified of the results of the examinations. Papers and test material remain the property of the department. Applicants may, upon request, review the results with the department.

4. Fees received from operators whose application for certification has been rejected will be returned.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-06, 23-26-07

33-19-01-07. Issuance of certificates.

1. Upon satisfactory compliance with the certification qualifications, fee, and examination ~~and fee~~ requirements provided herein, the department will issue a certificate to the applicant. The certificate will indicate the operator certification grade, the class of facility or system the applicant is certified to operate, the certificate number, and date of issuance.

2. To maintain certification, all certified operators are required to earn continuing education credits by attending training programs, seminars, workshops, and schools established or officially recognized by the department.

   a. The number of continuing education credits that can be earned by attending officially recognized training programs, seminars, workshops, and schools must be established and regulated by the department ~~with the advice and assistance of the board of certification~~.

   b. The number of continuing education credits to be earned within a three-year period of time ~~must be established and regulated by the department with the advice and assistance of the board of certification~~ is twelve.

~~Continuing education credit (CECs) requirements are as follows:~~

~~Certification Grade I - 12 CECs~~
~~Certification Grade II - 16 CECs~~
~~Certification Grade III - 20 CECs~~
~~Certification Grade IV - 24 CECs~~

c. Training programs offered by other government agencies, educational institutions, and operator organizations may be used for the continuing education credit requirements at the discretion of the department.

d. ~~Former North Dakota~~ Certified operators ~~who are no longer residents of the state and~~ who no longer operate ~~plants~~ facilities or systems within the boundaries of the state are ~~not compelled to be active in~~ exempt from the continuing education credit requirements. They may maintain valid North Dakota operator's certificates by paying the required annual renewal fees. If they return to work as an operator in the state ~~as a transient or permanent resident~~, the continuing education credit requirements are in effect. ~~All certified North Dakota operators presently not living in the state (this includes military personnel)~~ and they must earn the required number of training credits ~~commensurate with certification grade level~~ during their first year upon returning to North Dakota.

e. A certified operator not in compliance with the continuing education credit requirements, as determined by the department ~~and reviewed by the board of certification~~, is subject to revocation or suspension of the operator's certification.

~~The department may revoke or suspend the certificate of an operator issued hereunder if it is found that the operator has practiced fraud or deception in obtaining the certificate or in the performance of the operator's duty as an operator; or when it is found that reasonable care, judgment, or the application of the operator's knowledge or ability was not used in the performance of the operator's duties; or when it is found that the operator is incompetent and unable properly to perform the operator's duties as an operator. No certificate may be revoked or suspended except after a hearing before the chief, environmental health and engineering services, state department of health and consolidated laboratories, or the chief's designated representative. If a certificate is suspended or revoked as herein provided, a new application for certification may be considered by the department if, when, and after the conditions upon which suspension or revocation was based have been corrected and~~

~~evidence of this fact has been satisfactorily submitted to the department. A new certificate may then be granted by the department.~~

3. Certificates ~~expire annually~~ are valid for a maximum of one year and expire on the first day of July ~~or at a date one year after issuance~~. Certificates which have been revoked for a cause, invalidated, or replaced by one of higher grade are not renewable, except as noted in this chapter. Annual certificate renewal cards must be issued by the department upon receipt of the renewal fee as previously set forth.

4. An operator whose certification is invalidated because of failure to renew may apply for renewal within one year following the certificate's expiration date. The operator may be issued a certificate of the same category, grade, and classification if the request for renewal is received by the department within one year after the expiration date of the certificate, the continuing education requirements are satisfied, and all delinquent fees are paid. Failure to renew certification for a period of more than one year following expiration of the certificate will require requalification by reapplication, reexamination, and payment of examination fees before recertification is granted.

5. ~~To become certified in a higher grade level of the same category, certified operators shall satisfy the qualifications, application, and examination requirements of the new grade and, upon receipt of the proper certification fee by the department, a new certificate for the new grade must be issued to the operator.~~

~~6.~~ Certificates remain valid as long as the operator exercises reasonable care and judgment in the application of duties and satisfies the continuing education and annual renewal requirements as previously set forth. Certificates may be revoked as provided in North Dakota Century Code chapter 23-26. No certificate will be valid if obtained through fraud, deceit, misrepresentation, or the submission of false or inaccurate data, information, or qualifications.

~~7.~~ 6. The department may issue certificates by reciprocity, without written examination, to any person holding a certificate from any other state, territory, possession of the United States of America, or any country providing that the requirements for certification of operators under which the operator's certificate was issued are equal to or higher than specified under this chapter for a like certificate and providing further that reciprocal privileges are granted to certified operators in North Dakota.

~~8.~~ 7. ~~Certification certificates~~ Certificates in an appropriate category, grade, and classification may be issued without

examination to qualifying operators as provided by North Dakota Century Code chapter 23-26.

~~9.~~ 8. A temporary restricted operator's permit may be issued by the department upon application by the facility or system owner on behalf of the operator where circumstances may exist to warrant issuance. A temporary restricted operator's permit will be valid for one year from the date of issuance. When the operator satisfies the minimum grade level qualifications and requirements for certification, the operator shall submit an application for certification to the department and write the appropriate category and class examination during the first examination session offered by the department following the date of application.

9. The department may revoke or suspend the certificate of an operator issued hereunder if it is found by the department that the operator has practiced fraud or deception by willfully changing records or by omission, or knowingly giving false information to the department, or failed to take corrective action required by the department, or failed to take required samples, or failed to protect the public health or the state's water resources; or when it is found that reasonable care, judgment, or the application of the operator's knowledge or ability was not used in the performance of the operator's duties. A certificate may not be revoked or suspended except after a hearing before the department. If a certificate is suspended or revoked as herein provided, a new application for certification may be considered by the department if, when, and after the conditions upon which suspension or revocation was based have been corrected and evidence of this fact has been satisfactorily submitted to the department. A new certificate may then be granted by the department.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-05, 23-26-07

33-19-01-08. Water treatment facility classifications. Water treatment facilities must be classified in one of ~~four~~ five classes. Classifications must be based on population served, design population, type of treatment ~~facility~~, raw water quality and volume of water to be treated, and complexity of sludge handling units. Facilities may be classified one level higher than indicated solely by population at the discretion of the department if the facility has special design features or complex features or characteristics unusually difficult to operate, by reason of raw water unusually difficult to treat, by reason of volume of water treated, or by reason of a combination of such conditions or circumstances.

1. Class IA. All water facilities using simple chemical or physical treatment processes and designed to serve a population of less than five hundred persons.

2. Class I. All water facilities using chemical treatment processes and designed to serve a population of ~~less than~~ five hundred to five thousand persons. This will include water facilities utilizing ~~chlorination~~ disinfection, fluoridation, corrosion control, ~~sequesting~~ sequestering, or combinations of these processes or other processes that involve simple chemical addition and a minor degree of operational control.

~~2.~~ 3. Class II.

a. All water facilities using chemical treatment processes and designed to serve a population of five thousand to fifteen thousand persons. This will include water facilities utilizing ~~chlorination~~ disinfection, fluoridation, corrosion control, sequestering, or combinations of these processes or other processes that involve simple chemical addition and a moderate degree of operational control.

b. All water plants using chemical softening processes and filtration requiring a moderate degree of operational control serving a population of less than one thousand persons.

c. All water plants using coagulation, sedimentation, and filtration for clarification requiring a moderate degree of operational control serving a population of less than one thousand five hundred persons.

d. All water plants using chemical oxidation of iron or manganese and filtration requiring a moderate degree of operational control serving a population of less than two thousand persons.

e. All water plants using processes requiring a moderate degree of operational control but not listed in subdivisions b, c, and d and serving a population of less than two thousand persons.

~~3.~~ 4. Class III.

a. All water facilities using chemical treatment processes and designed to serve a population of fifteen thousand persons or more. This will include water facilities utilizing ~~chlorination~~ disinfection, fluoridation, corrosion control, sequestering, or combinations of these processes or other processes that involve simple chemical addition and a high degree of operational control.

b. All water plants using chemical softening processes and filtration requiring a high degree of operational control serving a population of one thousand to five thousand persons.

c. All water plants using coagulation, sedimentation, and filtration for clarification requiring a high degree of operational control serving a population of one thousand five hundred to ten thousand persons.

d. All water plants using chemical oxidation of iron or manganese and filtration requiring a high degree of operational control serving a population of two thousand to fifteen thousand persons.

e. All water plants using processes requiring a high degree of operational control but not listed in subdivisions b, c, and d and serving a population of two thousand to fifteen thousand persons.

~~4.~~ 5. Class IV.

a. All water plants using chemical softening processes and filtration requiring a high degree of operational control serving a population of five thousand or more persons.

b. All water plants using coagulation, sedimentation, and filtration for clarification requiring a high degree of operational control serving a population of ten thousand or more persons.

c. All water plants using chemical oxidation of iron or manganese and filtration requiring a high degree of operational control serving a population of fifteen thousand or more persons.

d. All water plants using processes requiring a high degree of operational control but not listed in subdivisions a, b, and c and serving a population of fifteen thousand or more persons.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-03, 23-26-07

33-19-01-08.1. Water distribution and storage system classifications. Water distribution and storage systems must be classified in one of ~~four~~ five classes. Classifications must be based on population served, design population, type of distribution and storage system, and the volume of water to be handled. Systems may be classified one level higher than indicated solely by population at the discretion of the department by reason of the incorporation in the

system of special design features or complex features or characteristics unusually difficult to operate, by reason of conditions of volume and flow, or by reason of a combination of such conditions and circumstances.

1. Class IA. All water distribution and storage systems serving a population of less than five hundred persons.

2. Class I. All water distribution and storage systems serving a population of ~~less than~~ five hundred to one thousand five hundred persons.

~~2.~~ 3. Class II. All water distribution and storage systems serving a population of one thousand five hundred to fifteen thousand persons.

~~3.~~ 4. Class III. All water distribution and storage systems serving a population of fifteen thousand to fifty thousand persons.

~~4.~~ 5. Class IV. All water distribution and storage systems serving a population of fifty thousand persons or more.

History: Effective June 1, 1990; amended effective February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-03, 23-26-07

33-19-01-09. Wastewater treatment facility classifications. Wastewater treatment facilities must be classified in one of ~~four~~ five classes. Classifications must be based on population served, design population, type of treatment ~~works~~, character and volume of wastes to be treated, and the use and nature of the water resources receiving the facility effluent. Facilities may be classified one level higher than indicated solely by population at the discretion of the department if the facility has special design features or complex features or characteristics unusually difficult to operate, by reason of a waste unusually difficult to treat, by reason of conditions of flow, or by reason of the receiving water quality classification requiring an unusually high degree of facility operational control, or by reason of a combination of such conditions or circumstances.

1. Class IA. All wastewater stabilization ponds, land treatment facilities, wetlands treatment facilities, or other nonmechanical facilities requiring a minor degree of operational control serving a population equivalent of less than five hundred persons.

2. Class I. All wastewater stabilization ponds, land treatment facilities, wetlands treatment facilities, or other nonmechanical facilities requiring a minor degree of operational control serving a population equivalent of five hundred to less than ten thousand persons.

~~2.~~ 3. Class II.

a. All mechanical facilities, mechanically aerated stabilization ponds, oxidation ditches, or other facilities requiring a moderate degree of operational control serving a population equivalent of less than ten thousand persons.

b. All wastewater stabilization ponds, land treatment facilities, wetlands treatment facilities, or other nonmechanical facilities requiring a minor degree of operational control serving a population equivalent of ten thousand persons or more.

~~3.~~ 4. Class III.

a. All mechanical facilities, mechanically aerated stabilization ponds, oxidation ditches, or other facilities requiring a moderate degree of operational and laboratory control serving a population equivalent of ten thousand persons or more.

b. All activated sludge facilities, trickling filter facilities, rotating biological contactor facilities, separate sludge stabilization facilities, or other mechanical facilities requiring a high degree of operational and laboratory control serving a population equivalent of less than ten thousand persons.

~~4.~~ 5. Class IV. All activated sludge facilities, trickling filter facilities, rotating biological contactor facilities, separate sludge stabilization facilities, or other mechanical facilities requiring a high degree of operational and laboratory control serving a population equivalent of ten thousand persons or more.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-03, 23-26-07

33-19-01-09.1. Wastewater collection and transfer system classifications. Wastewater collection and transfer systems must be classified in one of ~~four~~ five classes. Classifications must be based on population served, design population, type of collection and transfer system, and the character and volume of wastes to be handled. Systems may be classified one level higher than indicated solely by population at the discretion of the department by reason of the incorporation in the system of special design features or complex features or characteristics unusually difficult to operate, by reason of conditions of flow, or by reason of a combination of such conditions and circumstances.

1. Class IA. All wastewater collection and transfer systems serving a population of less than five hundred persons.

2. Class I. All wastewater collection and transfer systems serving a population of ~~less than~~ five hundred to one thousand five hundred persons.

~~2.~~ 3. Class II. All wastewater collection and transfer systems serving a population of one thousand five hundred to fifteen thousand persons.

~~3.~~ 4. Class III. All wastewater collection and transfer systems serving a population of fifteen thousand to fifty thousand persons.

~~4.~~ 5. Class IV. All wastewater collection and transfer systems serving a population of fifty thousand persons or more.

History: Effective June 1, 1990; amended effective February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-03, 23-26-07

33-19-01-10. Change of classification. Classification of any treatment facility or distribution and storage or collection and transfer system may be changed at the discretion of the department by reason of changes in any condition or circumstance on which the original classification was based. The department shall provide notice of any classification change to the owner of the facility or system.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-03, 23-26-07

33-19-01-11. Certification requirements.

1. Operator certification is mandatory for all persons ~~employed~~ in direct responsible charge of the operation or maintenance of water treatment facilities, water distribution and storage systems, wastewater treatment facilities, or wastewater collection and transfer systems as required by ~~subsection 8 of~~ North Dakota Century Code section ~~23-26-07~~ 23-26-08 and applicable federal laws and regulations.

2. ~~Four~~ Five grades of operators for water treatment facilities, water distribution and storage systems, wastewater treatment facilities, and wastewater collection and transfer systems are hereby established. To qualify for certification in a given grade, an applicant must satisfy the education and experience requirements, or their equivalents, of the grade for which the certification application is submitted.

3. All applicants must pass a certification examination~~, with a score of seventy percent or greater,~~ as developed and administered by the department for the class of facility or system for which the certification application is submitted~~, except those operators qualifying for certification as specified in North Dakota Century Code section 23-26-05~~.

~~4. The following operator grade level qualifications are intended to be compatible with and correspond to the facility or system classification of the same class level.~~

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-05, 23-26-07

33-19-01-12. ~~Water treatment facility operator~~ Operator qualifications. The following grade qualifications are intended to be as nearly compatible as possible to the corresponding ~~plant~~ facility or system classification.

1. Grade IA.

   a. Completion of high school or equivalent, and a minimum of six months of acceptable operation of a facility or system of class IA or higher.

   b. A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for minimum experience requirements, unless an exception is granted under section 33-19-01-07.

2. Grade I.

   a. ~~Post high school education in the allied sciences and a minimum one year of acceptable operation of water treatment facilities of class I or higher;~~

   ~~b.~~ Completion of high school or equivalent, and a minimum one year of acceptable operation of a ~~water treatment~~ facility ~~of~~ or system class I or higher; or

   ~~c.~~ b. A combination of education qualifications and experience that will be satisfactory to the department. No substitute ~~shall~~ may be permitted for minimum experience requirements, unless an exception is granted under section 33-19-01-07.

~~2.~~ 3. Grade II.

   a. A four-year college degree ~~in civil, sanitary, environmental, or chemical engineering or allied sciences~~

and a minimum one year of acceptable operation of ~~water treatment facilities~~ a facility or system of class I or higher, one year of which must have been in a position of direct responsible charge;

b. Two years post high school education ~~in the allied sciences~~ and a minimum two years of acceptable operation of ~~water treatment facilities~~ a facility or system of class I or higher, one year of which must have been in a position of direct responsible charge;

c. Completion of high school or equivalent, and a minimum three years of acceptable operation of ~~water treatment facilities~~ a facility or system of class I or higher, one year of which must have been in a position of direct responsible charge; or

d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute ~~shall~~ may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.

~~3.~~ 4. Grade III.

a. A four-year college degree ~~in civil, sanitary, environmental, or chemical engineering or allied sciences~~ and a minimum two years of acceptable operation of ~~water treatment facilities~~ a facility or system of class II or higher, ~~one year~~ two years of which must have been in a position of direct responsible charge;

b. Two years post high school education ~~in the allied sciences~~ and a minimum three years of acceptable operation of ~~water treatment facilities~~ a facility or system of class II or higher, two years of which must have been in a position of direct responsible charge;

c. Completion of high school or equivalent, and a minimum ~~five~~ four years of acceptable operation of ~~water treatment facilities~~ a facility or system of class II or higher, two years of which must have been in a position of direct responsible charge; or

d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute ~~shall~~ may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.

~~4.~~ 5. Grade IV.

a. A four-year college degree ~~in civil, sanitary, environmental, or chemical engineering or allied sciences~~ and a minimum three years of acceptable operation of ~~water treatment facilities~~ a facility or system of class III or higher, two years of which must have been in a position of direct responsible charge;

b. Two years of post high school education ~~in civil, sanitary, environmental, or chemical engineering or allied sciences~~ and a minimum ~~five~~ four years of acceptable operation of ~~water treatment facilities~~ a facility or system of class III or higher, two years of which must be in a position of direct responsible charge;

c. ~~Graduation from an accredited~~ Completion of high school or equivalent ~~with special training in chemistry, bacteriology, and hydraulics~~ and a minimum ~~seven~~ five years of acceptable operation of ~~water treatment facilities~~ a facility or system of class III or higher, ~~three~~ two years of which must have been in a position of direct responsible charge; or

d. A combination of ~~educational~~ education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-03, 23-26-05, 23-26-07

33-19-01-13. Water distribution system operator qualifications.

~~1. Grade I.~~

~~a. Post high school education in the allied sciences or trades and a minimum one year of acceptable operation of water distribution system of Class I or higher;~~

~~b. Completion of high school or equivalent, and a minimum one year of acceptable operation of a water distribution system of Class I or higher; or~~

~~c. A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for minimum experience requirements unless an exception is granted under section 33-19-01-07.~~

~~2. Grade II.~~

a. A four-year college degree in civil, sanitary, mechanical, or environmental engineering or allied sciences and a minimum one year of acceptable operation of water distribution system of Class I or higher, one year of which must have been in a position of direct responsible charge;

b. Two years post high school education in the allied sciences or trades and a minimum two years of acceptable operation of water distribution systems of Class I or higher, one year of which must have been in a position of direct responsible charge;

c. Completion of high school or equivalent, and a minimum three years of acceptable operation of water distribution systems of Class I or higher; or

d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.

3. Grade III.

a. A four-year college degree in civil, sanitary, mechanical, or environmental engineering or allied sciences and a minimum two years of acceptable operation of water distribution system of Class II or higher, one year of which must have been in a position of direct responsible charge;

b. Two years post high school education in the allied sciences or trades and a minimum three years of acceptable operation of water distribution systems of Class II or higher, two years of which must have been in a position of direct responsible charge;

c. Completion of high school or equivalent, and a minimum five years of acceptable operation of water distribution systems of Class II or higher, two years of which must have been in a position of direct responsible charge; or

d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.

4. Grade IV.

a. A four-year college degree in civil, sanitary, mechanical, or environmental engineering or allied sciences and a

~~minimum three years of acceptable operation of water distribution systems of Class III or higher, two years of which must have been in a position of direct responsible charge;~~

~~b. Two years of post high school education in civil, sanitary, mechanical, or environmental engineering or allied sciences and trades and a minimum five years of acceptable operation of water distribution systems of Class III or higher, two years of which must be in a position of direct responsible charge;~~

~~c. Graduation from an accredited high school or equivalent with special training in pipeline construction, mechanical trades, and hydraulics and a minimum seven years of acceptable operation of water distribution systems of Class III or higher, three years of which must have been in a position of direct responsible charge; or~~

~~d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.~~ Repealed effective February 1, 1994.

History: ~~Amended effective June 1, 1990.~~
General Authority: ~~NDCC 23-26-07~~
Law Implemented: ~~NDCC 23-26-07~~

33-19-01-14. Wastewater treatment facility operator qualifications.

~~1. Grade I.~~

~~a. Post high school education in the allied sciences and a minimum one year of acceptable operation of wastewater treatment facility of Class I or higher;~~

~~b. Completion of high school or equivalent, and a minimum one year of acceptable operation of a wastewater treatment facility of Class I or higher; or~~

~~c. A combination of education qualifications and experience that will be satisfactory to the department. No substitute shall be permitted for minimum experience requirement unless an exception is granted under section 33-19-01-07.~~

~~2. Grade II.~~

~~a. A four-year college degree in civil, sanitary, environmental, or chemical engineering or allied sciences~~

and a minimum one year of acceptable operation of wastewater treatment facility of Class I or higher, one year of which must have been in a position of direct responsible charge;

b. Two years post high school education in the allied sciences and a minimum two years of acceptable operation of wastewater treatment facility of Class I or higher, one year of which must have been in a position of direct responsible charge;

c. Completion of high school or equivalent, and a minimum three years of acceptable operation of wastewater treatment facilities of Class I or higher; or

d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute shall be permitted for the minimum experience requirement unless an exception is granted under section 33-19-01-07.

3. Grade III.

a. A four-year college degree in civil, sanitary, environmental, or chemical engineering or allied sciences and a minimum two years of acceptable operation of wastewater treatment facilities of Class II or higher, one year of which must have been in a position of direct responsible charge;

b. Two years post high school education in the allied sciences and a minimum three years of acceptable operation of wastewater treatment facilities of Class II or higher, two years of which must have been in a position of direct responsible charge;

c. Completion of high school or equivalent, and a minimum five years of acceptable operation of wastewater treatment facilities of Class II or higher, two years of which must have been in a position of direct responsible charge; or

d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute shall be permitted for the minimum experience requirement unless an exception is granted under section 33-19-01-07.

4. Grade IV.

a. A four-year college degree in civil, sanitary, environmental, or chemical engineering or allied sciences and a minimum three years of acceptable operation of wastewater treatment facilities of Class III or higher,

~~two years of which must have been in a position of direct responsible charge;~~

~~b. Two years of post high school education in civil, sanitary, environmental, or chemical engineering or allied sciences and a minimum five years of acceptable operation of wastewater treatment facilities of Class III or higher, two years of which must have been in a position of direct responsible charge;~~

~~c. Graduation from an accredited high school or equivalent with special training in microbiology, chemistry, and hydraulics and a minimum seven years of acceptable operation of wastewater treatment facilities of Class III or higher, three years of which must have been in a position of direct responsible charge; or~~

d. ~~A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.~~ Repealed effective February 1, 1994.

History: ~~Amended effective June 1, 1990.~~
General Authority: ~~NDCC 23-26-07~~
Law Implemented: ~~NDCC 23-26-07~~

33-19-01-15. Wastewater collection system operator qualifications.

~~1. Grade I.~~

~~a. Post high school education in the allied sciences or trades and a minimum one year of acceptable operation of wastewater collection system of Class I or higher;~~

~~b. Completion of high school or equivalent, and a minimum one year of acceptable operation of a wastewater collection system of Class I or higher; or~~

~~c. A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for minimum experience requirements unless an exception is granted under section 33-19-01-07.~~

~~2. Grade II.~~

~~a. A four-year college degree in civil, sanitary, mechanical, or environmental engineering or allied sciences and a minimum one year of acceptable operation of wastewater~~

collection system of Class I or higher, one year of which must have been in a position of direct responsible charge;

b. Two years post high school education in the allied sciences or trades and a minimum two years of acceptable operation of wastewater collection system of Class I or higher, one year of which must have been in a position of direct responsible charge;

c. Completion of high school or equivalent, and a minimum three years of acceptable operation of wastewater collection systems of Class I or higher; or

d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute shall be permitted for the minimum experience requirement unless an exception is granted under section 33-19-01-07.

3. Grade III.

a. A four-year college degree in civil, sanitary, mechanical, or environmental engineering or allied sciences and a minimum two years of acceptable operation of wastewater collection system of Class II or higher, one year of which must have been in a position of direct responsible charge;

b. Two years post high school education in the allied sciences or trades and a minimum three years of acceptable operation of wastewater collection system of Class II or higher, two years of which must have been in a position of direct responsible charge;

c. Completion of high school or equivalent, and a minimum five years of acceptable operation of wastewater collection system of Class II or higher, two years of which must have been in a position of direct responsible charge; or

d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.

4. Grade IV.

a. A four-year college degree in civil, sanitary, mechanical, or environmental engineering or allied sciences and a minimum three years of acceptable operation of wastewater collection systems of Class III or higher, two years of which must have been in a position of direct responsible charge;

~~b. Two years of post high school education in civil, sanitary, mechanical, or environmental engineering or allied sciences and trades and a minimum five years of acceptable operation of wastewater collection systems of Class III or higher, two years of which must have been in a position of direct responsible charge;~~

~~c. Graduation from an accredited high school or equivalent with special training in pipeline construction, mechanical trades, and hydraulics and a minimum seven years of acceptable operation of wastewater collection systems of Class III or higher, three years of which must have been in a position of direct responsible charge; or~~

~~d. A combination of education qualifications and experience that will be satisfactory to the department. No substitute may be permitted for the minimum experience requirement, unless an exception is granted under section 33-19-01-07.~~ Repealed effective February 1, 1994.

History: ~~Amended effective June 1, 1990.~~
General Authority: ~~NDCC 23-26-07~~
Law Implemented: ~~NDCC 23-26-07~~

33-19-01-16. Substitutions or equivalents. In determining the qualifications of operators desiring to be certified, the following substitutions or equivalents may be used:

1. One year of acceptable operating experience may be considered equivalent to one year of high school.

2. Experience applied to the educational requirement may not also be applied to the experience requirement.

3. An acceptable high school equivalency certificate may be used to substitute for graduation from high school.

4. No substitutions or equivalents will be allowed in lieu of the minimum acceptable experience in the operation of water treatment, water distribution and storage, wastewater treatment, and wastewater collection and transfer facilities or systems.

5. The department may waive the experience requirements in an exceptional set of circumstances~~, with the advice and assistance of the board~~.

History: Amended effective June 1, 1990; February 1, 1994.
General Authority: NDCC 23-26-07
Law Implemented: NDCC 23-26-03, 23-26-07

CHAPTER 33-34-01

NORTH DAKOTA GASOLINE SPECIFICATIONS

TEST	MOTOR ~~a~~	~~b~~	~~c~~	~~d~~
Water and Sediment.	~~None~~	~~None~~	~~None~~	None
Color, Dye.	~~e~~	~~e~~	~~e~~	~~e~~ a
~~Dye Content~~				
Antiknock Compound g/gal. max	~~f~~	~~f~~	~~f~~	~~f~~ b
Distillation Test				
10 percent Evap. degrees F. max . . .	122[c]	131[d]	140[e]	~~140~~ 158[f]
50 percent Evap. degrees F. min . . .	170	170	170	170
50 percent Evap. degrees F. max . . .	230	235	240	~~240~~ 250
90 percent Evap. degrees F. max . . .	365	365	365	~~365~~ 374
End Point degrees F. max.	437	437	437	437
Residue percent max	~~2~~	~~2~~	~~2~~	2
Vapor Pressure g (Reid) lbs. max. . . .	15.0[c]	13.5[d]	11.5[e]	~~10.5~~ 9.0[f]
Vapor/Liquid Ratio				
Minimum Test Temp. degrees F.	105[h]	116[i]	124[j]	~~124~~ 133[k]
V/L max	20	20	20	20
Corrosion (copper strip) max.	~~No. 1~~	~~No. 1~~	~~No. 1~~	No. 1
Sulfur percent max (lead free gasolines)	~~0.1~~	~~0.1~~	~~0.1~~	0.1
Sulfur percent max (leaded gasolines).	~~0.15~~	~~0.15~~	~~0.15~~	0.15
Gum, mgs/100 ml max	~~5~~	~~5~~	~~5~~	5
Knock Value				
Motor and Research Octane No., min. .	~~e~~	~~e~~	~~e~~	~~e~~ a
~~Octane Number Lean Rating, min.~~	——	——	——	——
~~Octane Number Rich Rating, min.~~	——	——	——	——

NORTH DAKOTA GASOLINE SPECIFICATIONS (Continued)

TEST	STOVE AND LIGHT	AVIATION 80	AVIATION 100	AVIATION 100LL
Water and Sediment	None			
Color Saybolt, min.	15			
Color, Dye	None	Red(k l)	Green	Blue
Dye Content				
Permissible blue dye (f m) max. mg/gal		0.5	4.7	5.7
Permissible yellow dye (g n) max. mg/gal		None	5.9	None
Permissible red dye (h o) max. mg/gal		8.65	None	None
Antiknock Compound (j p) ml/gal. max	Trace	0.5(j p)	4.0	2.0
Distillation Test				
10 percent Evap. degrees F. max	158	167	167	167
50 percent Evap. degrees F. max	266	221	221	221
90 percent Evap. degrees F. max	365	275	275	275
End Point degrees F. max.	---	338	338	338
Sum of 10 and 50 degrees F Evap. Points degrees F. min	---	307	307	307
Distillation Recovery percent min	---	97	97	97
Residue percent max	2	1.5	1.5	1.5
Loss percent max.	---	1.5	1.5	1.5
Vapor Pressure (Reid) lbs. max.	10	7.0	7.0	7.0
min.	---	5.5	5.5	5.5
Corrosion (copper strip) max.	None	No. 1	No. 1	No. 1
Sulfur percent max (leaded gasolines)	---	0.05	0.05	0.05
Potential Gum (m g) (5 hr. aging gum) max. mg/per 100 ml.	---	6	6	6
Freezing Point degrees F. max	---	-72	-72	-72
Net Heat of Combustion min. BTU/lb	---	18.720	18.720	18.720
Visible Lead Precipitate (n r) max. mg/100 ml.	---	3	3	3

Water Reaction.	---	Volume change not to exceed (+)(-) 2 ml		
Permissible antioxidants (σ s) max. lb/1000 bbl.	---	4.2	4.2	4.2
Knock Value				
Octane Number Lean Rating, min. . . .	---	80	100	100
Octane Number Rich Rating, min. . . .	---	87	+	+
Performance number, min	---	---	130	130
Oxidation stability, Minutes min. . . .	480	---	---	---

FOOTNOTES TO NORTH DAKOTA GASOLINE SPECIFICATIONS

a. ~~Applies to gasoline sold during the months of January, February, March, November, and December.~~ The minimum octane for premium gasoline shall be 91 as determined by the sum of the research method plus the motor method all divided by two ((R+M)/2). The minimum octane for super or midgrade gasoline shall be 89 as determined by the sum of the research method plus the motor method all divided by two ((R+M)/2). The minimum octane for leaded and unleaded gasoline shall be 87 as determined by the sum of the research method plus the motor method all divided by two ((R+M)/2). A person may not sell gasoline in any manner, including coloring, which deceives, tends to deceive, or has the effect of deceiving the purchaser as to grade or type.

b. ~~Applies to gasoline sold during the months of March, April, October, and November.~~ The lead content of gasoline must be in accordance with environmental protection agency requirements.

c. ~~Applies to gasoline sold during the months of April, May, June, September, and October.~~ Applies to gasoline sold during the months of January, February, March, November, and December.

d. ~~Applies to gasoline sold during the months of May, June, July, August, and September.~~ Applies to gasoline sold during the months of March, April, October, and November.

e. ~~The minimum octane for premium gasoline shall be 91 as determined by the sum of the Research Method plus the Motor Method all divided by two ((R+M)/2). The minimum octane for super or midgrade gasoline shall be 89 as determined by the sum of the Research Method plus the Motor Method all divided by two ((R+M)/2). The minimum octane for leaded and unleaded gasoline shall be 87 as determined by the sum of the Research~~

~~Method plus the Motor Method all divided by two ((R+M)/2). No person shall sell gasoline in any manner, including coloring, which shall deceive, tend to deceive, or has the effect of deceiving the purchaser as to grade or type.~~ Applies to gasoline sold from September sixteenth through the month of October.

f. ~~The only blue dye which shall be present in the finished gasoline shall be essentially 1, 4 dialkylaminoantraquinone.~~ Applies to gasoline sold during the months of April, May, June, July, and August and September first through September fifteenth. For the month of May, the specification only applies to gasoline and gasoline-oxygenate blend tankage at refineries, importers, pipelines, and terminals.

g. ~~The only yellow dye which shall be present in the finished gasoline shall be essentially p-diethylaminoazobenzene (Color Index No. 11020).~~ North Dakota and environmental protection agency regulations allow 1.0 pounds per square inch higher vapor pressure for gasoline-ethanol blends containing 9 to 10 volume percent ethanol for the same period.

h. ~~The only red dye which shall be present in the finished gasoline shall be essentially methyl derivatives of azobenzene 4 azo 2 naphthol (methyl derivatives of Color Index No. 26105) or alkyl derivatives of azobenzene 4 azo 2 naphthol.~~ Applies to gasoline sold during the months of January, February, March, November, and December.

i. ~~The lead content of gasoline shall be in accordance with environmental protection agency requirements.~~ Applies to gasoline sold during the months of March, April, May, October, and November.

j. ~~The tetraethyllead shall be added in the form of an aviation antiknock mixture containing not less than 61 percent by weight of tetraethyllead and sufficient ethylene dibromide to provide two bromine atoms per atom of lead. The balance shall contain no added ingredients other than kerosene, and approved inhibitors, and blue dye, as specified, herein.~~ Applies to gasoline sold during the months of June and October and during the period from September sixteenth through September thirtieth.

k. ~~If mutually agreed upon between purchaser and supplier, Grade 80 may be required to be free from tetraethyllead. In such case the fuel shall not contain any dye and color shall not be darker than +20 Saybolt.~~ Applies to gasoline sold during the months of July, August, and September.

l. ~~Vapor pressure shall follow the seasonal requirements for regular and premium gasoline.~~ If mutually agreed upon between

purchaser and supplier, grade 80 may be required to be free from tetraethyllead. In such case the fuel may not contain any dye and color may not be darker than +20 saybolt.

m. ~~If mutually agreed upon between purchaser and supplier, aviation gasoline may be required to meet a sixteen hour aging gum test instead of the five hour aging gum test. In some cases the gum content shall not exceed 10 mg per 100 ml and the visible lead precipitate shall not exceed 4 mg per 100 ml. In such fuel the permissible antioxidants shall not exceed 8.4 lb per 1000 bbl (42 gallons).~~ The only blue dye which may be present in the finished gasoline is essentially 1,4-dialkylaminoanthraquinone.

n. ~~The visible lead precipitate requirement applies only to leaded fuels.~~ The only yellow dye which may be present in the finished gasoline is essentially p-diethylaminoazobenzene (Color Index No. 11020).

o. ~~Permissible antioxidants are as follows:~~

~~N,N' diisopropyl para phenylenediamine~~
~~N,N' di secondary butyl para phenylenediamine~~
~~2,4 dimethyl 6 tertiary butylphenol~~
~~2,6 ditertiary butyl 4 methylphenol~~
~~2,6 ditertiary butylphenol~~

~~Mixed tertiary butylphenols, composition:~~

~~75 percent minimum 2,6 ditertiary butylphenol plus 25 percent max. tertiary and tritertiary butylphenols.~~ The only red dye which may be present in the finished gasoline is essentially methyl derivatives of azobenzene-4-azo-2-naphthol (methyl derivatives of Color Index No. 26105) or alkyl derivatives of azobenzene-4-azo-2-naphthol.

p. The tetraethyllead must be added in the form of an aviation antiknock mixture containing not less than 61 percent by weight of tetraethyllead and sufficient ethylene dibromide to provide two bromine atoms per atom of lead. The balance must contain no added ingredients other than kerosene, and approved inhibitors, and blue dye, as specified herein.

q. If mutually agreed upon between purchaser and supplier, aviation gasoline may be required to meet a sixteen-hour aging gum test instead of the five-hour aging gum test. In some cases the gum content may not exceed 10 mg per 100 ml and the visible lead precipitate may not exceed 4 mg per 100 ml. In such fuel the permissible antioxidants may not exceed 8.4 lb per 1000 bbl [42 gallons].

r. The visible lead precipitate requirement applies only to leaded fuels.

s. Permissible antioxidants are as follows:

N,N'-diisopropyl-para-phenylenediamine
N,N' di-secondary-butyl-para-phenylenediamine
2,4-dimethyl-6-tertiary-butylphenol
2,6-ditertiary-butyl-4-methylphenol
2,6-ditertiary butylphenol

Mixed tertiary butylphenols, composition:

Seventy-five percent minimum 2,6 ditertiary butylphenol plus twenty-five percent maximum tertiary and tritertiary butylphenols.

APRIL 1994

CHAPTER 33-04-13

DISCLOSURE OF RECORDS

[Repealed effective April 1, 1994]

STAFF COMMENT: Chapter 33-04-13.1 contains all new material but is not underscored so as to improve readability.

CHAPTER 33-04-13.1
DISCLOSURE OF RECORDS

33-04-13.1-01. Definitions.

1. "Guardian" means a person who has been appointed as legal guardian through some judicial process.

2. "Relative" means those connected by ties of consanguinity or affinity. Adopted children must be treated the same as

natural children for purposes of this definition and are not considered a relative of the natural parents or their relatives.

History: Effective April 1, 1994.
General Authority: NDCC 23-02.1-04, 28-32-02
Law Implemented: NDCC 23-02.1-27

33-04-13.1-02. General provisions.

1. In order to protect vital records from loss, mutilation, or destruction and to prevent improper disclosure of confidential information, a person may not be allowed direct actual physical access to the original vital records in the custody and care of the state and local registrars. Every person wishing to review records or desiring information contained in such records must make a request to the state or local registrars or their assistants. Each request must be reasonably particularized in scope.

2. Nothing in this section may be construed to permit disclosure of information contained in the "confidential information for medical and health use only" section of vital records unless specifically authorized by the state registrar for statistical research or if authorized by a court of competent jurisdiction.

3. The state registrar may furnish data from vital records for statistical research purposes, subject to such conditions as the state registrar may impose. Data may not be furnished from records under this subsection until the state registrar has prepared in writing the conditions under which the data will be used and received an agreement signed by a responsible agent of the research organization agreeing to meet with and conform to such conditions.

4. Upon written application by any local registrar, the state registrar may authorize, in written form, the local registrar to prepare and issue certified copies of original certificates of death and certificates of fetal death in the immediate possession of the local registrar. To ensure uniformity in the preparation and issuance of certified copies, the state registrar shall prescribe the format to be used for such certifications, the nature of the certification statements used, and the length of time for which original certificates of death and fetal death may be retained by the local registrar for purposes of issuance of certified copies. The state registrar may revoke such authorization for reasonable cause including actions inconsistent with North Dakota Century Code chapter 23-02.1 and rules adopted under that chapter.

History: Effective April 1, 1994.

General Authority: NDCC 23-02.1-04, 28-32-02
Law Implemented: NDCC 23-02.1-27

33-04-13.1-03. Certificates of birth, certificates of death, and certificates of fetal death.

1. Information on birth certificates and certificates of fetal death presumed to relate to births or fetal deaths which occurred out of wedlock may not be disclosed to persons other than to the child's guardian, to the person to whom the record relates if that person is at least eighteen years old, to the legal parent of the child, or upon order of a court of competent jurisdiction.

2. Information in vital records indicating cause of death may not be disclosed except to a relative or personal representative of the deceased, to the attorney or the agent of a relative or personal representative of the deceased, or upon order of a court of competent jurisdiction.

3. Whenever it is deemed necessary to establish an applicant's right to confidential information from vital records, the state registrar may require written application, identification of the applicant, or a sworn notarized statement. The state registrar may furnish information, at the written request of the applicant entitled to such information, to any person or agency designated by the applicant.

History: Effective April 1, 1994.
General Authority: NDCC 23-02.1-04, 28-32-02
Law Implemented: NDCC 23-02.1-27

CHAPTER 33-04-14
COPIES OF DATA FROM VITAL RECORDS

33-04-14-01. General provisions.

1. Full or short form certified copies of vital records may be made by mechanical, electronic, or other reproductive processes, except that information contained in the "confidential information for medical and health use only" section of vital records on birth and fetal death certificates shall not be included.

2. When a certified copy is issued, each certification shall be signed and certified as a true copy by the officer in whose custody the record is entrusted and shall include the date issued, the name of the issuing officer, the state registrar's signature or an authorized facsimile thereof (or the same for the deputy state registrar), and the seal of the issuing office shall be affixed thereon.

3. When the state registrar finds evidence that a certificate was registered through misrepresentation or fraud, the state registrar shall have authority to withhold the issuance of a certified copy of such certificate until a court determination of the facts has been made.

History: Amended effective April 1, 1994.
General Authority: NDCC 23-02.1-04, 28-32-02
Law Implemented: NDCC 23-02.1-28

STAFF COMMENT: Chapters 33-07-01.1 and 33-07-02.1 contain all new material but are not underscored so as to improve readability.

ARTICLE 33-07

LICENSING MEDICAL HOSPITALS

CHAPTER 33-07-01
HOSPITALS

[Superseded by Chapter 33-07-01.1]

CHAPTER 33-07-01.1
HOSPITALS

33-07-01.1-01. General provisions - Definitions.

1. Institutions covered by medical hospital licensure laws. The following types of institutions are covered by North Dakota Century Code chapter 23-16 for the purpose of rules and are deemed to come within the provisions of North Dakota Century Code section 23-16-01 which provides for licensure of any institution that maintains and operates organized facilities for the diagnosis, treatment, or care of two or more nonrelated persons suffering from illness, injury, or deformity or where obstetrical or other care is rendered over a period exceeding twenty-four hours:

   a. General acute, primary care, and specialized hospitals, including rehabilitation and psychiatric hospitals.

   b. Skilled nursing facilities and nursing facilities.

c. Outpatient facilities, including surgical centers and trauma centers, excluding physicians' clinics.

d. Maternity homes that receive more than one patient in six months.

2. Institutions not covered by medical hospital licensure laws. The following types of institutions that provide some medical or nursing service are deemed not to come within the provisions of North Dakota Century Code chapter 23-16:

a. Any institutions that are regularly licensed by the social service board of North Dakota, such as homes for unmarried mothers.

b. Federal and state institutions. For state institutions, the primary purpose of which is the provision of medical care, the department has the responsibility for inspection on the same basis as those institutions that are covered by North Dakota Century Code chapter 23-16. Upon the findings of such inspections, recommendations will be formulated by the department.

c. Chiropractic hospitals licensed under North Dakota Century Code chapter 23-17.

d. Homes in which the only persons receiving nursing care are those related to the householder by blood or marriage.

e. Homes in which only one person receives care at any one time.

3. An institution shall hold licensure in the same category for which it seeks federal certification.

4. The following terms are defined for purposes of this chapter and North Dakota Century Code chapter 23-16:

a. "Abuse" includes mental, physical, sexual, and verbal abuse which would result in temporary or permanent mental or physical injury, harm, or ultimately death. Mental abuse includes humiliation, harassment, threats of punishment, or deprivation. Physical abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Sexual abuse includes sexual harassment, sexual coercion, sexual contact, or sexual assault. Verbal abuse includes any use of oral, written, or gestured language that includes disparaging and derogatory terms to patients or their families used within their hearing distance to describe the patients, regardless of their age, ability to comprehend, or disability.

b. "Acute care" means care for an episode of illness, injury, deformity, or pregnancy which may have a rapid onset or be severe in nature or have a short duration which requires medical treatment and continuous nursing care in a hospital setting.

c. "Authentication" means identification of the individual who made the medical record entry by that individual in writing, and verification that the contents are what the individual intended.

d. "Bed capacity" is bed space designed for inpatient care, including space originally designed or remodeled for inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room is the maximum number for which adequate floor area is provided. In measuring the floor area of patient rooms for the purpose of determining bed capacity, only the net usable space in the room may be considered. Space in toilet rooms, washrooms, closets, vestibules, and corridors may not be counted.

(1) Areas to be included:

(a) Bed space in all nursing units, including:

[1] Intensive care or cardiac care units.

[2] Minimal or self-care units.

(b) Isolation units.

(c) Pediatrics units, including:

[1] Pediatric bassinets.

[2] Incubators located in the pediatrics department.

(d) Observation units equipped and staffed for overnight use.

(e) All space designed for inpatient bed care even if currently closed or assigned to easily convertible, nonpatient uses such as storage.

(f) Space in areas originally designed as solaria, waiting rooms, offices, conference rooms, classrooms, and such which have necessary fixed equipment (nurse's call, lighting, etc.) and are accessible to a nurse's station exclusively staffed for inpatient bed care.

(g) Bed space under construction if planned for immediate completion (not an unfinished "shell" floor).

(2) Areas to be included:

(a) Newborn nurseries in the obstetrical department.

(b) Labor and delivery rooms.

(c) Recovery rooms.

(d) Emergency units.

(e) Preparation or anesthesia induction rooms.

(f) Rooms designed for diagnostic or treatment procedures.

(g) Hospital staff sleeping quarters, including accommodations for oncall staff.

(h) Corridors.

(i) Solaria, waiting rooms, offices, conference rooms, classrooms, and such which are not readily equipped and staffed for inpatient bed care.

(j) Unfinished shell space. An area which is finished except for movable equipment shall not be considered unfinished space.

e. "Department" means the North Dakota state department of health and consolidated laboratories.

f. "Governing body" means the individual or group in whom the ultimate authority and legal responsibility is vested for the conduct of the institution.

g. "Hospital" means a facility that provides continuous nursing services, the principal activity or business of which is the reception of a person for diagnosis, medical care, and treatment of human illness to meet the needs of the patient served.

(1) "General acute hospital" means a facility with physician services available, permanent facilities that include inpatient beds, and continuous registered nurse staffing on a twenty-four-hour basis for treatment or care for illness, injury, deformity, abnormality, or pregnancy.

(a) In addition to medical staff and nursing services, the hospital shall regularly maintain either directly or through agreement the following services to meet the needs of the patients served:

[1] Dietary services.

[2] Medical records services.

[3] Pharmaceutical services.

[4] Laboratory services.

[5] Radiology services.

[6] Emergency services.

[7] Social services.

[8] Basic rehabilitation services.

[9] Housekeeping and related services including laundry.

[10] Central services.

(b) Complementary services are optional services which the hospital may provide and include:

[1] Nuclear medicine services.

[2] Surgical services.

[3] Recovery services.

[4] Anesthesia services.

[5] Respiratory care services.

[6] Obstetrical services.

[7] Specialized rehabilitation services.

[8] Psychiatric services.

(2) "Primary care hospital" means a facility that has available twenty-four-hour licensed health care practitioner and nursing services, provides inpatient care to ill or injured persons prior to their transportation to a general acute hospital, or provides inpatient care to persons needing acute-type

care for a period of no longer than an average of ninety-six hours.

(a) In addition to medical staff and nursing services, the hospital shall regularly maintain either directly or through agreement the following services to meet the needs of the patients served:

[1] Dietary services.

[2] Medical records services.

[3] Pharmaceutical services.

[4] Laboratory services.

[5] Radiology services.

[6] Emergency services.

[7] Social services.

[8] Basic rehabilitation services.

[9] Housekeeping and related services including laundry.

[10] Central services.

(b) Complementary services are optional services which the hospital may provide and include respiratory care services.

(3) "Specialized hospital" means a facility with hospital characteristics which provides medical care for persons with a categorical illness or condition.

(a) In addition to medical staff and nursing services, the hospital shall regularly provide directly or through agreement the following services to meet the needs of the patients served:

[1] Dietary services.

[2] Medical records services.

[3] Pharmaceutical services.

[4] Laboratory services.

[5] Radiology services.

[6] Emergency services.

[7] Social services.

[8] Basic rehabilitation services.

[9] Housekeeping and related services including laundry.

[10] Central services.

(b) Complementary services are optional services which the hospital may provide and include:

[1] Nuclear medicine services.

[2] Surgical services.

[3] Recovery services.

[4] Anesthesia services.

[5] Respiratory care services.

[6] Obstetrical services.

(c) Hospitals meeting the definition of a specialized hospital shall be licensed as such and may include the following:

[1] "Rehabilitation hospital" means a facility or unit providing specialized rehabilitation services to patients for the alleviation or amelioration of the disabling effects of illness or injury. Specialized rehabilitation services are characterized by the coordinated delivery of interdisciplinary care intended to achieve the goals of maximizing the self-sufficiency of the patient. A rehabilitation hospital is a facility licensed to provide only specialized rehabilitation services or is a distinct unit providing only specialized rehabilitation services located in a general acute hospital. A rehabilitation hospital must arrange to provide the services identified in section 33-07-01-35.

[2] "Psychiatric hospital" means a facility or unit providing psychiatric services to patients with a diagnosis of mental illness. A psychiatric hospital is a

hospital licensed to provide only psychiatric services or is a distinct unit providing only psychiatric services located in a general acute hospital. Psychiatric hospitals must provide services consistent with section 33-07-01-36.

h. "Licensee" means an individual, officer, or member of the governing body of a hospital or related institution.

i. "Licensed health care practitioner" means an individual who is licensed or certified to provide medical, medically related, or advanced registered nursing care to individuals in North Dakota.

j. "Medical staff" in general acute and specialized hospitals means a formal organization of physicians (and dentists) and may include other licensed health care practitioners with the delegated authority and responsibility to maintain proper standards of patient care and to plan for continued improvement of that care. Medical staff in primary care hospitals means one or more licensed health care practitioners with the delegated authority and responsibility to maintain proper standards of medical care and to plan for continued improvement of that care.

k. "Misappropriation of patient property" means the deliberate misplacement, exploitation, or wrongful temporary or permanent taking or use of a patient's belongings or money, or both.

l. "Neglect" includes one severe incident or a pattern of incidents of willful failure to carry out patient services as directed or ordered by the licensed health care practitioner, willful failure to give proper attention to patients, or failure to carry out patient services through careless oversight.

m. "Nursing facilities" are the following:

(1) "Basic care facility" means a facility consistent with North Dakota Century Code chapter 23-09.3 and North Dakota Administrative Code chapter 33-03-24.

(2) "Nursing facility" means a facility consistent with North Dakota Century Code chapter 23-16 and North Dakota Administrative Code chapters 33-07-03.1 and 33-07-04.1.

n. "Outpatient facility" (including ambulatory surgical centers and trauma centers - excluding physicians' clinic) means a facility, located in or apart from a hospital; providing community service for the diagnosis or diagnosis

and treatment of ambulatory patients (including ambulatory inpatients) in need of physical or mental care (see chapter 33-03-01):

(1) Which is operated in connection with a hospital; or

(2) Which offers to patients not requiring hospitalization the services of licensed health care practitioners in various medical specialties, and which makes provision for its patients to receive a reasonably full range of diagnostic and treatment services; and

(3) Which is subject to the requirements of chapter 33-03-01.

o. "Qualified activities coordinator" means a qualified therapeutic recreation specialist who is eligible for registration as a therapeutic recreation specialist by the national therapeutic recreation society (branch of national recreation and park association) under its requirements; is a qualified occupational therapist as defined in North Dakota Century Code chapter 43-40; is certified as an occupational therapist assistant; or has two years of experience in a social or recreational program within the last five years, one year of which was full-time employee in a patient activities program in a health care setting; or has completed a training course approved by the department.

p. "Separate license for building on separate premises" means, in the case of a hospital or related institution where two or more buildings are used in the housing of patients, a separate license is required for each building. Separate licenses are required even though the buildings may be operated under the same management.

q. "Signature" means the name of the individual written by the individual or an otherwise approved identification mechanism used by the individual which may include the approved use of a rubber stamp or an electronic signature.

r. "Writing" means the use of any tangible medium for entries into the medical record, including ink or electronic or computer coding, unless otherwise specifically required.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06, 31-08-01.2, 31-08-01.3

33-07-01.1-02. Issuance of license. The department shall issue licenses to hospitals that meet the licensing requirements. The license

must reflect the annual or provisional status of the hospital. The license applies only to the hospital designated on the license.

1. The department shall issue an annual license to a hospital when that hospital is in full compliance with the provisions of these licensing requirements, as determined by periodic onsite surveys conducted by the department, submission of the survey reports and other information from the accrediting agency, or both. Each license is valid only in the hands of the entity to whom it is issued and is not subject to sale, assignment, or other transfer, voluntary or involuntary, nor is a license valid for any premises other than those for which originally issued.

2. The department may issue a provisional license, valid for a specified period of time not to exceed ninety days, when there are numerous deficiencies or a serious specific deficiency in relationship to compliance with these licensing requirements.

   a. A provisional license may be renewed at the discretion of the department provided the licensee demonstrates to the department that it has made substantial progress towards compliance and can effect compliance within the next ninety days. A provisional license may be renewed no more than twice.

   b. Whenever any hospital that has been out of compliance, as determined by the department, notifies the department that it has completed a plan of correction and corrected its deficiencies, the department will review the plan and may conduct an onsite survey to ascertain completion of the plan of correction. Upon finding compliance, the department may issue an annual license.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-03. Waiver provision. Rules adopted under North Dakota Century Code chapter 23-16 may be waived by the department for a specified period in specific instances, provided such a waiver does not adversely affect the health and safety of the patients and if compliance with the requirement would result in unreasonable hardship upon the hospital. Requirements related to fire safety may only be considered for waiver by the department if approved in writing by the state fire marshal's office.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-04. Access by the department. Upon presenting identification to the hospital's chief executive officer or designee, authorized agents of the department shall have access to the hospital to determine compliance with licensure requirements. Such access includes:

1. Entry to all hospital premises.

2. Inspection and examination of all of the hospital's records and documents as required by this chapter.

3. Interviewing of any hospital staff, medical staff, or members of the governing body with their consent.

4. Examination of any patient and interview of any patient or the person with legal authority to act on behalf of the patient if this person is available at the facility at the time of the visit, with his or her consent.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-05. Continuing surveillance. At any time, the department may evaluate a hospital's compliance with these licensure requirements through an announced or unannounced onsite review scheduled at the discretion of the department.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-06. Hospitals accredited by nationally recognized accrediting agencies.

1. A hospital may request that the department consider it in compliance with this chapter if it is in compliance with the standards of a nationally recognized accrediting agency.

2. Hospitals requesting to be licensed through an accrediting agency shall initially submit to the department a copy of the entire accrediting agency survey report. Subsequent accreditation survey or revisit documentation must be submitted prior to licensure renewal. If an accreditation survey or revisit has not occurred since the prior licensure renewal, the hospital shall include notice of prior submission of required accreditation information at the time of annual licensure renewal.

3. Hospitals requesting licensure in accordance with national accreditation status shall comply with all requirements of this section. Licensure requirements not covered by the

standard survey of an accrediting agency may be monitored by the department.

4. Hospitals that receive a denial of accreditation from the accrediting agency are subject to an onsite survey by the department to determine compliance with the licensure requirements.

5. For hospitals that choose not to apply for a license through the accrediting procedure even though qualified to do so under this section, an onsite survey will be conducted by the department to determine compliance with the licensure requirements.

6. For those portions of the accrediting agency survey report which the department accepts, the hospital will be considered to be in compliance with the corresponding licensure requirements.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-07. Plans of correction.

1. Hospitals shall submit to the department plans of correction addressing the areas of noncompliance with the licensure requirements in this chapter.

2. Plans of correction are required within ten calendar days of receipt of the deficiency statement and are subject to acceptance, acceptance with revisions, or rejection by the department.

3. The department may require a directed plan of correction. A directed plan of correction is a plan of correction, submitted by a hospital in response to cited deficiencies, which has been developed in coordination with the department and has been accepted by the department.

4. Plans of correction must be completed within sixty days of the survey completion date, unless an alternative schedule of correction has been approved by the department.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-15-06

33-07-01.1-08. Enforcement.

1. Hospitals are subject to one or more enforcement actions, which may include a ban or limitation on admissions, suspension or revocation of a license, or a denial to license for the following reasons:

   a. Noncompliance to the licensure requirements in this chapter have been identified which:

      (1) Present imminent danger to patients;

      (2) Have a direct or immediate relationship to the health, safety, or security of the hospital's patients;

      (3) If left uncorrected, have a potential for jeopardizing patient health or safety if left uncorrected; or

      (4) Is a recurrence of the same or substantially same violation in a twenty-four-month period.

   b. Failure to correct any deficiency pursuant to a plan of correction, unless the department approves in writing an extension or modification of the plan of correction.

   c. Gross incompetence, negligence, or misconduct in operating the hospital as determined through department investigation or through a court of law.

   d. Fraud, deceit, misrepresentation, or bribery in obtaining or attempting to obtain a license.

   e. Lending, borrowing, or using the license of another hospital.

   f. Knowingly aiding or abetting in any way the improper granting of a license.

2. Conditions or practices which the department has determined to present an imminent danger to patients in the hospital must be abated or eliminated immediately or within a fixed period of time as specified by the department.

3. The department shall notify the hospital in writing when a decision is made to initiate a ban or limitation on admissions, a suspension or revocation of a license, or a denial to license. The notice must include the basis of the department's decision and must advise the hospital of the right to:

   a. Request a review by the department.

(1) The hospital's request for a review shall be made to the department in writing within thirty days from the date the department determined the hospital to be noncompliant with the licensure requirements as identified in subsection 1 unless imminent danger to the patients in the hospital has been identified. The request for a review must include documentation that assures the areas of noncompliance have been corrected and the dates this was achieved. Compliance must be achieved prior to the forty-fifth day to allow for completion of a revisit by the department by that date.

(2) If a request for an onsite review is made, the department shall review all material relating to the deficiencies specific to the basis on which the enforcement action has been made. The department shall determine, based on review of the material and an onsite revisit if necessary, whether or not to sustain the enforcement action.

b. Request a hearing before the health council on the department's decision to initiate a ban or limitation on admissions, a suspension or revocation of a license, or denial to license.

(1) The request for a hearing must be filed with the department in writing within sixty days from the date the department notified the hospital of the decision to initiate the enforcement action. A request for a review under subdivision a does not extend the time period in which the hospital must request a hearing before the health council under this subsection.

(2) The request for a hearing under this section must be accompanied by written documents including all of the following information:

(a) A copy of the notice received from the department.

(b) The reason or basis for the requested hearing.

(c) The statute or rule related to each disputed issue.

(d) The name, address, and telephone number of the person to whom all notices must be mailed or delivered regarding the requested hearing.

(3) Within ten days of receipt of the request for a hearing, the department shall request a hearing

officer from the office of administrative hearings as provided in North Dakota Century Code chapter 54-57.

(4) The hearing officer must make written findings of fact and conclusions of law, and must recommend a decision to the health council. The recommended decision must set forth the reasons for the decision and the evidence upon which the decision is based.

(5) The health council may accept, modify, or reject the recommended decision. If the health council rejects the recommended decision, it may remand the matter to the office of administrative hearings with directions. The health council, through its directions, may require the receipt of additional evidence, and submission of amended findings of fact, conclusions of law, and recommended decision which reflects consideration of additional evidence. The health council, through its directions, may require that the matter be referred to the same or a different hearing officer, and the office of administrative hearings shall comply with that direction unless compliance is impossible.

4. All enforcement determinations by the department to limit or ban admissions, revoke or suspend a license, or to deny a license become final within sixty days unless a request for a hearing before the health council has been filed by the hospital with the department. The enforcement action takes effect ninety days from the date on which the department notified the hospital of the decision to implement an enforcement action unless the hospital has requested a hearing.

5. The department may place a public notice in the newspapers in the area in which the hospital is located to notify the public of the enforcement action that is to be imposed and the effective dates. The department shall notify the hospital in writing of the impending public notice fifteen days prior to the publication of the notice.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-09. Governing body. The governing body is legally responsible for the quality of patient care services, for patient safety and security, for the conduct, operation, and obligations of the hospital as an institution, and for ensuring compliance with all federal, state, and local laws.

1. General acute hospital. The hospital must have a governing body legally responsible for directing the operation of the hospital in accordance with its mission. Hospitals operated by governmental organizations, with the exception of those sponsored by the federal government, shall provide written notification to the department of their designated governing bodies and the legal authority establishing these designations. No contracts, arrangements, or other agreements may limit or diminish the responsibility of the governing body in any way.

   a. The governing body, in order to achieve and maintain generally accepted standards of professional practice and patient care services in the hospital, shall establish, cause to implement, maintain, and, as necessary, revise its practices, policies, and procedures for the ongoing evaluation of the services operated or delivered by the hospital and for the identification, assessment, and resolution of problems that may develop in the conduct of the hospital.

   b. The governing body shall receive orientation and continuing education addressing the mission of the hospital, their roles and responsibilities, patients' rights, and the organization, goals, and operation of the hospital.

   c. The governing body shall adopt written bylaws reflecting its legal responsibility and accountability to the patients and its obligation to the community. The bylaws must specify at least the following:

      (1) The role and purpose of the hospital.

      (2) The duties and responsibilities of the governing body.

      (3) The responsibilities of any governing body committees, including the requirement that minutes reflect all business conducted, including findings, conclusions, and recommendations.

      (4) The relationships and responsibilities of the governing body, hospital administration, and medical staff, and the mechanism established by the governing body for holding such parties accountable.

      (5) The mechanisms for adopting, reviewing, and revising governing body bylaws.

      (6) The mechanisms for formal adoption of the organization, bylaws, rules, and regulations of the medical staff.

d. Meetings of the governing body must be held in order for the governing body to evaluate the conduct of the hospital, including the care and treatment of patients as well as its own performance. Based on these evaluations, the governing body shall take necessary actions sufficient to correct noted problems. A record of all governing body proceedings which reflects all business conducted, including findings, conclusions, and recommendations, must be maintained for review.

e. The governing body shall ensure the establishment and maintenance of a coordinated quality improvement program that integrates the review activities of all hospital services for the purpose of enhancing the quality of patient care.

f. The governing body shall ensure that policies and procedures are reviewed at a minimum of every three years and when changes in standards of practice occur and shall at a minimum include:

(1) Personnel records including application forms and verification of credentials where applicable.

(2) Periodic performance appraisals.

(3) Patient care needs and services as determined by the hospital.

(4) Patient rights to include at least the following and require that each patient admitted be notified of these rights.

(a) The right to considerate and respectful care.

(b) The right to treatment and services consistent with acceptable professional standards of practice.

(c) The right to make informed decisions involving care in collaboration with the licensed health care practitioner.

(d) The right to personal privacy and confidentiality of information.

(e) The right to review the patient's own medical record and to have information explained.

(f) The right to formulate advanced directives consistent with the federal Self Determination Act.

(g) The right to consent or decline to participate in proposed research studies.

(h) The right to expect reasonable continuity of care at the time when hospital care is no longer needed.

(i) The right to be informed of hospital policies and practices that relate to patient care, treatment, and responsibilities.

(j) The right to be free from abuse, neglect, and misappropriation of patient property.

(5) The orientation program for all new employees.

(6) The governing body shall ensure the establishment and maintenance of a risk management plan that includes a mechanism for reporting, investigating, acting on, and documenting incidents and identified risks.

(7) The transfer and discharge of patients, including discharge planning to meet the patients' needs.

(8) An effective procedure for reporting transfusion reactions and adverse drug reactions to the licensed health care practitioner. The governing body shall ensure that blood transfusions and intravenous medications are administered in accordance with state law.

(9) An effective disaster plan.

g. The governing body shall develop a procedure to ensure that all personnel for whom licensure or certification is required have a valid and current license or certificate.

h. The governing body shall take all appropriate and necessary actions to monitor and restore compliance when deficiencies with statutory or regulatory requirements are identified.

i. The governing body shall appoint a chief executive officer who is responsible to the governing body for the management of the hospital. The governing body shall assure the chief executive officer's effective performance through ongoing documented monitoring and evaluation of that performance against written criteria developed for the position. Criteria must include, at a minimum, the hospital's compliance with statutory and regulatory requirements, the corrective actions required and taken to achieve such compliance, and the maintenance of corrective

actions to achieve continued compliance in previously deficient areas.

j. The governing body shall ensure that the medical staff comply with the following:

(1) Determine in accordance with state law which categories of licensed health care practitioners are eligible candidates for appointment to the medical staff.

(2) Appoint a physician as chief of staff who has been approved by the medical staff and is qualified for membership on the medical staff. The chief of staff is responsible for directing the medical staff organization and shall report to the governing body.

(3) Ensure the implementation of written criteria for selection, appointment, and reappointment of medical staff members and for the delineation of their medical privileges.

(4) Ensure that staff membership or professional privileges in the hospital are not dependent solely upon certification, fellowship, or membership in a specialty body or society.

(5) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff in accordance with written procedures.

(6) Ensure that actions taken on applications for medical staff appointments and reappointments including the delineation of privileges are put in writing.

(7) Approve and ensure that the medical staff has written bylaws, rules, and regulations.

(8) Require that members of the medical staff abide by the medical staff bylaws, rules, and regulations.

(9) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

(10) Require that members of the medical staff practice only within the scope of privileges granted by the governing body.

k. The governing body shall ensure that the following patient care practices are implemented and monitored and take corrective action as necessary to attain compliance:

(1) Every patient of the hospital, whether an inpatient, emergency service patient, or outpatient, must be provided care that meets generally acceptable standards of professional practice.

(2) Every patient must be under the care of a licensed health care practitioner who is credentialed by the medical staff.

(3) Patients must be admitted to the hospital only by a licensed health care practitioner with admitting privileges.

(4) Staff must be available at all times, sufficient to meet the patient care needs.

(5) A patient's licensed health care practitioner shall arrange for the care of the patient by an alternate licensed health care practitioner during his or her unavailability.

(6) One or more licensed health care practitioners must be on duty or call at all times and available to the hospital within thirty minutes to give necessary orders or medical care to patients in case of emergency.

(7) Every patient must receive effective discharge planning consistent with identified patient and family needs from the hospital. Discharge planning must be initiated in a timely manner. Patients, along with necessary medical information, must be transferred or referred to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.

(8) That all medical orders must be in writing and signed and dated by a licensed health care practitioner.

l. The governing body is responsible for providing a physical plant equipped with the needed facilities and services for the care of patients in compliance with construction standards contained in chapter 33-07-02.1

m. The governing body is responsible for services furnished in the hospital whether or not they are furnished by outside entities under contracts. The governing body shall ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable laws, codes, rules, and regulations.

(1) The governing body shall ensure that the services performed under a contract are provided in a safe and effective manner.

(2) The hospital shall maintain a list of all contracted services, including the scope and nature of the services provided.

2. A primary care hospital shall have a governing body that is legally responsible for the conduct of the hospital and shall at least:

a. Adopt written bylaws reflecting its legal responsibility and accountability to the patients and its obligation to the community. The bylaws must specify at least the following:

(1) The role and purpose of the hospital.

(2) The duties and responsibilities of the governing body.

(3) The responsibilities of any governing body committees, including the requirement that minutes reflect all business conducted, including findings, conclusions, and recommendations.

(4) The relationships and responsibilities of the governing body, hospital administration, and medical staff, and the mechanism established by the governing body for holding such parties accountable.

(5) The mechanisms for adopting, reviewing, and revising governing body bylaws.

(6) The mechanisms for formal adoption of the organization, bylaws, rules, and regulations of the medical staff.

b. Ensure that the medical staff:

(1) Are approved by the governing body after considering the recommendations of the existing members of the medical staff.

(2) Have current bylaws and written policies that are approved by the governing body.

(3) Are accountable to the governing body for the quality of care provided to patients.

(4) Are selected on the basis of individual character, competence, training, experience, and judgment.

c. Approve a chief executive officer who is responsible for managing the hospital.

d. In accordance with a written policy, ensure that:

(1) Every patient is under the care of a licensed health care practitioner who is a member of the medical staff.

(2) Whenever a patient is admitted to the hospital by a physician assistant, the physician assistant's supervising physician must be notified of that fact, by phone or otherwise, within four hours after the admission and a written notation of that consultation and of the physician's approval or disapproval must be placed in the patient's medical record.

(3) A licensed health care practitioner must be on duty or on call at all times and available to the hospital to give necessary orders and medical care in the case of emergency.

(4) Sufficient staff must be available at all times to meet patient care needs.

(5) That all medical orders must be in writing and signed and dated by a licensed health care practitioner.

e. Maintain a list of all contracted services, including the scope and nature of the services provided, and ensure that a contractor providing services to the hospital:

(1) Furnishes services that permit the hospital, including the contracted services, to comply with all applicable laws, codes, rules, and regulations.

(2) Provides the services in a safe and effective manner.

f. Ensure that the medical and nursing staff of the hospital are licensed, certified, or registered in accordance with state statutes and rules and that each such staff member provides health services within the scope of his or her license, certification, or registration.

g. Ensure that all drugs and biologicals are administered by, or under the supervision of, personnel in accordance with federal and state laws and rules and in accordance with medical staff policies and procedures which have been approved by the facility's governing body.

h. Ensure that each order for drugs and biologicals is consistent with federal and state law and is in writing and signed by the licensed health care practitioner who is

both responsible for the care of the patient and legally authorized to prescribe.

i. Ensure that blood transfusions and intravenous medications are administered in accordance with state law.

j. Establish a quality improvement committee, at least one member to be an appropriately licensed health care practitioner.

k. Provide a physical plant equipped with the needed facilities and services for patients in compliance with construction standards contained in chapter 33-07-02.1

l. Have written contracts for referral purposes. The hospital shall have agreements with at least the following:

(1) A general acute hospital.

(2) A provider of specialized diagnostic imaging or laboratory services that are not available at the facility.

3. Specialized hospitals are subject to the governing body requirements for general acute hospitals in this section.

History: Effective April 1, 1994
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-10. Physical environment.

1. The general acute hospital must be constructed, arranged, and maintained to ensure the safety and well-being of the patients and must provide facilities for diagnosis and treatment and for special services appropriate to the hospital.

a. The physical plant must comply with the construction standards of chapter 33-07-02.1.

b. In addition to the construction standards, all hospitals shall provide an environment that appropriately responds to the physical, functional, and psychosocial needs of the patients. The hospital shall provide adequate space, lighting levels, ventilation, and safety measures consistent with the services being offered and the patients being served.

2. Primary care hospitals are subject to the physical environment requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the physical environment requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-11. Fire control.

1. General acute hospitals shall comply with the fire code standards. This compliance is subject to review and approval by the state fire marshal's office.

2. Primary care hospitals are subject to the fire control requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the fire control requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-12. Disaster plan.

1. The general acute hospital shall have a written procedure to be followed in case of fire, explosion, or other emergency. It shall specify persons to be notified, locations of alarm signals and extinguishers, evacuation routes, procedures for evacuating helpless patients, frequency of fire drills at not less than four fire drills per year per shift, and assignment of specific tasks and responsibilities to the personnel of each shift. The plan should be developed with the assistance of qualified fire and safety experts.

2. Primary care hospitals are subject to the disaster plan requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the disaster plan requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-13. Quality improvement. The hospital shall have an ongoing, facilitywide, written quality improvement program and risk management program approved by the governing body with implementation plans that evaluate and improve the quality of patient care, governance, and managerial and support activities.

1. The general acute hospital shall develop and implement a quality improvement program for assessing and improving quality which describes objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and improvement activities.

   a. The quality improvement program must include a written plan for all services including indicators of care which are important to the health and safety of the patients.

   b. The indicators of the written quality improvement plan must relate to the quality of care and must be objective, measurable, and based on current knowledge and clinical experience.

   c. Written documentation of the quality improvement activities and risk management activities must be prepared and reported through established channels to the governing body at least four times a year.

2. Primary care hospitals are subject to the quality improvement requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the quality improvement requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-14. Infection control. The hospital shall have a hospitalwide program for the surveillance, prevention, and control of infections consistent with the occupational safety and health administration and centers for disease control standards regulations specific to infection control.

1. The general acute hospital shall establish and implement an infection control program that is responsible for the infection surveillance, prevention, and control in the hospital.

   a. The responsibilities of the program include:

      (1) The establishment of a written infection control plan that includes the use of aseptic techniques, universal precautions, and appropriate procedures for each department or service.

      (2) The establishment of policies and procedures for reporting, surveillance, monitoring, and documentation of infections and the development and implementation of systems used to collect and analyze

data and activities to prevent and control infections.

(3) Ensuring the assignment of the responsibility for the management of infection surveillance, prevention, and control to a qualified person or persons.

b. Written documentation of the activities of the infection control program must be prepared and reported through established channels.

c. There must be procedures available for the immediate isolation of all patients in whom infectious conditions or other conditions that jeopardize the safety of the patient or other patients are thought to exist.

d. There must be inspections and cleaning of air-intake sources, screens, and filters at a frequency consistent with manufacturer's recommendations and hospital policies.

e. Proper facilities must be maintained and appropriate procedures used for disposal of all infectious and other wastes.

2. A primary care hospital is subject to the infection control requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the infection control requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-15. Medical staff.

1. The general acute hospital shall have an organized medical staff that is accountable to the governing body in accordance with written bylaws, rules, and regulations approved by the governing body. The medical staff shall adopt and enforce bylaws, rules, and regulations to carry out its responsibilities which specifically provide, but are not limited to, the following:

a. Describe the organization, composition, and accountability of the medical staff.

b. The mechanism for appointment, reappointment, and renewal of medical staff membership, and the granting of clinical privileges initially and at least every twenty-four months as a part of an evaluation of staff membership. Medical staff membership and clinical privileges shall be granted

by the governing body based on medical staff recommendations in accordance with the bylaws, rules, regulations, and policies of the medical staff and the hospital.

c. The acceptance and processing of initial applications for medical staff membership, granting and denying of medical staff reappointment, and medical staff membership or disciplinary matters related to clinical privileges.

d. The equal application of procedures for evaluating eligible licensed health care practitioners for staff membership, including procedures for determination of qualifications, credentials, and privileges; criteria for evaluation of qualifications; procedures requiring information about current mental and physical health status; current license status in this state; procedures to address the issue of staff members who are reportedly impaired by substance abuse; and current competence in delivering health care services.

(1) The following information must be collected from a licensed health care practitioner prior to appointment or reappointment to the medical staff and the granting or renewing of clinical privileges or association in any capacity with the hospital:

(a) The name of any hospital or facility with which the licensed health care practitioner has had any association, employment, privileges, or practice and, if such association, employment, privileges, or practice have been suspended, restricted, terminated, curtailed or not renewed, the reasons for such.

(b) The substance of any pending professional liability actions or other professional misconduct proceedings in this or any other state.

(c) Any judgment or settlement of any professional liability action and any finding of professional misconduct in this or any other state.

(d) Any information relative to findings pertinent to violations of patients' rights.

(e) A waiver by the licensed health care practitioner of any confidentiality provisions concerning the information.

(2) Prior to granting or renewing privileges or association to any licensed health care practitioner,

the hospital shall query the national practitioner data bank regarding physicians and request all previous hospital or clinical practice information.

(3) A file must be maintained on each licensed health care practitioner granted privileges or otherwise associated with the hospital which must contain the information collected. This file must be updated at least every twenty-four months and contain all relevant information gathered in accordance with this section.

(4) A physician assistant and advanced registered nurse practitioner shall keep on file at the hospital and available for review by the department, upon request, documents that are required to be filed with the board of medical examiners or the board of nursing as appropriate.

f. A statement of the duties, privileges, and responsibilities of each category of medical staff.

(1) Regardless of any other categories having privileges in the hospital, there must be an active staff that includes physicians and may also include other licensed health care practitioners which is organized and which performs all the duties pertaining to medical staff, including the maintenance of the proper quality of all medical care and treatment of inpatients and outpatients in the hospital.

(2) Active medical staff meetings must be held regularly and written minutes of all meetings must be kept. Documentation on meetings must be prepared and reported through established channels.

g. Additional privileges may be granted a staff member for the use of their employed allied health personnel in the hospital in accordance with policies and procedures recommended by the medical staff and approved by the governing body. The staff member requesting this additional privilege shall submit for review and approval by the medical staff and the governing body:

(1) The curriculum vitae of the identified allied health personnel.

(2) Written protocol with a description of duties, assignments, and functions including a description of the manner of performance within the hospital by the allied health personnel in relationship with other hospital staff.

h. The responsibility for such quality improvement activities as pharmacy and therapeutics, surgical case and tissue review, infection control, utilization review, patient care evaluation, use of blood and blood components, review of unexpected mortalities, review of morbidities in circumstances other than those related to the natural course of disease or illness, and the maintenance of complete medical records.

i. That the findings of tissue removed at operation which is examined by a pathologist be made a part of the patient's medical record.

j. The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients; patient grievances; professional liability insurance premiums, settlements, awards, and costs incurred by the hospital for patient injury prevention; and safety improvement activities.

k. The identification of clinical conditions and procedures requiring consultation.

l. The provision for the exchange of information between medical, administrative, and nursing staffs.

m. The procedure for submitting recommendations to the governing body regarding matters within the purview of the medical staff.

n. The procedures to be used to grant to current medical staff members formal professional review for actions involving credentialing, competence, or professional conduct concerning hospital privileges. The formal professional review must be conducted in accordance with a fair hearing and appeal process identified in the medical staff bylaws, substantially in the following manner:

   (1) The medical staff member must be given a notice stating:

      (a) That a professional review action has been proposed to be taken against the medical staff member.

      (b) The reasons for the proposed action.

      (c) That the medical staff member has the right to request a hearing on the proposed action.

(d) Any time limit, which may not be less than thirty days, within which to request such a hearing.

(e) A summary of the medical staff member's rights in a hearing.

(2) If a hearing is requested, the medical staff member involved must be given notice of the hearing on a timely basis.

(3) Any action relating to professional incompetence or professional conduct adversely affecting the clinical privileges of the medical staff member must be reported by the governing body of the hospital, within fifteen days, to the state board charged with responsibility for licensure of the professional practice and any disciplinary action affecting practice longer than thirty days must be reported to the national data bank.

2. The primary care hospital shall have a medical staff that includes at least one or more physician, physician assistant, or advanced registered nurse practitioner which does the following:

a. Adopts bylaws, rules, and regulations for self-governance of medical staff activities and enforces the bylaws, rules, and regulations after their approval by the governing body. The bylaws, rules, and regulations must at least contain the following:

(1) A description of the qualifications a medical staff candidate must meet in order to be recommended to the governing body for appointment.

(2) A statement of the duties and privileges of each category of medical staff.

(3) The requirement for a physical examination to be made and the medical history taken of a patient by a member of the medical staff no more than fourteen days before or twenty-four hours after the patient's admission to the primary care hospital.

b. Responsible for quality improvement activities including pharmacy and therapeutics, infection control, utilization review, patient care evaluation, use of blood and blood components, review of unexpected mortalities, review of morbidities in circumstances other than those related to the natural course of the disease or illness, and maintenance of complete medical records.

c. A licensed health care practitioner on staff must:

(1) Provide health care services to the patients in the hospital whenever needed and requested.

(2) Prepare guidelines for the medical management of health problems, including conditions requiring medical consultation and patient referral.

(3) Provide medical direction for the hospital's health care activities.

(4) Participate in developing, executing, and periodically reviewing the hospital's written policies and the services provided to patients.

(5) Review and sign the records of each patient admitted and treated no later than one month after that patient's discharge from the hospital.

(6) Arrange for, or refer patients to, needed services that are not provided at the hospital.

(7) Assure that adequate patient medical records are maintained and transferred as necessary when a patient is referred.

d. A physician assistant or advanced registered nurse practitioner must keep on file at the primary care hospital and available for review by the department, upon request, documents that are required to be filed with the board of medical examiners or the board of nursing as appropriate.

3. Specialized hospitals are subject to the medical staff requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-16. Nursing services.

1. The general acute hospital shall have a plan of administrative authority with delineation of responsibilities and duties for nursing personnel, including written job descriptions.

a. Nursing services must be under the direction of a nurse executive (director of nursing) who is a registered nurse licensed to practice in North Dakota. The nurse executive must have written administrative authority, responsibility, and accountability for the integration and

coordination of nursing services consistent with the overall hospital plan and philosophy of patient care. The nurse executive shall retain overall responsibility for:

(1) Development, maintenance, and periodic review of a nursing service philosophy, objectives, standards of practice, policies and procedures, and job descriptions for each level of nursing service personnel.

(2) Whenever the nurse executive is not available in person or by phone, the nurse executive shall designate in writing a specific registered nurse to be available in person or by phone to direct nursing services.

b. There must be sufficient qualified nursing personnel to meet the nursing care needs of the patients.

(1) At least one registered nurse must be on duty per shift twenty-four hours per day seven days per week when a patient is present. The nurse executive or other registered nurse designated as the nurse executive's alternate must be on call and available within twenty minutes at all times.

(2) In hospitals providing obstetrical or surgical services, additional nursing staff must be available to care for these patients as determined necessary dependent on facility policy and patient needs.

2. Primary care hospitals shall provide twenty-four-hour licensed nursing services whenever a patient is in the hospital and meet the following standards:

a. Nursing services must be under the direction of a nurse executive (director of nursing) who is a registered nurse licensed to practice in North Dakota. The nurse executive must have written administrative authority, responsibility, and accountability for the integration and coordination of nursing services consistent with the overall hospital plan and philosophy of patient care. The nurse executive shall retain overall responsibility for:

(1) Development, maintenance, and periodic review of nursing service philosophy, objectives, standards of practice, policies and procedures, and job descriptions for each level of nursing service personnel.

(2) Determine and schedule adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care as needed.

b. Registered nurse staffing must be on duty at least sixteen hours per day when a patient is in the hospital with licensed nursing coverage for the remainder of the twenty-four-hour period. The nurse executive or another registered nurse designated as the nurse executive's alternate must be on call and available within twenty minutes at all times.

c. When no patients are in the facility, staffing must include at least a licensed nurse with a registered nurse on call and available within twenty minutes to respond immediately to patient needs.

3. Specialized hospitals are subject to the nursing services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-17. Patient care plan.

1. The general acute hospital shall ensure that a patient care plan is developed for each patient in coordination with the patient and appropriate health care personnel consistent with the licensed health care practitioner's orders.

   a. Initial assessment must begin upon admission and the patient care plan must be developed and implemented consistent with patient needs. The initial written patient care plan must be completed within twenty-four hours of admission and updated as needed.

      (1) Patient care plans must be kept current. Plans must address patient needs, including the methods and approaches to be implemented and modifications necessary to ensure that the patient attains or maintains the highest practicable level of functioning.

      (2) Patient care plan goals must be identified, measurable, and made known to all appropriate personnel.

   b. Progress notes must be reflective of the patient care plan and be informative and descriptive of the care given. The progress notes must include information and observations of significance which contribute to the continuity of patient care.

   c. Discharge planning must be initiated upon admission and kept current.

(1) Appropriate discharge instructions must be provided to patients and family members dependent upon the patient's identified needs.

(2) Patients, along with necessary medical information, must be transferred or referred to appropriate facilities, agencies, or outpatient services for followup or ancillary care as needed.

2. Primary care hospitals are subject to the patient care plan requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the patient care plan requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-18. Education programs.

1. The general acute hospital shall design, implement, and document educational programs to orient new employees and to keep all staff current on new and expanding programs, techniques, equipment, and concepts of quality care. The following topics must be covered annually:

   a. Infection control measures, including blood-borne pathogens.

   b. Safety and emergency procedures, including procedures for fire and other disasters.

   c. Procedures for life-threatening situations, including cardiopulmonary resuscitation and the lifesaving techniques for choking victims.

   d. Patient rights.

2. Primary care hospitals are subject to the education programs requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the education programs requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-19. Dietary services.

1. The general acute hospital shall provide dietary service to meet the needs of the patients served and shall ensure the following:

   a. The hospital shall designate an employee to be responsible for the total food service of the facility. If this employee is not a licensed registered dietitian, the employee must have at least completed a food service course approved by the American dietetic association and receive at least monthly consultation from a licensed registered dietitian consultant.

   b. There must be current written policies and procedures for the dietary department.

   c. The number of employees must be adequate to effectively perform all functions necessary to meet the dietary needs of the patients.

   d. A person must be designated to be in charge of the dietary service when the department head is not present.

   e. Dietary personnel must practice recognized hygienic techniques in accordance with the food service sanitation manual issued by the North Dakota state department of health and consolidated laboratories, division of food and lodging.

   f. The dietitian must have available a diet manual of regimens for all therapeutic diets, approved jointly by the dietitian and medical staff. Copies must be available in the dietary service area.

   g. At least three meals or their equivalent must be served daily, at regular times, with not more than a fourteen-hour span between a substantial evening meal and breakfast.

   h. Regular and therapeutic diets must be prescribed in writing by the licensed health care practitioner. Regular and therapeutic menus must be planned in writing and served as ordered, with supervision or consultation from the dietitian.

   i. Facilities must be provided for the general dietary needs of the hospital patients and staff, and for maintenance of sanitary conditions in the storage, preparation, service, and distribution of food.

      (1) Appropriate lighting and ventilation must be maintained.

(2) Facilities for storage of personal effects outside of food preparation area must be provided for food service personnel.

(3) Lavatories, specifically for handwashing, with hot and cold running water, soap dispenser, and disposable towels, must be conveniently located.

(4) Dry or staple food items must be stored off the floor in a ventilated room that is free of sewage or wastewater backflow or contamination by condensation, leakage, rodents, or vermin, and separate from cleaning supplies.

(5) Effective procedures for cleaning all equipment and work areas must be developed and consistently followed.

(6) Dishwashing procedures and techniques must be carried out in compliance with state and local health codes.

(7) Waste that is not disposed of by mechanical means must be kept in leakproof nonabsorbent containers with closefitting covers and must be disposed of daily in a manner that will prevent transmission of disease, a nuisance, a breeding place for flies, or a feeding place for rodents. Containers must be thoroughly cleaned inside and outside each time they are emptied.

2. Primary care hospitals are subject to the dietary services requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the dietary services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-20. Medical records services.

1. The general acute hospital shall establish and implement procedures to ensure that the hospital has a medical records service with administrative responsibility for medical records.

   a. A medical record must be maintained and kept confidential, in accordance with accepted medical record principles, for every patient admitted for care in the hospital.

(1) Only authorized personnel may have access to the record.

(2) Written consent of the patient must be presented as authority for release of medical information.

(3) Medical records may not be removed from the hospital environment except upon subpoena or court order.

(4) If a hospital discontinues operation, it shall make known to the department where its records are stored. Records are to be stored in a facility offering retrieval services for at least ten years after the closure date. Prior to destruction, public notice must be made to permit former patients or their representatives to claim their own records. Public notice must be in at least two forms, legal notice and display advertisement in a newspaper of general circulation.

b. Records must be preserved in original or any other method of preservation, such as by microfilm, for a period of at least the tenth anniversary of the date on which the patient who is the subject of the record was last treated in the hospital.

(1) If a patient was less than eighteen years of age at the time of last treatment, the hospital may authorize the disposal of medical records relating to the patient on or after the date of the patient's twenty-first birthday or on or after the tenth anniversary of the date on which the patient was last treated, whichever is later.

(2) The hospital may not destroy medical records that relate to any matter that is involved in litigation if the hospital knows the litigation has not been finally resolved.

(3) It is the governing body's responsibility to determine which records have research, legal, or medical value and to preserve such records beyond the above-identified timeframes until such time in the governing body's determination the record no longer has a research, legal, or medical value.

c. 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 service, coordinate the training of the personnel, and make at least quarterly visits to the hospital to evaluate the records and the operation of the service.

d. Personnel must be available so that medical records services may be provided as needed.

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

f. Upon discharge, all clinical information pertaining to a patient's hospitalization must be centralized in the patient's medical record. The original of all reports must be filed in the medical record.

g. Records must be retrievable by disease, operation, and licensed health care practitioner and must be kept up to date. For abstracting, any recognized system may be used. Indexing must be current within six months following discharge of the patient.

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

(1) The chief complaint must include a concise statement of complaints that led the patient to consult the patient's licensed health care practitioner and the date of onset and duration of each.

(2) The physical examination statement must include all findings resulting from an inventory of systems.

(3) The provisional diagnosis must be an impression (diagnosis) reflecting the examining licensed health care practitioner's evaluation of the patient's condition based mainly on physical findings and history.

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

(5) A definitive final diagnosis must be expressed in terminology of a recognized system of disease nomenclature.

(6) The discharge summary must be a recapitulation of the significant findings and events of the patient's hospitalization and the patient's condition on discharge.

(7) The consultation report must be a written opinion signed by the consultant including the consultant's findings.

(8) All diagnostic and treatment procedures must be recorded in the medical record.

(9) Tissue reports must 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 must be made by the laboratory and filed in the medical record.

(10) When an autopsy is performed, findings in a complete protocol must be filed in the record.

(11) Complete records, both medical and dental, of each dental patient must be a part of the hospital record.

i. All entries into the medical record must be authenticated by the individual who made the written entry.

(1) All entries that the licensed health care practitioner personally makes in writing must be signed and dated by that licensed health care practitioner.

(2) Telephone and verbal orders may be used provided they given only to qualified licensed personnel and reduced to writing and signed or initialed by a licensed health care practitioner responsible for the care of the patient within forty-eight hours.

(3) In hospitals with medical students and unlicensed residents, the attending licensed health care practitioner shall countersign at least the history and physical examination and summary written by the medical students and unlicensed residents.

(4) Signature stamps may be utilized consistent with hospital policies as long as the signature stamp is utilized only by the licensed health care

practitioner whose signature the signature stamp represents. Written assurance must be on file from the licensed health care practitioner to indicate that the practitioner is the sole user of the signature stamp.

(5) Electronic signatures may be utilized if the hospital's medical staff and governing body adopt a policy that permits authentication by electronic signature. The policy must include:

(a) The categories of medical staff and other staff within the hospital who are authorized to authenticate patients' medical records using electronic signatures.

(b) The safeguards to ensure confidentiality, including:

[1] Each user must be assigned a unique identifier that is generated through a confidential access code.

[2] The hospital shall certify in writing that each identifier is kept strictly confidential. This certification must include a commitment to terminate the user's use of that particular identifier if it is found that the identifier has been misused. Misused means that the user has allowed another individual to use the user's personally assigned identifier, or that the identifier has otherwise been inappropriately used.

[3] The user must certify in writing that the user is the only individual with user access to the identifier and the only individual authorized to use the signature code.

[4] The hospital shall monitor the use of the identifiers periodically and take corrective action as needed. The process by which the hospital will conduct the monitoring must be described in the policy.

(c) A process to verify the accuracy of the content of the authenticated entries, including:

[1] A system that requires completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps, or obvious contradictory statements appearing within those designated fields. The system must require that correction

or supplementation of previously authenticated entries must be made by additional entries, separately authenticated and made subsequent in time to the original entry.

[2] The system must make an opportunity available to the user to verify that the document is accurate and that the signature has been properly recorded.

[3] As a part of the quality improvement activities, the hospital shall periodically sample records generated by the system to verify the accuracy and integrity of the system.

(d) A user may terminate authorization for use of an electronic signature upon written notice to the staff member in charge of medical records or other person designated by the hospital's policy.

(e) Each report generated by the user must be separately authenticated.

(f) A list of these codes must be maintained under adequate safeguards by hospital administration.

j. Current records and those on discharged patients must be completed promptly.

(1) Past history and physical examination information must be completed within twenty-four hours following admission.

(2) All reports or records must be completed and filed within a period consistent with current medical practice and not longer than thirty days following discharge.

(3) 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.

2. Primary care hospitals are subject to the medical records services requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the medical records services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06, 31-08-01.2, 31-08-01.3

33-07-01.1-21. Pharmaceutical services.

1. General acute hospitals shall provide pharmaceutical services consistent with chapter 61-07-01. The hospital, upon receipt, shall submit to the department a copy of the annual board of pharmacy hospital inspection report under subsection 2 of section 61-07-01-13 and plans of correction to the department.

2. Primary care hospitals are subject to the pharmaceutical services requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the pharmaceutical services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-22. Laboratory services.

1. General acute hospitals shall have a well-organized, adequately supervised, clinical laboratory service available with the necessary space, facilities, and equipment and qualified, licensed staffing to perform these services commensurate with the hospital's needs for its patients. At a minimum, the hospital must adhere to the following:

   a. The medical director of laboratory service must be a physician who is a member of the medical staff with delineated clinical privileges for interpretation of diagnostic studies.

   b. The medical director of the laboratory service shall assure procedures and tests are within the scope of education, training, and experience of the individuals employed to perform technical procedures in the laboratory.

   c. Provisions must be made to assure twenty-four-hour availability of emergency laboratory services either directly or through contract.

   d. Examination in the fields of hematology, chemistry, microbiology, sero-immunology, clinical microscopy, and other services necessary to meet patient care needs must

be provided within the hospital or by contractual agreement.

e. All surgically removed tissues must be examined by a pathologist and signed reports must be included in the patient's medical record. If the hospital provides anatomical pathology services, such may be provided either by the hospital directly or per contractual arrangement with a certified laboratory. Written policies and procedures must be established through the medical staff and pathologist governing prompt transportation of specimens and submission of reports.

f. There must be a quality control program designed to ensure reliability of the laboratory data and which includes written provisions for no less than:

   (1) The method of quantitative and qualitative testing and the frequency of control performance, including control data and evaluation criteria.

   (2) The frequency and method of quality control testing and calibration of instruments, equipment, and commercially prepared testing kits.

   (3) A preventive and corrective maintenance program for instruments and equipment involved in laboratory testing.

   (4) Participation in an approved external proficiency testing program if one is available.

   (5) Maintenance of records documenting all quality control and related activities.

g. An autopsy service must be provided either directly by the hospital or by contractual arrangement with another institution having an approved laboratory. Hospitals providing the service directly must have adequate space, equipment, and personnel for services provided.

h. Each hospital shall provide appropriate facilities and equipment for the procurement, storage, safekeeping, and administration of whole blood and blood products either directly or through participation in a multifacility community blood collection, storage, and processing system. Written policies and procedures for all phases of operation of blood banks and transfusion services must be established and revised as needed.

i. Reports indicating the name and address of the testing laboratory must be authenticated, dated, and clearly indicate the results of all pathological and clinical

laboratory examinations, including autopsies, and made part of the patient's medical record.

2. The primary care hospital shall maintain, or have available through contract, clinical laboratory services adequate to fulfill the needs of its patients and meeting the following:

   a. The hospital, at a minimum, shall provide basic laboratory services essential to immediate diagnosis and treatment, including:

      (1) Chemical examinations of urine by stick or tablet methods, or both (including urine ketones).

      (2) Hemoglobin or spun hematocrit.

      (3) Blood sugar by whole blood testing device.

      (4) Examination of stool specimens for occult blood.

      (5) Primary culturing for transmittal to a certified laboratory.

   b. The hospital shall provide, or have a contractual agreement with a certified laboratory for, any additional laboratory services that are needed by a patient.

   c. Emergency provision of basic laboratory services must be available twenty-four hours a day.

   d. The hospital shall assign personnel to direct and conduct the laboratory services.

   e. Only personnel designated as qualified by the medical staff by virtue of education, experience, and training may perform and report laboratory test results.

   f. Each hospital shall provide appropriate facilities and equipment for the procurement, storage, safekeeping, and administration of whole blood and blood products either directly or through participation in a multifacility community blood collection, storage, and processing system. Written policies and procedures for all phases of operation of blood banks and transfusion services must be established and periodically revised.

3. Specialized hospitals shall provide laboratory services to meet the needs of patients served consistent with the laboratory services requirements for general acute hospitals in this section. If onsite laboratory services are not necessary to meet the needs of patients served, such as in hospitals serving only psychiatric or substance abuse

patients, the laboratory services may be provided through a contractual agreement with a certified laboratory.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-23. Radiology services.

1. The general acute hospital shall provide and maintain radiology services sufficient to perform and interpret the radiological examinations necessary for the diagnosis and treatment of patients, to the extent that the complexity of services are commensurate with the size, scope, and nature of the hospital. Additional required services must be provided by shared services or referral of patients.

   a. The physician responsible for the direction and supervision of radiology services must be board certified or eligible for certification by the American board of radiology or equivalent. The physician responsible for radiology services must be a member of the medical staff. This individual's responsibilities must be identified in the policy and procedure manual or other document.

   b. Technicians and technologists employed in the radiology services must have had sufficient training and experience to carry out the procedures safely and efficiently commensurate with the size, scope, and nature of the service. A means for evaluating qualifications must be established and used. The physician responsible for radiology services shall document as to the acceptability of the qualifications specific to each radiology technician or technologist.

   c. The hospital shall provide for emergency radiology services at all times.

   d. Complete signed reports of the radiological examinations must be made part of the patient's record and duplicate copies, as well as the films, must be kept in the hospital for a period of five years.

   e. Written reports of each radiological interpretation, consultation, and treatment must be signed by the physician responsible for conducting the radiological examination and must be a part of the patient's medical record.

   f. Radiation workers must be checked by film dosimeter to determine the amount of radiation to which they are routinely exposed. Records must be maintained to reflect

each individual's exposure level. These checks must be conducted on a monthly basis until the radiation exposure history for the radiation worker indicates levels below maximum permissible dose for a period of one year. When radiation dose levels have remained below the maximum permissible dose for a year, radiation doses may be monitored on a quarterly basis as long as the exposure remains below the maximum permissible dose.

2. Primary care hospitals are subject to the radiology services requirements for general acute hospitals in this section.

3. Specialized hospitals shall provide radiology services to meet the needs of patients served consistent with the radiology services requirements for general acute hospitals in this section. If onsite radiology services are not necessary, such as in hospitals serving only psychiatric or substance abuse patients, the radiology services may be provided through a contractual agreement with an institution providing radiology services.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-24. Nuclear medicine services.

1. If the acute hospital provides nuclear medicine services, the services must be provided to meet the needs of the patients and in a safe and effective manner.

   a. The hospital shall have available written verification of compliance with article 33-10.

   b. The hospital shall have evidence of licensure to handle radioactive materials.

   c. The physician responsible for the direction of the nuclear medicine services must be a physician who is qualified to provide nuclear medicine services and who is a member of the medical staff.

   d. Nuclear medicine services may be ordered only by a licensed health care practitioner whose qualifications and medical staff privileges allow such referrals.

   e. Personnel employed in nuclear medicine services must meet the qualification and training requirements, perform the functions, and carry out the responsibilities specified by the director and approved by the medical staff.

f. The diagnostic procedures must be interpreted by a licensed health care practitioner who has been approved by the medical staff to do so. The licensed health care practitioner shall document, sign, and date reports of procedures, interpretations of procedures, and consultations.

g. The hospital shall retain copies of nuclear medicine reports consistent with current standards of practice.

h. The nuclear medicine services shall develop and implement policies in accordance with standards of practice specific for the services provided, and consistent with chapter 61-05-01, including:

(1) Handling, maintenance, and inspection of equipment.

(2) Protection of patients and personnel from radiation hazards.

(3) Testing of equipment for radiation hazards.

(4) Maintenance of personnel radiation monitoring devices.

(5) Preparation and administration of radio-pharmaceutical.

(6) Documentation of receipt, storage, use, and disposal of radioactive materials.

2. Primary care hospitals may not provide nuclear medicine services.

3. Specialized hospitals providing nuclear medicine services are subject to the nuclear medicine services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-25. Emergency services.

1. Each general acute hospital shall provide emergency services to its inpatients. If the hospital does not provide emergency services to the public, it shall be prepared to provide immediate lifesaving measures to persons who may appear for emergency care and arrange for their transfer to another hospital that does provide a public emergency service.

a. Each hospital shall have a well-defined plan for emergency care service based on the capability of the hospital and its specialized supportive services.

   (1) The hospital plan for emergency care services must be developed to coordinate with representatives of community emergency medical services agencies or groups.

   (2) Hospitals without emergency service for the public shall have written policies and procedures governing the handling of emergencies.

b. Every hospital with an emergency service shall provide treatment to every person in an emergency without discrimination on account of economic status or source of payment.

c. Every emergency service shall have a qualified licensed health care practitioner designated in charge of the emergency medical services to ensure that emergency patient care services meet the standards herein and for the coordination of professional coverage according to a plan established by the medical staff and approved by the governing body.

d. A hospital must have one or more licensed health care practitioners qualified by training and experience in care of emergency patients on duty or call at all times and available to respond to emergencies within thirty minutes. The licensed health care practitioner shall determine the nature, level, and urgency of care required of all persons seeking treatment and categorize them accordingly, assuring that serious cases are accorded priority treatment.

e. The staffing pattern of nursing or allied health personnel must be consistent with the scope and complexity of the emergency services provided. At least one licensed person who is qualified by training and experience in emergency care must be assigned to the emergency services at all times.

f. A current roster of licensed health care practitioners, medical specialists, or consultants on emergency call, including alternates, must be kept posted at all times in the emergency service area.

g. There must be current written policies governing emergency services. The policies and procedures must pertain to at least the following:

(1) Medical staff and obligation for emergency patient care.

(2) Circumstances under which definitive care will not be provided and procedures to be followed in referrals.

(3) Procedures that may or may not be performed in the emergency service area.

(4) Handling of persons who are emotionally ill, under the influence of drugs or alcohol, dead on arrival, or other categories of special cases as determined necessary.

(5) Procedures for early transfer of severely ill or injured to special in-house treatment areas or to other facilities.

(6) Written instructions to be given for followup care and disposition of all cases.

(7) Notification of patient's personal licensed health care practitioner and transmission of relevant reports.

(8) Disclosure of patient information in accordance with federal and state law.

(9) Communication with police, health authorities, and emergency vehicle operators.

(10) Appropriate utilization of observation beds.

(11) Procurement of equipment and drugs.

(12) Location and storage of medications, supplies, and special equipment.

(13) Operation of the emergency service in times of disaster.

h. A list of poison antidotes and the telephone number of the poison control center must be posted in a prominent place in the emergency service area.

i. The emergency service shall have necessary supportive services available on a twenty-four-hour basis. These services must include onsite clinical laboratory service plasma expanders, provision for blood or blood products; pharmaceutical service; onsite radiology service including protocol to govern the interpretation by a radiologist of diagnostic images produced by X-ray, or other modalities if provided, including a procedure for the prompt

communication of the radiologist's interpretation; and surgical and anesthesia service or referral process for surgical and anesthesia service.

j. At a minimum, the following special supplies and equipment must be available in a complete set of adult and pediatric sizes for the provision of emergency services:

(1) Oxygen.

(2) Pulse oximeter.

(3) Complete set of bag/valve/mask ventilation devices.

(4) Complete set of oral and nasal airways.

(5) Suction equipment.

(6) Endotracheal intubation, pericardiocentesis thoracotomy, and cricotracheotomy trays.

(7) Electrocardiograph.

(8) Cardiac monitor and defibrillator with battery pack.

(9) Moveable equipment cart for use as a crash cart.

(10) American heart association advanced cardiac life support recommended drug inventory.

(11) Intravenous fluids including lactated ringers solution and dextrose five percent in water.

(12) Infusion pump.

(13) Pressure infuser.

(14) Gastric lavage equipment.

(15) Urinary catheter kits.

(16) Emergency obstetrical pack.

(17) Spine board.

(18) Rigid cervical collars.

(19) Fracture splints.

(20) Sterile dressings and bandages.

(21) Sterile burn sheets.

(22) Gurney or exam table.

k. Facilities must be provided to assure prompt diagnosis and emergency treatment.

(1) Facilities must be separate from, and independent of, the operating rooms.

(2) The location of the emergency services must be easily accessible from an exterior entrance of the hospital.

l. Adequate emergency room medical records on every patient must be kept and must include:

(1) Patient identification and history of disease or injury.

(2) Physical findings and laboratory and X-ray reports, if any.

(3) Time of arrival, time of treatment, major diagnosis, treatment provided, and disposition including discharge instructions.

2. Primary care hospitals are subject to the emergency services requirements for general acute hospitals in this section. Primary care hospitals providing emergency services to the public may provide low intensity outpatient services consistent with those services commonly provided in a physician's office and consistent with the privileges granted to the licensed health care practitioner rendering the service.

3. Specialized hospitals are subject to the emergency services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-26. Social services.

1. Social services must be provided in all general acute hospitals by a qualified social worker or a social services designee to meet the needs of the patients. Hospitals utilizing social services designees must have quarterly consultation by a qualified social worker.

a. Records of social service activity related to individual patient's needs must be kept, and must be available to the professional personnel concerned. Functions and activities recorded must include, as appropriate:

(1) Assessment, planning, implementation, and evaluation of psychosocial and rehabilitation needs of patients.

(2) Evaluation of financial status of patients.

(3) Referrals to community agencies.

b. The hospital shall provide facilities that will serve the personnel of the service. The services must be easily accessible to patients and to the medical staff, and must assure privacy for interviews.

2. Primary care hospitals are subject to the social services requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the social services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-27. Basic rehabilitation services.

1. General acute hospitals shall provide basic rehabilitation services, including physical, occupational, and speech pathology and audiology to meet the needs of the patients served.

a. Basic rehabilitation services must be provided by qualified staff licensed or certified consistent with state law either directly or through contract or referral to an appropriate facility.

b. Basic rehabilitation services must be provided consistent with a written plan of treatment and based on the orders of the licensed health care practitioner who is authorized by the medical staff to order such services. The licensed health care practitioner's orders must be incorporated into the patient's medical record.

c. Sufficient qualified staff must be available to ensure the following services are provided:

(1) Evaluate the patient.

(2) Initiate the plan of treatment.

(3) Instruct and supervise supportive personnel when they are used to provide services.

(4) Provide education as needed to the patient and significant others.

d. Documentation of basic rehabilitation services provided must be placed in the patient's medical record, including the nature, duration, frequency, and complexity of the treatment and the results.

e. If basic rehabilitation services are offered on an outpatient basis, the quality of the service must be consistent with the inpatient basic rehabilitation services in accordance with the complexity of the services provided.

f. Specialized rehabilitation services must be provided in a distinct, clearly defined, special unit of a general acute hospital, or in a rehabilitation hospital. Hospitals holding themselves out to the public as providing specialized rehabilitation services are subject to licensure as a specialized rehabilitation hospital as described in section 33-07-01-35.

2. Primary care hospitals are subject to the basic rehabilitative services requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the basic rehabilitative services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-28. Housekeeping and related services including laundry.

1. The general acute hospital shall provide the housekeeping and related services necessary to maintain a sanitary and comfortable environment.

a. The hospital shall provide personnel to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. The hospital shall establish, implement, and update consistent with current standards of practice procedures whereby:

(1) Housekeeping personnel use accepted practices and procedures to keep the facility free from offensive odors; accumulations of dirt, rubbish, and dust; and safety hazards.

(2) Floors are cleaned regularly. Polishes on floors provide a nonslip finish. Throw or scatter rugs are not used, except for nonslip entrance mats.

(3) Walls and ceilings are maintained free from cracks and are cleaned and painted as needed.

(4) Grounds are kept free from refuse and litter.

b. The hospital must be maintained free from insects and rodents.

(1) A pest control program must be operated in the hospital. Pest control services must be provided by maintenance personnel of the hospital or by contract with a pest control company. Care must be taken to use the least toxic and least flammable effective insecticides and rodenticides. These compounds must be stored in nonpatient areas and in nonfood preparation and storage areas. Poisons must be locked in cabinets provided for this purpose.

(2) Windows and doors, if appropriate, must be screened during the insect breeding season.

(3) Harborages and entrances for insects and rodents must be eliminated.

(4) Garbage and trash must be stored in appropriately covered containers in areas separate from those used for the preparation and storage of food and must be removed from the premises in a timely manner to avoid infection control problems.

c. The hospital shall establish and implement procedures whereby the hospital has available at all times a quantity of linen essential for the proper care and comfort of patients and that linens are handled, stored, and processed so as to control the spread of infection.

(1) Clean linen and clothing must be stored in clean, dry, and dust-free areas easily accessible to the patient rooms.

(2) Soiled linen must be sorted and stored in well-ventilated areas, separate from other laundry spaces, and may not be permitted to accumulate. Soiled linen and clothing must be stored separately in suitable bags or covered containers. Contaminated and potentially infectious soiled linen must be handled with particular attention to avoid contamination of clean linen.

(3) Soiled linen may not be sorted, laundered, rinsed, or stored in bathrooms, patient rooms, kitchens, or food storage areas.

(4) When linen is sent to an outside laundry, it must be the responsibility of the hospital to determine that work is done in accordance with approved standards.

2. Primary care hospitals are subject to the housekeeping and related services including laundry requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the housekeeping and related services including laundry requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-29. Surgical services.

1. The general acute hospital that provides surgical services shall have effective policies and procedures regarding surgical privileges, maintenance of the operating rooms, and evaluation of the surgical patient.

   a. Surgical services must be provided in a manner sufficient to meet the surgical needs of the patients. The surgical service must have a defined organization, must be integrated with other departments and services of the hospital, and must be governed by current written policies and procedures.

   b. Surgical services must be directed by a physician who is qualified by training and experience and approved by the medical staff and governing body.

   c. A roster of physicians, specifying the surgical privileges of each, must be maintained and available to staff in the surgical services area and in the files of the hospital administration.

   d. The operating rooms must be supervised by a qualified registered nurse.

      (1) A licensed practical nurse or a surgical technician may by used as "scrub nurse" under the supervision of the registered nurse.

      (2) A registered nurse may perform circulating duties in the operating room in accordance with applicable

state law. Licensed practical nurses and surgical technicians may assist in circulating duties under the supervision of a registered nurse who is immediately available to respond to emergencies.

e. The following equipment must be available for use in the surgical services area: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, tracheotomy tray, and such other instruments or equipment available for lifesaving measures.

f. The surgical services area must be located so that traffic in and out can be and is controlled and there is no through traffic.

g. All infections of clean surgical cases must be recorded and reported to administration and medical staff. A written procedure must be established for the investigation of such cases.

h. The operating room register must be maintained as identified by hospital policy and procedure.

i. There must be a complete history and physical examination, including any indicated laboratory and X-ray examination reports, in the medical record of every patient prior to surgery, except in life-threatening emergencies. If this has been transcribed, but not yet recorded in the patient's record, there must be a statement to that effect, an admission note identifying any abnormal findings, and the preoperative diagnosis in writing by the physician in the patient's medical record.

j. An operative report describing techniques, findings, and tissue removed or altered must be dictated or written immediately after the surgery and signed by the surgeon.

k. There must be a properly executed informed consent form consistent with hospital policies for operation in the patient's medical record prior to surgery, except in life-threatening emergencies.

l. If outpatient surgical services are offered by a hospital, the quality of the services must be consistent with the inpatient surgical services in accordance with the complexity of the services.

2. Primary care hospitals may not provide surgical services.

3. If a specialized hospital provides surgical services, the specialized hospital is subject to the surgical services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-30. Recovery services.

1. Postoperative recovery services must be provided by all general acute hospitals in which surgery is performed.

   a. Recovery services must be provided in a room where patients who have undergone surgical procedures can be immediately observed, receive specialized care by selected and trained personnel, and when necessary, prompt emergency care can be initiated.

   b. The services of the postoperative recovery room may be utilized for postpartum if the delivery room or place of delivery is in close proximity to the postoperative recovery room. Postpartum patients, after appropriate observation, must be returned to the obstetrical service area.

   c. A physician shall be responsible for the conduct of the recovery services and for the establishment of admission and discharge policies and procedures.

   d. A registered nurse who has education and experience in postoperative recovery services shall supervise all personnel performing nursing service functions.

      (1) A licensed nurse shall be in attendance at all times when patients are in the recovery room.

      (2) There must be sufficient nursing personnel to provide the specialized care required for the postsurgical patient.

   e. Known contaminated cases must be returned to the isolation room or a private room.

   f. A member of the medical staff shall provide initial orders for the care of each patient upon admission to the recovery services.

      (1) A member of the medical staff shall be responsible for the patient's discharge from the recovery services.

      (2) Patients under or recovering from anesthesia, and those who have received sedatives or analgesics, must remain under continuous, direct nursing supervision until vital signs have stabilized. Any nurse

performing this duty must have been instructed in the management of postanesthetic patients, must have no other clinical duties while supervising such patients, and must have immediate recourse to the attending surgeon or anesthesiologist, or certified registered nurse anesthetist, present in the hospital.

(3) Side rails must be attached to movable carts and beds and raised above mattress level when occupied by anesthetized patients. Cribs must be provided for the anesthetized or postsurgical child.

g. Personnel with communicable diseases must be excluded from the recovery services.

h. Drugs, supplies, and equipment must be immediately and continually accessible in the unit during postoperative care, including emergencies. These include cardiac-respiratory resuscitation materials.

2. Primary care hospitals may not provide recovery services.

3. If a specialized hospital provides surgical services, the hospital is required to provide recovery services consistent with the recovery services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-31. Central services.

1. General acute hospitals shall provide central services consistent with at least the following:

a. The central services must be provided with adequate direction, staffing, and facilities to provide service to all services in the hospital.

b. Policies and procedures must be developed, implemented, and updated as needed for all decontamination and sterilization services provided and at a minimum must include:

(1) Sterilization of equipment and supplies.

(2) Shelf life of stored sterile items.

(3) Reuse of disposable items.

(4) Reprocessing of disposable items to be reused.

(5) Proper handling of linen.

2. Primary care hospitals are subject to the central service requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the central services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-32. Anesthesia services.

1. General acute hospitals providing surgical services shall provide anesthesia services to meet the needs of the patients served and shall ensure the following:

   a. The anesthesia service must be under the direction of a qualified physician who is a member of the medical staff.

   b. The anesthesia service must be organized under current written policies and procedures regarding staff qualifications, the administration of anesthetics, the maintenance of safety controls, and required electronic monitoring of patient vital signs and oxygen levels during the anesthetic procedures consistent with current standards of practice. The anesthesia service is responsible for all anesthetics administered in the hospital.

   c. The patient must receive a preoperative visit from the anesthesiologist or the certified registered nurse anesthetist involved in the case.

   d. The anesthesia service shall establish policies, procedures, rules, and regulations for the control, storage, and safe use of combustible anesthetics, oxygen, and other medicinal gases in accordance with national fire protection association standards; types of anesthesia to be administered and procedures for each; personnel permitted to administer anesthesia; infection control; safety regulations to be followed; and responsibility for regular inspection, maintenance, and repair of anesthesia equipment and supplies.

   e. Anesthesia services may be initiated only when ordered by a member of the medical staff and must be administered only by persons qualified and licensed in the management of such materials.

f. An intraoperative anesthetic record must be made a part of the patient's medical record. Drugs used, vital signs, and other relevant information must be recorded at regular intervals during anesthesia.

(1) There must be a preanesthesia evaluation by an individual qualified and licensed to administer anesthesia, performed within forty-eight hours prior to the surgery, with findings recorded in the patient's medical record.

(2) Except in emergency, anesthetic may not be administered until the patient has had a history and physical examination, and a record made of the findings.

g. Postanesthetic followup visits must be made within forty-eight hours after the procedure by the anesthesiologist, certified registered nurse anesthetist, or responsible physician who shall note and record any postoperative abnormalities or complications from anesthesia.

2. Primary care hospitals may not provide anesthesia services.

3. Specialized hospitals providing surgical services shall comply with the anesthesia services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-33. Respiratory care services.

1. If the general acute hospital provides respiratory care services, the services must be under the supervision of a licensed health care practitioner, organized and integrated with other services of the hospital.

a. Respiratory care policies and procedures must be developed, implemented, and updated as needed for at least the following:

(1) Responsibility of the service to the medical staff.

(2) Clear protocol as to who can perform specific procedures.

(3) Written procedures for each type of therapeutic or diagnostic procedure.

(4) Written procedures for the cleaning, disinfection, or sterilization of all equipment that is not disposable.

(5) Written procedures for infection control.

(6) Written procedures for the control of all water used for respiratory therapy, is applicable.

(7) Protocol that establishes calibration and operation of equipment consistent with manufacturer's specifications and ensures that all equipment is maintained according to an established schedule.

b. All treatments involving respiratory care must be recorded in the patient's medical record by the person rendering the service, and must include type of therapy, date and time of treatments, any adverse reactions to treatments, and records of periodic evaluations by the licensed health care practitioner.

c. All treatments must be administered by respiratory therapists or other qualified staff in compliance with state law.

2. If the primary care hospital provides respiratory care services, the hospital shall comply with the respiratory care services requirements for general acute hospitals in this section.

3. If the specialized hospital provides respiratory care services, the hospital shall comply with the respiratory care services requirements for general acute hospitals in this section.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-34. Obstetrical services.

1. All general acute hospitals providing obstetrical services shall provide for the admission, medical care, transfer, or discharge of obstetric and neonatal patients. Obstetrical services must include the following:

a. The obstetrical services must have an organized obstetric staff with a chief of obstetrical services who is either certified or qualified in obstetrics or a physician who regularly practices obstetrics as head of the obstetrical service. The level of qualification and expertise of the chief of the obstetrical services must be appropriate to

the level of care rendered in the hospital. Responsibilities of the chief of the obstetrical service include:

(1) The general supervision of the care of obstetrical patients.

(2) The identification of clinical conditions and procedures requiring consultation.

(3) The arrangement of conferences held at regular intervals to review surgical procedures and operations, complications, and mortality.

(4) The provision for exchange of information between medical, administrative, and nursing staffs.

b. Only members of the medical staff with appropriate privileges may admit and care for patients in the obstetrical service areas.

c. Obstetrical patients under the effect of an analgesic or an anesthetic, in active labor or delivery, must be monitored and attended in accordance with the current standards of practice for obstetric-gynecologic services as identified by the association of women's health, obstetric and neonatal nursing and defined by hospital policies and procedures.

d. Fetal maturity must be established and documented prior to elective inductions and Caesarean sections.

e. There must be a written policy and procedure established in accordance with the current standards of practice as identified by the association of women's health, obstetric, and neonatal nursing concerning the administration and documentation of oxytocic drugs and their effects. Oxytocin may be used for medical induction or stimulation of labor only when qualified personnel, determined by the medical staff, can attend the patient closely. If electronic fetal monitoring is not available, the patient must be monitored on a one-to-one basis during the administration of the oxytocic drugs. The following areas must be included in the written policy and procedure for administration and documentation of oxytocic medications:

(1) The licensed health care practitioner shall evaluate the patient for induction or stimulation, especially with regard to indications for use of oxytocic medications.

(2) The licensed health care practitioner or other individuals starting the oxytocin shall be familiar with its effects and complications and be qualified to identify both maternal and fetal complications.

(3) A qualified licensed health care practitioner shall be immediately available as necessary to manage complications effectively.

f. Birthing and delivery rooms must be equipped and staffed to provide emergency resuscitation for infants in accordance with the current association of women's health, obstetric, and neonatal nursing standards of practice. Only personnel qualified and trained to do so may use infant emergency resuscitation equipment.

g. Equipment and personnel trained to use the equipment to maintain a neutral thermal environment for the neonate must be available and utilized as needed.

h. Nursing staff for obstetrical services must include:

(1) Nursing supervision by a registered nurse must be provided for the entire twenty-four-hour period the obstetrical services is occupied.

(2) At least one nurse trained in obstetrical and nursery care must be assigned to the care of mothers and infants at all times. Infants must be visually or electronically monitored at all times.

(3) A registered nurse must be in attendance at all deliveries, and must be available to monitor the mother's general condition and that of the fetus during labor.

i. A clean nursery must be provided near the mothers' rooms with adequate lighting and ventilation and must include the following:

(1) Bassinets equipped to provide for the medical examination of the newborn and for the storage of necessary supplies and equipment.

(2) A glass observation window through which infants may be viewed.

(3) Each nursery must have immediately on hand equipment necessary to stabilize the sick infant in accordance with current standards of practice established by the association of women's health, obstetric, and neonatal nursing and defined in hospital policies.

j. The hospital shall identify specific rooms and beds to be used exclusively for obstetrical patients, obstetrical and gynecological patients, and nursery patients as provided in a plan specifically approved by the department.

(1) Obstetrical services must be located and arranged to provide maximum protection for obstetrical and neonatal patients from infection and cross-infection from patients in other services of the hospital.

(2) Obstetrical services must be located in the hospital so as to prevent through traffic to any other part of the hospital.

2. Primary care hospitals may not provide obstetrical services.

3. If a specialized hospital provides obstetrical services, the specialized hospital is subject to the obstetrical services requirements for general acute hospitals.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-35. Specialized rehabilitation services in hospitals.

1. Specialized rehabilitation services in a general acute hospital must be provided in a distinct, clearly defined, special unit and are subject to the specialized rehabilitation services in hospitals requirements for specialized hospitals in this section. If in the course of the inspection of a general acute hospital, the department finds from a review of the rehabilitation services rendered and the adequacy of the consultation and referral resources that the hospital practice and staffing warrants the establishment of a specialized rehabilitation service, the department shall recommend the establishment of such service.

2. Primary care hospitals may not provide specialized rehabilitation services.

3. The specialized rehabilitation hospital shall provide preventive, diagnostic, therapeutic, and rehabilitative services to patients in accordance with the licensure requirements in this chapter.

a. The rehabilitation hospital shall provide for services to inpatients and outpatients by a core group of professionals, who are licensed or certified consistent with state laws, which must include, dependent on the patient's needs, the following:

(1) Occupational therapist.

(2) Physical therapist.

(3) Physician.

(4) Psychologist.

(5) Rehabilitation nurse.

(6) Social worker.

(7) Speech and language pathologist.

(8) Therapeutic recreation specialist.

b. Additional services that must be provided to inpatients and outpatients, either directly by the rehabilitation hospital or by arrangement, dependent upon the identified needs and program goals, include:

(1) Audiology.

(2) Chaplaincy.

(3) Chemical dependency counseling.

(4) Dental services.

(5) Dietary services and nutritional counseling.

(6) Driver evaluation and education.

(7) Environmental modification.

(8) Laboratory services.

(9) Licensed health care practitioner services.

(10) Orthotics and prosthetics.

(11) Pharmaceutical services.

(12) Physiatry.

(13) Radiology services.

(14) Rehabilitation engineering.

(15) Respiratory care services.

(16) Sexual counseling.

(17) Vocational testing and rehabilitation.

c. For inpatients, unless contraindicated in writing by the qualified physiatrist, the rehabilitation hospital shall provide at a minimum three hours of services per patient per day, which must include one or a combination of the following: physical therapy, occupational therapy, speech-language pathology, prosthetics and orthotics services, or therapeutic recreational therapy.

d. Rehabilitation hospitals must be accredited by the commission on accreditation of rehabilitation facilities in the category of comprehensive inpatient rehabilitation prior to licensure as a rehabilitation hospital by the department.

e. If a hospital licensed by the department provides specialized rehabilitation services in addition to other hospital services, the hospital shall adhere to the rules of this section in addition to the rules for other hospital services.

f. Submission of documents and onsite review must be as follows:

(1) The rehabilitation hospital, upon receipt, shall submit all commission on accreditation of rehabilitation facilities survey results, recommendations, and plans of correction to the department.

(2) Based on the commission on accreditation of rehabilitation facilities survey results, the department may require changes or additions to the recommendations or plans of corrections if endangerment to the health, well-being, or safety of patients is involved.

(3) Onsite review must be conducted by the department to assess compliance with licensure requirements not included in the commission on accreditation of rehabilitation facilities standards.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-36. Psychiatric services in hospitals.

1. General acute hospitals providing psychiatric services are subject to the psychiatric services in hospitals requirements for specialized hospitals in this section. If, in the course

of the inspection of a general acute hospital, the department finds from a review of the psychiatric treatment rendered and the adequacy of the consultation and referral resources that the hospital practice and staffing warrants the establishment of a psychiatric service, the department shall notify the hospital of the need to establish the service in a manner that complies with this section.

2. Primary care hospitals may not provide psychiatric services.

3. Any facility that provides or purports to provide psychiatric inpatient or inpatient and outpatient diagnosis or treatment on other than an emergency basis shall comply with this section. A hospital may not hold itself out to the public as providing psychiatric services unless such psychiatric service has been licensed by the department and meets the requirements for a psychiatric hospital in this section.

   a. Hospitals accredited by a national accrediting entity in the category of psychiatric services shall submit, upon receipt, all accreditation survey results, recommendations, and plans of correction to the department.

   b. In hospitals without an approved psychiatric service, psychiatric care to patients with a primary diagnosis of a psychiatric disorder may be rendered on an emergency basis by appropriate members of the medical staff as determined by the hospital. Psychiatric consultation must be available and utilized appropriately as determined by the hospital.

   c. The organization and responsibilities of the medical staff for psychiatric services must be in accordance with licensure requirements, except as amended and modified:

      (1) The physician in charge of the psychiatric services must be a psychiatrist who is licensed to practice medicine in North Dakota.

      (2) The psychiatrists on the staff of the psychiatric hospital or psychiatric services of a general acute hospital must have as minimum qualifications at least three years' approved residency training in psychiatry or equivalent training and experience. If physicians other than psychiatrists are authorized to treat patients in a psychiatric hospital or in a psychiatric service there must be timely evidence of psychiatric consultation after the patient is admitted, and ongoing consultation with a psychiatrist who is a member of the psychiatric staff, as needed.

(3) There must be other medical staff in appropriate specialties, available at all times to the psychiatric staff.

d. The organization and staffing of the nursing service must be in accordance with the licensure requirements, except as amended and modified:

(1) The registered nurse supervising the nursing services of the psychiatric services must have experience and demonstrated competency in psychiatric nursing.

(2) The nursing personnel of the psychiatric services in a general acute hospital must be a separate staff who are assigned to the psychiatric services.

(3) There must be at least one registered nurse with experience in psychiatric nursing on duty at all times on each psychiatric nursing unit. The number of registered nurses and other nursing personnel must be adequate to provide the individual patient care required to carry out the patient care plan for each patient.

e. The following services or consultative resources are required: clinical psychological services, social work services, and occupation and recreational therapy services. These services must be under the direction of a psychiatrist in charge of the psychiatric services in a general acute hospital or the psychiatric diagnosis or treatment units in a psychiatric hospital. The staff used to support these services must be adequate in number and be qualified by professional education, experience, and demonstrated ability. If registration or licensing of personnel is required by statute or regulation, the registration number must be on file and available upon request.

f. Personnel development and training for psychiatric services staff must include the following:

(1) There must be written evidence of orientation training for all staff and ongoing, planned, and scheduled inservice training for all staff.

(2) Ongoing interdisciplinary staff conferences must be held to ensure communication, coordination, and participation of all professional staff and personnel involved in the care of patients.

g. Specialized procedures for psychiatric services must be provided for and implemented as follows:

(1) A patient may not be subject to the withholding of privileges or to any system of rewards, except as part of a treatment plan.

(2) Electroconvulsive therapy, experimental treatments involving any risk to the patient, or aversion therapy may not be prescribed, unless:

(a) The patient's treatment team has documented in the patient's record that all reasonable and less intensive treatment modalities have been considered, the treatment represents the most effective therapy for the patient at that time, the patient has been given a full explanation of the nature and duration of the proposed treatment and why the treatment team is recommending the treatment, and the patient has been informed of the right to accept or refuse the proposed treatment and, if the patient consents, has the right to revoke the consent for any reason at any time prior to or between treatments.

(b) The treatment was recommended by qualified staff members trained and experienced in the treatment procedure and has been approved by the psychiatrist.

(c) The patient has given written informed consent to the specific proposed treatment. In the alternative, oral informed consent is sufficient if that consent is witnessed by two persons not part of the patient's treatment team. In either case, such consent must be limited to a specified number of maximum treatments over a period of time and must be revocable at any time before or between treatments. Such withdrawal of consent is immediately effective.

(d) If a patient's treatment team determines that the patient could benefit from one of those specified treatments but also believes that the patient does not have the capacity to give informed consent to the treatment, appropriate consent consistent with applicable state laws must be obtained before such treatment may be administered to the patient.

(3) A patient may not be subject to chemical, physical, or psychological restraints, including seclusion, other than in accordance with the policy and procedures for seclusion and restraint approved by the medical staff and governing body. A copy of the

applicable regulations must be made available to patients upon request.

(4) A patient may not be the subject of any research, unless conducted in strict compliance with federal regulations on the protection of human subjects. Patients considered for research approved by the hospital must receive and understand a full explanation of the nature of the research, the expected benefit, and the potential risk involved. Copies of the federal regulations must be made available to patients or their advocates involved in, or considering becoming involved in, research.

h. If the treatment team determines that continued voluntary inpatient treatment is not indicated, the treatment team shall discharge the patient with an appropriate postdischarge plan. The postdischarge plan must address folowup needs, future consultative needs, or in the event of patient regression or deterioration, treatment or admission needs.

i. Care of patients for psychiatric services must include the following:

(1) Each psychiatric unit shall have available recreational and occupational therapy and other appropriate facilities adequate in size in relation to patient population, number of beds, and program.

(2) Restraints and seclusion facilities must be available, and written policies must be established for their use. Mechanical restraints or seclusion may be used only on the written order of a physician. This written order must be valid for specific periods of time. In an emergency, the licensed professional in charge may order restraints. Confirmation of the order by a physician must be secured. Policies and procedures regarding use of restraints and seclusion must be reviewed annually. The patient medical record must indicate justification for the restraint, time applied and released, and other pertinent information.

(3) A current policy and procedure manual must be maintained for the psychiatric service. The manual must include procedures for the care and treatment of patients including the care of suicidal and assaultive patients, and the elopement of patients. The manual must identify the relationship with state agencies and community organizations providing psychiatric services. It must also describe plans

for the evaluation and disposition of psychiatric emergencies.

(4) The design of facilities and the selection of equipment and furnishings must be conducive to the psychiatric program and must minimize hazards to psychiatric patients.

j. The psychiatric services shall develop an interdisciplinary team composed of mental health professionals, health professionals, and other persons who may be relevant to the patient's treatment. At least one member of the team must be a psychiatrist. The team and patient or advocate shall formulate and evalulate an appropriate treatment plan for the patient.

(1) The director of the interdisciplinary team shall assure that staff trained and experienced in the use of modalities proposed in the treatment plan participate in its development, implementation, and review.

(2) The director of the interdisciplinary team is responsible for:

(a) Ensuring that the person in treatment is encouraged to become increasingly involved in the treatment planning process.

(b) Implementing and reviewing the individualized treatment plan and participating in the coordination of service delivery with other service providers.

(c) Ensuring that the unique skills and knowledge of each team member are utilized and that specialty consultants are utilized when needed.

(3) Although an interdisciplinary team must be under the direction of a psychiatrist, specific treatment modalities may be under the direction of other mental health professionals when they are specifically trained to administer or direct such modalities.

k. A comprehensive individualized treatment plan must:

(1) Be formulated to the extent feasible with the consultation of the patient. When appropriate to the patient's age, or with the patient's consent, the patient's family, personal guardian, or appropriate other persons should be consulted about the plan.

(2) Be based upon diagnostic evaluation that includes examination of medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental aspects of the patient's situation.

(3) Set forth treatment objectives and prescribe an integrated program of therapies, activities, experiences, and appropriate education designed to meet these objectives.

(4) Result from the collaborative recommendation of the patient's interdisciplinary team.

(5) Be maintained and updated with progress notes, and be retained in the patient's medical record.

(6) State the basis for the restraints if the plan provides for restraints. The patient medical record must indicate what less restrictive alternatives were considered and why they were not utilized.

(7) Be written in terms easily explainable to the lay person. A copy of the current treatment plan must be available for review by the person in treatment.

(8) Note when the most appropriate form of treatment for the individual is not available or is to expensive to be feasible.

l. At least once every seven days every person in treatment must be plan reviewed. A report of the review and findings must be summarized in the patient's medical record and the treatment plan must be updated as necessary.

m. Subject to certain limitations authorized by a parent, legal guardian, legal custodian, or a court of law concerning a minor or guardian of an incapacitated person or restrictions by the treating physician or psychiatrist, which in their professional judgment is in the best interest of the patient, each patient has the right to:

(1) Receive or refuse treatment for mental and physical ailments and for the prevention of illness or disability.

(2) The least restrictive conditions necessary to achieve the purposes of the treatment plan.

(3) Be treated with dignity and respect.

(4) Be free from unnecessary restraint and isolation.

(5) Visitation and telephone communications.

(6) Send and receive mail.

(7) Keep personal clothing and possessions.

(8) Regular opportunities for outdoor physical exercise.

(9) Participate in religious worship of choice.

(10) Be free from unnecessary medication.

(11) Exercise all civil rights, including the right to habeas corpus.

(12) Not be subjected to experimental research without the express written consent of the patient or of the patient's guardian.

(13) Not be subjected to psychosurgery, electroconvulsive treatment, or aversive reinforcement conditioning, without the express and informed written consent of the patient or the patient's guardian.

n. Each hospital must have a clearly defined appeal system through which any patient who wishes to voice objections concerning the patient's treatment must be heard and have objections determined.

(1) Each hospital shall monitor the appeal system to see that it works properly and records must be maintained for review by the department in order to investigate any complaint.

(2) All patients must be advised of such system and be encouraged to use it when they believe their treatment plan is not necessary or appropriate to their needs.

o. Medical record requirements for psychiatric hospitals and psychiatric services of general acute hospitals must include the following:

(1) Medical records must stress the psychiatric components of the patient's condition and care including history of findings and treatment rendered for the psychiatric condition for which the patient is hospitalized.

(2) A provisional or admitting diagnosis must be made on every patient at the time of admission and include the diagnoses of current diseases as well as the psychiatric diagnoses.

(3) Data from all pertinent sources must be included, in addition to data obtained from the patient.

(4) A psychiatric evaluation must be performed within forty-eight hours of admission, include a medical history, contain a record of mental status, and note the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functions, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretive, fashion.

(5) A complete neurological examination must be recorded at the time of the admission physical examination, when indicated.

(6) Social service records, including reports of interviews with patients, family members, and others must provide an assessment of home plans, family attitudes, and community resource contacts, with appropriate recommendations for family or community resource involvement, as well as a social history.

(7) Reports of consultations, reports of electroencephalograms, and other pertinent reports of special studies.

(8) The patient's comprehensive treatment plan must be recorded, must be based on an inventory of the patient's strengths as well as disabilities, and must include a substantiated diagnosis in the terminology of the most current edition of the American psychiatric association's diagnostic and statistical manual, short-term and long range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it provides adequate justification and documentation for the diagnoses and for the treatment and rehabilitation activities carried out.

(9) The treatment received by the patient must be documented to assure that all active therapeutic efforts such as individual and group psychotherapy, durg therapy, milieu therapy, occupational therapy, recreational therapy, industrial or work therapy, nursing care, and other therapeutic interventions are included.

(10) The discharge summary must include a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning followup or

aftercare as well as a brief summary of the patient's condition on discharge.

(11) Confidentiality of the psychiatric record must be recognized and safeguarded in medical records services of the hospital.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

CHAPTER 33-07-02.1
GENERAL STANDARDS OF CONSTRUCTION AND EQUIPMENT FOR HOSPITALS

33-07-02.1-01. Site. The site of the hospital must be away from nuisances that may be detrimental to the proposed services, such as commercial or industrial developments, or other types of facilities that produce noise or air pollution. A site plan must be submitted to the department.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3)(4), 28-32-02
Law Implemented: NDCC 23-16-05

33-07-02.1-02. Plans and specifications.

1. Hospitals shall contact the department prior to any substantial changes in or alterations to any portion of the structure to determine to what extent they are subject to review. A substantial change must include any alterations affecting the fire safety or structural integrity of the building, changes in service areas or services provided within a service area, changes in bed capacity, or any other changes that may be governed by the standards of this article. The department may request plans, specifications, or other information as may be required and shall make the final determination on those areas subject to review.

2. Hospitals shall submit plans and specifications to the department for all construction, remodeling, and installations subject to review. The plans and specifications must be prepared by an architect or engineer, as appropriate, licensed in North Dakota.

3. Start of construction prior to completion and approval by the department of the final plans and specifications is not permitted.

4. Routine maintenance does not require the submission of plans and specifications. For purposes of this subsection, "routine maintenance" includes repair or replacement of existing equipment, room finishes, and furnishings and similar activities.

5. All construction, remodeling, and installations must be in accordance with the final plans and specifications as approved by the department. Modifications or deviations from the approved plans and specifications must be submitted to and approved by the department.

6. The department may make inspections of construction, remodeling, or installations and arrange conferences with the hospital to assure conformance with the approved plans and specifications.

7. The construction specifications must require the contractor to perform tests to assure that all systems conform to the approved plans and specifications.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3)(4), 28-32-02
Law Implemented: NDCC 23-16-05

33-07-02.1-03. Codes and standards.

1. Hospitals must be designed, constructed, equipped, maintained, and operated in compliance with:

   a. This chapter.

   b. The Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1992-93 Edition, compiled by the American institute of architects committee on architecture for health.

   c. The national fire protection association 101 Life Safety Code, 1985 Edition.

   d. North Dakota Century Code section 54-21.3-04.1, relating to accessibility for disabled persons.

   e. Chapter 33-09-03 relating to certificate of need.

   f. Chapter 47-04-03.1 relating to sanitary requirements for food establishments.

   g. Article 62-03 relating to plumbing standards.

   h. Article 24-02 relating to electrical wiring standards.

   i. The rules adopted by the insurance commissioner relating to boiler inspection.

   j. Article 33-15 governing air pollution control, relating to incinerators.

k. Article 33-10 relating to radiological health.

2. Hospitals shall comply with all applicable building codes, ordinances, and rules of city, county, or state jurisdictions.

3. These minimum standards are established to bring about a desired performance result. If specific limits are prescribed, equivalent solutions will be acceptable if they are approved in writing by the department as meeting the intent of these standards.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3)(4), 28-32-02
Law Implemented: NDCC 23-16-05

33-07-02.1-04. Special considerations.

1. Hospitals with a capacity of fifty beds or less may qualify for special consideration of these standards. Some functions allotted separate spaces or rooms in these standards may be combined, provided the resulting arrangement does not compromise safety and medical and nursing practices. In all other respects, these standards apply, including the space requirements.

2. If services are to be shared or purchased, modifications or deletions in space requirements may be allowed by the department. However, the services to be shared or purchased must be approved in writing by the department.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3)(4), 28-32-02
Law Implemented: NDCC 23-16-05

33-07-02.1-05. Patient rooms. Each patient room must meet the following requirements:

1. A patient room may not be located on a floor unless a portion of the floor is at or above grade level. A patient room may not have its floor more than thirty inches [.76 meter] below the adjacent grade.

2. Patient rooms must have adequate space to conveniently house necessary furniture and equipment, to provide for efficient patient care, to provide for convenient movement of stretchers, and for the transfer of patients to and from beds.

3. The smallest dimension of a rectangular single patient room may not be less than ten feet [3.05 meters] free of fixed obstructions and the floor area may not be less than one hundred twenty-five square feet [11.61 square meters].

4. The smallest dimension of a rectangular multiple patient room may not be less than eleven feet six inches [3.51 meters] free of fixed obstructions, except in specially arranged rectangular rooms such as toe-to-toe arrangements where the minimum clear width may not be less than ten feet [3.05 meters] free of fixed obstructions.

5. In other than rectangular-shaped rooms, the principles of space allocation specified by the minimum dimensions and floor area requirements in rectangular-shaped rooms must be adhered to.

6. Each patient room must have an outside wall with natural light provided by a window. The area of the glazing material in the window may not be less than one-tenth of the floor area of the patient room.

7. Multiple patient rooms must be designed to permit no more than two beds side by side parallel to the window wall.

8. A patient room may not be located more than one hundred twenty feet [36.58 meters] from the nurses station, the clean workroom, and the soiled workroom.

9. Patient toilet rooms must be functionally accessible and usable by the patients whom they serve.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3)(4), 28-32-02
Law Implemented: NDCC 23-16-05

33-07-02.1-06. Details.

1. At least one room must be provided for toilet training. It must be accessible from the corridor and may also serve the bathing area, and must provide three feet [.91 meter] clearance at the front and both sides of the water closet.

2. Ceilings must be acoustically treated in patient area corridors, nurses stations, labor rooms, dining areas, and dayrooms.

3. All lavatories and sinks required in patient care areas must have the water supply spout mounted so that its discharge point is a minimum distance of five inches [12.7 centimeters] above the rim of the fixture.

4. Flush valves installed on plumbing fixtures must be of quiet operating type equipped with silencers.

History: Effective April 1, 1994.
General Authority: NDCC 23-01-03(3)(4), 28-32-02
Law Implemented: NDCC 23-16-05

TITLE 37

Department of Transportation

DECEMBER 1993

ARTICLE 37-10

COMMERCIAL DRIVERS LICENSE

CHAPTER 37-10-01
ALCOHOL RELATED OFFENSES

37-10-01-01. Out-of-service order - Driving of commercial motor vehicle prohibited.

1. Prohibited alcohol offenses for commercial motor vehicle drivers. Notwithstanding any other provision of law, a person may not drive, operate, or be in actual physical control of a commercial motor vehicle within this state while having any measurable or detectable amount of alcohol in the person's system.

2. In addition to any other sanctions that may be imposed under law a person who drives, operates, or is in actual physical control of a commercial motor vehicle within this state must be placed out of service for twenty-four hours if the person:

a. Has any measurable or detectable amount of alcohol in the person's system;

b. Has a blood-alcohol concentration of at least four one-hundredths of one percent by weight; or

c. Refuses to submit to an alcohol test under North Dakota Century Code section 39-06.2-10.

3. The out-of-service order must show the halting officer's reason for stopping or detaining the commercial motor vehicle driver and must show that the halting officer had reasonable grounds to believe the person was driving or in actual physical control of a commercial motor vehicle, that the person was lawfully detained, and that the person:

   a. Had any measurable or detectable amount of alcohol in the person's system;

   b. Had a blood-alcohol concentration of at least four one-hundredths of one percent by weight; or

   c. Refused to submit to an alcohol test under North Dakota Century Code section 39-06.2-10.

   Any out-of-service order must be issued prior to the end of the detention of the driver. The law enforcement officer shall sign and note the time and date of the issuance on the out-of-service order.

4. The out-of-service order prohibits the person named in the order from driving a commercial motor vehicle for a period of twenty-four hours from the time of the issuance of such order. The driving of a commercial motor vehicle while subject to an out-of-service order is a violation of North Dakota Century Code section 39-06-42.

History: Effective October 1, 1993.
General Authority: NDCC 39-06.2-14
Law Implemented: NDCC 39-06.2-10.9

TITLE 43

Industrial Commission

April 1994

CHAPTER 43-02-01

43-02-01-05. Enforcement. The commission, its agents, representatives, and employees are charged with the duty and obligation of enforcing all rules and statutes of the state of North Dakota relating to coal exploration and evaluation.

It shall be the responsibility of all permit applicants and permitholders to obtain information pertaining to the regulation of coal exploration and evaluation before the operations of the permit applicants and permitholders have begun.

Whenever a corporate permittee violates North Dakota Century Code chapter 38-12.1 or any permit condition or rule implemented thereunder, a director, officer, or agent of the corporate permittee who knowingly causes such violation is subject to the criminal penalties imposed under subsection 2 of North Dakota Century Code section 38-12.1-08. "Knowingly" is to be understood as defined by North Dakota Century Code section 12.1-02-02. In addition, whenever a director, officer, or agent of a corporate permittee willfully or negligently violates North Dakota Century Code chapter 38-12.1 or any permit condition or rule implemented thereunder, civil penalties may be imposed under subsection 1 of North Dakota Century Code section 38-12.1-08. "Willfully" and "negligently" are to be understood as defined by North Dakota Century Code section 12.1-02-02.

History: Amended effective April 1, 1994.
General Authority: NDCC 38-12.1-04
Law Implemented: NDCC 38-12.1-04, 38-12.1-07, 38-12.1-08

43-02-01-20. Performance standards for coal exploration. The performance standards in this section are applicable to coal exploration which substantially disturbs land surface and on land designated unsuitable for mining under North Dakota Century Code section 38-14.1-05. Whether the land surface will be substantially disturbed shall be determined by the state geologist.

1. For purposes of this section, "substantially disturb" means, for purposes of coal exploration, to impact significantly upon land, air, or water resources by such activities as blasting, mechanical excavation, drilling or altering coal or water exploratory holes or wells, construction of roads and other access routes, and the placement of structures, excavated earth, or other debris on the surface of land.

2. Coal exploration activities which will substantially disturb land surface shall not be allowed to affect the following:

   a. Habitats of unique value for fish, wildlife, and other related environmental values.

   b. Threatened or endangered species of plants or animals listed by the Endangered Species Act of 1973, as amended [16 U.S.C. 1531 et seq.] and their critical habitats.

   c. Species such as eagles, migrating birds or other animals protected by state or federal law, and their habitats.

   d. Habitats of unusually high value for fish and wildlife, such as wetlands, riparian areas, cliffs, supporting raptors, areas offering special shelter or protection, reproduction and nursery areas, and wintering areas.

3. The person who conducts coal exploration shall, to the extent practicable, measure important environmental characteristics of the exploration area during the operations, to minimize environmental damage to the area and to provide supportive information for any permit application that person may submit as part of the permit application.

   a. Vehicular travel on other than established graded and surfaced roads shall be limited by the person who conducts coal exploration to that absolutely necessary to conduct the exploration. Travel shall be confined to graded and surface roads during periods when excessive damage to vegetation or rutting of the land surface could result.

   b. Any new road in the exploration area shall comply with the provisions of chapter 69-05.2-24.

   c. Existing roads may be used for exploration in accordance with the following:

(1) All applicable federal, state, and local requirements shall be met.

(2) If the road is significantly altered for exploration, including, but not limited to, change of grade, widening, or change of route, or if use of the road for exploration contributes additional suspended solids to streamflow or runoff, then subsection 7 and subsections 1 and 2 of section 69-05.2-24-01 shall apply to all areas of the road which are altered or which result in such additional contributions. A road is altered if it is constructed, reconstructed, improved, or maintained in any way that causes the changes described in this section.

(3) If the road is significantly altered for exploration activities and will remain as a permanent road after exploration activities are completed, the person conducting exploration shall ensure that the requirements of chapter 69-05.2-24, as appropriate, are met for the design, construction, alteration, and maintenance of the road.

d. Promptly after exploration activities are completed, existing roads used during exploration shall be reclaimed either:

(1) To a condition equal to or better than their preexploration condition; or

(2) To the condition required for permanent roads under chapter 69-05.2-24, as appropriate.

4. If excavations, artificial flat areas, or embankments are created during exploration, these areas shall be returned to the approximate original contour promptly after such features are no longer needed for coal exploration.

5. Suitable plant growth material, as defined in subsection 31 of North Dakota Century Code section 38-14.1-02 shall be removed, stored, and redistributed on disturbed areas as necessary to assure successful revegetation or as required by the commission.

6. Revegetation of areas disturbed by coal exploration shall be performed by the person who conducts the exploration or the person's agent. All revegetation shall be in compliance with the plan approved by the commission and carried out in a manner that encourages prompt vegetative cover and recovery of productivity levels compatible with approved postexploration land use and in accordance with the following:

a. All disturbed lands shall be seeded or planted to the same seasonal variety native to the disturbed area or to some suitable, commercially available mixture approved by the state geologist. If both the preexploration and postexploration land uses are intensive agriculture, planting of the crops normally grown will meet the requirements of this section.

b. The vegetative cover shall be capable of stabilizing the soil surface in regards to erosion.

7. With the exception of small and temporary diversions of overland flow of water around new roads, drill pads, and support facilities, no ephemeral, intermittent or perennial stream shall be diverted during coal exploration activities. Overland flow of water shall be diverted in a manner that:

   a. Prevents erosion.

   b. To the extent possible using the best technology currently available, prevents additional contributions of suspended solids to streamflow or runoff outside the exploration area.

   c. Complies with all other applicable state or federal requirements.

8. Each exploration hole, borehole, well, or other exposed underground opening created during exploration must be cased or sealed to meet the requirements of chapter 69-05.2-14 and section 43-02-01-14.

9. All facilities and equipment shall be removed from the exploration area promptly when they are no longer needed for exploration, except for those facilities and equipment that the state geologist determines may remain to:

   a. Provide additional environmental quality data.

   b. Reduce or control the onsite or offsite effects of the exploration activities.

   c. Facilitate future surface mining and reclamation operations by the person conducting the exploration, under an approved permit.

10. Coal exploration shall be conducted in a manner which minimizes disturbance of the prevailing hydrologic balance, and shall include appropriate sediment control measures such as those specified in section 69-05.2-16-08. The commission may specify additional measures which shall be adopted by the person engaged in coal exploration.

11. Toxic-forming materials shall be handled and disposed of in accordance with sections 69-05.2-16-11 and 69-05.2-21-03. If specified by the commission, additional measures shall be adopted by the person engaged in coal exploration.

History: Effective August 1, 1980; amended effective March 1, 1991; April 1, 1994.
General Authority: NDCC 38-12.1-04
Law Implemented: NDCC 38-12.1-04

43-02-07-08. Bond. Before any person receives a permit to drill, bore, excavate, or construct a geothermal energy extraction facility, the person shall submit to the commission and obtain its approval of a bond, on a form approved by the commission, conditioned as provided by law. At the discretion of the state geologist, an installation or facility bond may be required for the substantial modification of a geothermal energy extraction facility in existence prior to December 1, 1992. The state geologist has the discretion to waive the requirement for a facility bond if the applicant is an instrumentality of the state. Each such bond must be executed by a responsible surety company authorized to transact business in this state.

The amount and type of the bond is as follows:

1. Shallow-well and horizontal-loop facilities. ~~A fifteen thousand dollar facility blanket bond is required for all closed-loop systems using anything other than an approved heat transfer fluid, for all open-loop systems which are deemed by the state geologist to be an environmental risk, and for any other shallow well or horizontal loop system that the state geologist deems necessary.~~

   ~~The installer of all shallow well or horizontal loop facilities which do not require a facility bond shall carry an installation bond. The amount of the installation bond must be as follows:~~

   a. ~~A ten thousand dollar installation blanket bond for facilities of up to ten shallow wells and for all horizontal loop facilities.~~ The state geologist has the discretion to require a facility surety bond in the amount of fifteen thousand dollars for any shallow-well or horizontal-loop facility that, for any reason, constitutes a special threat to important ground water resources or the environment, or otherwise poses a significant public health hazard.

   b. ~~A twenty five thousand dollar installation blanket bond for facilities of more than ten wells but less than fifty shallow wells.~~ An installation surety bond in the amount of ten thousand dollars is required of installers of all shallow-well and horizontal-loop facilities. This is a blanket bond and must cover all permits for shallow-well and horizontal-loop facilities issued in one year commencing on the date the first permit covered by the bond is issued. Alternately, at the discretion of the state geologist, an installation surety bond in the amount of one hundred dollars for each well (loop) installed per year may be submitted.

c. ~~A fifty thousand dollar installation blanket bond for facilities of more than fifty shallow wells.~~ In lieu of the installation surety bond in subdivision b, the state geologist has the discretion to accept a cash bond of two thousand five hundred dollars for the installation of up to twenty loops per year for shallow-well closed-loop facilities.

d. Liability on the installation bond is conditioned on the compliance with North Dakota Century Code chapter 38-19 and the rules and orders of the commission. Liability on the installation bond continues until construction of the geothermal energy extraction facility has been completed and approved by the state geologist. At the discretion of the state geologist, liability may be terminated earlier when it can be demonstrated that only minor interior work remains to be completed and when completion of this work is subject to inordinate delays beyond the control of the geothermal system installer.

2. **Deep-well facilities.** A facility bond is required for all deep-well facilities. The amount of the facility bond must be a five thousand dollar bond for a deep-well facility with one supply well. The bond must increase in five thousand dollar increments for each additional supply well and each injection well.

The owner of a geothermal energy extraction facility is responsible for obtaining the facility bond in subdivision a of subsection 1 and subsection 2.

Liability on the facility bond in subdivision a of subsection 1 and subsection 2 is conditioned on compliance with North Dakota Century Code chapter 38-19 and the rules and orders of the commission, and continues until either of the following occurs: (1) the wells or loop systems have been satisfactorily plugged as provided in this chapter, the sites disturbed by any method of production of geothermal energy have been reclaimed in a manner approved by the state geologist, and all logs, plugging records, and other pertinent data required by statute or rules and orders of the commission are filed and approved; or (2) the liability on the bond has been transferred to another bond and such transfer approved by the commission.

The commission shall advise the surety and the principal when liability on a bond is terminated.

~~Liability on the installation bond is conditioned on compliance with North Dakota Century Code chapter 38-19 and the rules and orders of the commission, and continues until either of the following occurs: (1) the site disturbed during installation of the geothermal energy extraction facility has been reclaimed in a manner approved by the state geologist and a successful pressure test of the geothermal energy extraction facility has been completed and approved by the state~~

~~geologist. Such tests shall not be conducted without the state geologist first having been given five days' advanced written notice of the date and approximate time of the test or (2) the liability on the bond has been transferred to another bond and such transfer approved by the commission.~~

~~The commission shall advise the surety and the principal when liability on a bond is terminated.~~

The state geologist is authorized to act for the commission as to all matters within this section.

History: Effective March 1, 1984; amended effective October 1, 1990; December 1, 1992; April 1, 1994.
General Authority: NDCC 38-19-03
Law Implemented: NDCC 38-19-03

TITLE 45

Insurance, Commissioner of

FEBRUARY 1994

STAFF COMMENT: Chapter 45-03-18 contains all new material but is not underscored so as to improve readability.

CHAPTER 45-03-18
FIRE DISTRICT ASSIGNMENT

45-03-18-01. Application or renewal form to contain fire district number.

1. Applications for fire, allied, multiple peril crop, homeowner's multiple peril, farmowner's multiple peril, commercial multiple peril, or crop hail insurance coverage for property in this state must identify by fire district number the fire district in which the property is located.

2. A company using an in-house system (electronic or manual) in its application process to identify and record the fire district number based upon the property location and value, complies with this section if the data is accurate, accessible, and readily verifiable.

3. Companies that use agents for reporting this information may use form NDFD300 (8/93) (appendix A).

4. For renewal business or changes not requiring a new application:

   a. Companies using agents to report the information may use form NDFD300 (8/93) (appendix A).

   b. Companies using an in-house system may do so subject to the requirements of subsection 2.

5. In lieu of form NDFD300 (8/93) (appendix A), the company may amend its application or use a substantially similar supplemental form of the company's own design.

History: Effective August 9, 1993.
General Authority: NDCC 26.1-01-07.5
Law Implemented: NDCC 26.1-01-07.5

45-03-18-02. Applications involving multiple fire districts. In accordance with section 45-03-18-01, a company shall apportion the property premium attributable to each fire district on the basis of the location of the property and the insured value of the property in each district.

History: Effective August 9, 1993.
General Authority: NDCC 26.1-01-07.5
Law Implemented: NDCC 26.1-01-07.5

45-03-18-03. Atlas of fire district maps. The insurance department, in conjunction with the state fire marshal and the firemen's association, shall prepare an atlas of county maps showing the fire districts in each county. The atlas must certify the fire districts as of July first of each year. A copy of the atlas must be sent and billed to each company subject to section 45-03-18-01 which is licensed in this state. The charge for the atlas is twenty dollars per copy. Companies must be notified each year of the changes to the atlas and companies are responsible for distribution of the atlas, if necessary.

History: Effective August 9, 1993.
General Authority: NDCC 26.1-01-07.5
Law Implemented: NDCC 26.1-01-07.5

45-03-18-04. Company reporting of premium information. The insurance department is responsible for the collection, verification, and accuracy of data reported to the insurance department along with its annual statement. The company may file the appropriate information by computer diskette subject to the specifications set forth by the insurance department. If the company is unable to comply with these

specifications, the company may use the fire district reporting form and file manually. A copy of page fourteen of the annual statement must be submitted with the diskette and fire district reporting form for purposes of cross-checking data.

History: Effective August 9, 1993.
General Authority: NDCC 26.1-01-07.5
Law Implemented: NDCC 26.1-01-07.5

45-03-18-05. Reporting of property premiums only. In the lines of homeowner's multiple peril, farmowner's multiple peril, and commercial multiple peril insurance companies shall subtract any liability premium from the total premium to arrive at the property premium. For package policies containing numerous subcoverages with minor premiums attributable to each, those premiums must be included in the total amount reported.

History: Effective August 9, 1993.
General Authority: NDCC 26.1-01-07.5
Law Implemented: NDCC 26.1-01-07.5

APPENDIX A

NORTH DAKOTA – Fire District Assignment
Supplement to Property Insurance Application

N.D.C.C. 26.1-01-07.5 requires:

After December 31, 1993, no insurer may issue or renew a policy for fire, allied lines, multiple peril crop, homeowner's multiple peril, farmowner's multiple peril, commercial multiple peril, or crop hail insurance coverage for property in this state unless the application identifies each fire district in which the insured property is located. The application must identify the property and insured value of the property located within each fire district if the policy provides coverage for property that is not all within a single district. For purposes of this section, "fire district" means rural fire protection district, city or area served by a certified rural fire department.

INSTRUCTIONS:

If all property insured is located in one Fire District, indicate Fire District in Column A, "ALL" in column B, and complete columns C and D.

If some of the insured property falls into different Fire Districts, indicate each Fire District in Column A. In columns B, C, and D, provide a breakout of the property in each district, its corresponding insured value, and proportionate premium.

Do not include Liability premium in column D.

Insurance Company: _____

Policy #: _____ New _____ Renewal _____

Named Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

A Fire District #	B Location of Property	C Insured Value of Property	D Property Premium

Agent: _____ Date: _____

NDFD300 (8/93)

MARCH 1994

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

CHAPTER 45-06-06
NORTH DAKOTA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

45-06-06-01. Selection of the members of the board. The North Dakota small employer health reinsurance program is subject to the supervision and control of the board of directors, consisting of eight members appointed by the commissioner of insurance, and the commissioner or the commissioner's designated representative who serves as an ex officio member of the board.

1. In selecting members of the board, the commissioner shall include representatives of small employers and small employer carriers and other individuals determined to be qualified by the commissioner. At least five members of the board must be representatives of reinsurance carriers and must be selected from individuals nominated by small employer carriers doing business in this state.

2. Within thirty days of August 1, 1993, each carrier providing health benefit plans in the state shall make a filing with the commissioner indicating whether the carrier intends to operate as a small employer carrier pursuant to North Dakota Century Code chapter 26.1-36.3.

3. If the carrier intends to operate as a small employer carrier in this state, the carrier shall submit the name of an individual to be considered by the commissioner to serve on the board of directors of the small employer health reinsurance program.

4. The commissioner shall appoint the initial board members as follows: two members to serve a term of two years, three members to serve a term of four years, and three members to serve a term of six years. Subsequent board members shall serve for a term of three years. The commissioner, in appointing the initial board, shall designate which initial board members shall serve two-year, four-year, or six-year terms.

History: Effective August 20, 1993.
General Authority: NDCC 26.1-36.3-07
Law Implemented: NDCC 26.1-36.3-07

TITLE 48

Board of Animal Health

JANUARY 1994

CHAPTER 48-02-01

48-02-01-04. Bison.

1. **Tuberculosis.** A negative tuberculosis test is required on all bison except nursing calves accompanying negative-tested dams.

2. **Brucellosis.** Tests for brucellosis must be conducted by a state or federal laboratory or by a veterinarian approved in the state of origin. "Brucellosis test" means the blood agglutination test conducted and confirmed in a state or federal laboratory. ~~No female bison over twelve months (three hundred sixty-five days) of age may be imported unless officially calfhood vaccinated against brucellosis and properly identified.~~ A negative preentry test within thirty days will be required on test eligible bison females originating in free or class A states; those test eligible bison females originating from a class B state will require a negative preentry test within thirty days and be placed under quarantine and complete a negative ninety to one hundred eighty-day postentry test.

3. **Permits.** Permits shall be required on all bison.

4. **Dipping.** Dipping in a solution approved by the board shall be required on all bison originating from states where scabies permits are required. Two dippings, ten to fourteen days apart, may be required on bison originating from states determined by the board to have a large number of infested herds. In lieu of dipping, treatment with ivermectin administered by a licensed accredited veterinarian in accordance with the United States department of agriculture,

guidelines for veterinary services, found in 9 CFR part 73, is acceptable.

History: Amended effective September 1, 1988; January 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08

MARCH 1994

CHAPTER 48-02-01

48-02-01-10. All other animals. Importation of all animals not included in the preceding sections, including domesticated wild animals, game animals, game birds and eggs of game birds, shall be accompanied by a permit issued by the North Dakota game and fish department or the board of animal health~~, unless the purpose of importation is for bona fide scientific or educational purposes~~. The state veterinarian may require for the detection of any disease, tests and inspections upon any such animals and birds and eggs prior to importation and may deny importation if the results of such tests or inspections are other than negative.

History: Amended effective September 1, 1988; November 1, 1989; March 1, 1994.
General Authority: NDCC 36-21.1-12
Law Implemented: NDCC 36-21.1-12

STAFF COMMENT: Article 48-12 contains all new material but is not underscored so as to improve readability.

ARTICLE 48-12

NONTRADITIONAL LIVESTOCK

CHAPTER 48-12-01
NONTRADITIONAL LIVESTOCK

48-12-01-01. Purpose. The board has statutory authority to regulate the importation, possession, confinement, transportation, sale, and disposition of nontraditional livestock for the following reasons:

1. To prevent the introduction and spread of disease or parasite harmful to humans and animals.

2. To prevent the escape or release of an animal injurious to or competitive with agricultural, horticultural, forestry, wild animals, and other natural resource interests.

3. To prevent the mistreatment of animals.

4. To comply with the federal law concerning endangered and threatened species.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08, 36-12.1-12
Law Implemented: NDCC 36-01-08, 36-21.1-12

48-12-01-02. Definitions. For purposes of this chapter:

1. "Board" means the North Dakota board of animal health.

2. "Domestic animal" means dog, cat, horse, bovine animal, sheep, goat, bison, llama, alpaca, or swine.

3. "Herd" means all animals commingled with other animals of the same species owned by the same person, which are confined to specific premises.

4. "Hybrid" means an animal produced by crossing species or subspecies.

5. "License" means a document obtained from the board for the raising or propagation of a species in North Dakota.

6. "Nontraditional livestock" means any wildlife held in a cage, fence, enclosure, or other manmade means of confinement that limits its movement within definite boundaries, or an animal that is physically altered to limit movement and facilitate capture.

   Category 1: Those animals that are similar to but have not been included as domestic species, including turkeys, geese, ducks (morphologically distinguishable from wild turkeys, geese, ducks), pigeons, and mules or donkeys. (These animals are subject to the rules of domestic animals).

   Category 2: Those species that have been domesticated, including ostrich, emu, chinchilla, guinea fowl, ferret, ranch foxes, ranch mink, peafowl, all pheasants not in category 3, quail, chukar, and Russian lynx. Category 2 species imported must meet the health requirements as set forth in this chapter.

Category 3: Those species that are indistinguishable from wild, indigenous species or present a health risk to wild and domestic species, or both, including elk, deer (except those listed under subdivisions a and b of subsection 3 of section 48-12-01-03), reindeer, bighorn sheep, fallow deer, ring-necked pheasant, Bohemian pheasant, sichuan pheasant, Canadian lynx, bobcat, and raptor.

Category 4: Those species that are considered inherently or environmentally dangerous, including bears, wolves, and cats (not listed previously).

Category 5: Those species that are not categorized in categories 1 through 4 require a special license, the requirements of which will be established by the board.

7. "Permit" means a document obtained from the board for the importation of animals into North Dakota.

8. "Person" means any individual, partnership, firm, joint stock company, corporation, association, trust, estate, or other legal entity.

9. "Possess" means to own, control, restrain, transport, or keep in captivity.

10. "Zoo" means an organization with a class C exhibitor's permit, which follows United States department of agriculture (USDA) regulations and are inspected by UDSA - APHIS.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-03. Permit and license requirements. All nontraditional livestock premises must be licensed and comply with the administrative rules of the board and applicable statutes. Licenses are not required for categories 1 and 2. An owner of category 2 species must comply with all health requirements as set forth in subdivisions e and f of subsection 1.

1. Category 3, 4, or 5 nontraditional livestock may be imported into North Dakota only after the owner obtains all of the following:

   a. An importation permit from the board.

b. A north Dakota nontraditional livestock possession license from the board which is valid for the species to be imported or possessed. The license fee is five dollars for each game bird species and ten dollars for all other species. The maximum annual fee for a person holding more than one bird species license is twenty-five dollars. The maximum annual fee for a person holding more than one nonbird species license is seventy-five dollars.

c. Genetic testing for purity is required for all elk or elk hybrids prior to entry into zone 1 or 2, as those zones are described in subdivision c of subsection 7. Only genetically pure elk will be allowed in zone 1 or 2.

d. An animal may not be imported, without approval from the board, if the animal originated in a herd that has been quarantined for a reportable disease.

e. An examination by an accredited veterinarian accompanied by an approved certificate of veterinary inspection. Minimum specific disease test results and health statements that must be included on a certificate of veterinary inspection include:

(1) Animals in the shipment must be tested for any diseases prescribed by the board.

(a) Tuberculosis.

[1] Cervidae - all animals in the shipment must be tested negative within thirty to ninety days and the entire herd of origin within twelve months using the single strength cervical test, or if originating from an accredited free herd, only the animals in the shipment must be tested; or follow uniform method and rules and guidelines for the control of tuberculosis in cervidae as published by USDA/APHIS.

[2] Other species - use recognized approved testing protocol.

(b) Brucellosis.

[1] Cervidae - all animals in the shipment must be tested negative by two official brucellosis tests within thirty days, one of which must be the complement fixation test or follow uniform method and rules in control of brucellosis in cervidae as published by USDA/APHIS.

[2] Other species - use recognized industry testing protocol.

(c) Pseudorabies. Serologic testing methodology must be conducted in accordance with board pseudorabies standards within thirty days prior to entry for the following category, except for suckling piglets accompanying a negative sow:

Suidae: Wild suidae (See also subdivisions c and d of subsection 3.)

(d) Equine infectious anemia. Serologic testing must be conducted in accordance with state equine infectious anemia protocol within twelve months prior to entry for the following category of equidae, except suckling foals accompanying a negative dam:

Equidae: All wild equidae

(e) Rabies. Any native mammal of the order carnivora that has been taken from the wild may not enter the state if a diagnosis of rabies has been made in the past twelve months in the same species in the state of origin.

(f) Johne's disease. The following statement signed by an accredited veterinarian in the state or province of origin: "To the best of my knowledge, animals listed herein are not infected with paratuberculosis (Johne's disease) and have not been exposed to animals infected with paratuberculosis. To the best of my knowledge, the premises of origin have not been the site of a significant disease outbreak in the previous twenty-four months that was not contained and extirpated using recommended disease control".

(g) Diseases of birds.

[1] Pullorum and fowl typhoid.

[a] Captive wild birds as defined in this paragraph, unless going directly to slaughter, must originate from a producer who is participating in the pullorum-fowl typhoid control phase of the national poultry improvement plan (NPIP) plan or the birds must be tested serologically negative for pullorum and fowl typhoid within the

past thirty days. In the case of eggs and hatchling birds, the breeder flock must be a national poultry improvement plan participant or must have been tested negative in the past thirty days. Serum testing or national poultry improvement plan active status are required for birds of the order galliformes including prairie chicken (tympanuchus cupido), quail, pheasants (phasianus colchicus), chukar (alectoris chukar), gray (Hungarian) partridge (perdix perdix), and wild turkey (meleagris gallopavo).

[b] In lieu of pullorum and fowl typhoid testing of other birds, the following statement can be placed on the health certificate: "To my knowledge, birds listed herein are not infected with pullorum or fowl typhoid and have not been exposed to birds infected with pullorum or fowl typhoid during the past twelve months". This statement shall be signed by the owner or the owner's representative.

[2] Avian tuberculosis (mycobacterium avium). The certificate of veterinary inspection must read: "To my knowledge, birds listed herein are not infected with avian tuberculosis and have not been exposed to birds infected with avian tuberculosis during the last twelve months". This requirement applies to all birds, including ratites.

[3] Duck plague (duck virus enteritis, D.V.E.) and avian cholera. The statement, "To my knowledge, birds listed herein are not infected with duck plague or avian cholera and have not been exposed to birds known to be infected with duck plague or avian cholera within the past one hundred eighty days", must be written on the health certificate of all anseriformes entering the state. The statement shall be signed by the owner or the owner's representative. This statement applies to waterfowl (anseriformes).

[4] Exotic Newcastle disease (viscerotropic, velogenic viruses) psittacosis.

[a] The statement, "To my knowledge, birds listed herein are not infected with exotic Newcastle disease or psittacosis and have not been exposed to birds known to be infected with exotic Newcastle disease or psittacosis within the past thirty days", must be written on the health certificate of all psittacine birds entering the state. The statement shall be signed by the owner or the owner's representative. This statement applies to all psittacine birds.

[b] While in transit or while being offered for sale by a person holding a nontraditional livestock license and nontraditional livestock auction license, the following birds which have been associated with introductions of exotic Newcastle disease should be identified with a numbered leg band or other approved method of identification: yellow naped Amazon parrot (Amazona ochrocephala auropalliata), Mexican double yellow head parrot (Amazona ochrocephala oratrix), Mexican red head parrot (Amazona viridigenalis), spectacled Amazon parrot (Amazona albifrons), yellow cheeked Amazon parrot (Amazon autumnalis), green conure (aratinga holochlora, A. strenua, A. leucophthalmus), military machaw (ara militaris), lilac crowned Amazon parrot, (Amazona finschi).

[5] Mycoplasmosis. All wild turkeys of the species meleagris gallopavo, unless going directly to slaughter, must originate from a producer who is participating in the mycoplasmosis control phase of the national poultry improvement plan or the birds must have been tested serologically nagative for mycoplasma gallisepticum and M. synoviae within the past thirty days. In the case of eggs and hatchling birds, the breeder flock must be a national poultry improvement plan participant or must have been tested negative in the past thirty days.

f. Additional disease testing may be required from the board prior to importation or sale if there is reason to believe other diseases, parasites, or other health risks are present.

2. It is a violation of this rule to release or abandon any nontraditional livestock without prior written authorization from the board. Game bird releases must be stipulated in the license application.

3. The board finds that the following species, hybrids, or viable gametes (ova or semen) are detrimental to existing animals and their habitat through parasites, disease, habitat degradation, or competition. Possession of the following species, hybrids, or viable gametes is restricted to a special license (applies to category 5).

   a. In the family bovidae, subfamily caprinae: chamois (rupicapra), tahr (hemitragus), goats, ibexes (capra), - except domestic goat (capra hircus), barbary sheep or aoudad (ammotragus), mouflon species (ovis musimon), subfamily hippotraginae: oryx and gemsbok (oryx), addax (addax), subfamily redinunae: reed bucks (redunca), subfamily alcelaphinae: wildebeests (connochaetes), hartebeests (alcelaphus), sassabees, blesbok, bontebok, topi (damaliscus), subfamily water buffalo (bubalus).

   b. In the family cervidae, all of the following species and hybrids: moose (alces alces), axis deer (axis axis), rusa deer (cervus timorensis), sambar deer (cervus unicolor), sika deer (cervus nippon), roe deer (capreolus capreolus and capreolus pygarus), red deer (cervus elaphus).

   c. All wild species of the family suidae (Russian boar, European boar) and hybrids.

   d. In the family tayassuidae: the collared peccary or javelina (tayassu tajacu) and hybrids.

4. A special license application will be reviewed by the nontraditional livestock advisory council. The advisory council shall recommend action to be taken by the board.

5. These special license species may not be released, imported, transported, sold, bartered, or traded within the state except as authorized. The special license animals may be transported out of the state in compliance with the nontraditional livestock rules of the receiving state and federal laws.

6. Persons with proof of possession prior to the effective date of these rules may possess special license species.

7. The following nontraditional livestock are "restricted species", on the basis of specific animal health risks that they pose to wildlife and domestic livestock: white-tailed deer (odocoileus virginianus) and reindeer (caribou) (rangifer sp.), red deer and red deer hybrid.

   a. Importation of white-tailed deer into North Dakota is allowed only for nontraditional livestock farms having a valid license. The only white-tailed deer that may be permitted entry or transported west of the one hundredth meridian are those originating from states west of the one hundredth meridian where meningeal worm has not been reported. This also applies to intrastate movement.

   b. Importation of reindeer (rangifer sp.) into North Dakota is prohibited except under the following conditions:

      (1) All animals in shipment must be tested negative to four brucellosis serological tests.

      (2) All animals in the shipment must originate in a herd located south of the border of Canada and the United States which is certified brucellosis (B. suis and B. abortus) and tuberculosis free as determined by whole herd testing.

      (3) Animals must have never been exposed to tuberculosis positive animals.

   c. The importation or intrastate movement of red deer and red deer and elk hybrids requires a special license. A license will not be issued for premises in zone 1 or 2. Zone 1 is that area bordered by a that which begins at the junction of the Montana border and Missouri River, runs east along the Missouri River to highway 49, south to highway 21, west to highway 22, to the Slope-Bowman County line, and west to Montana. Zone 2 is that area bordered by a line that begins at the Minnesota state line on highway 2, runs west to Towner and north along the Souris River to the Canadian border.

8. Reclassification of any species listed as restricted is contingent upon compelling scientific information indicating that risks posed by these species to native wildlife populations and domestic livestock can be eliminated or managed effectively through application of new diagnostic or management technologies.

9. Any diseased, prohibited, or restricted animal determined by the board to pose a significant threat to the state's wildlife resources, domestic animals, or human health must be held in quarantine at the owner's expense until disposition is

determined. Possession or transfer of such animals is prohibited if contrary to the determination of the board.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-04. Zoos. Exemptions to specific testing may be allowed by the state veterinarian for endangered or highly valuable animals in instances where risk of death due to drug immobilization or physical restraint outweighs the likelihood that the animal harbors the disease in question. This applies to licensed zoos and class B brokers (as defined by the United States department of agriculture) dealing with another licensed zoo. Zoos, research facilities, and education facilities shall comply with requirements established for nontraditional livestock.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-05. Escaped nontraditional livestock.

1. The board may authorize an agent to seize, capture, or destroy categories 3, 4, and 5 nontraditional livestock that have escaped their possessor's control, and which are determined to be detrimental to nature, wildlife, habitat, or other wildlife resources by threat of predation, spread of disease or parasites, habitat competition, interbreeding with native wildlife and domestic animals, or other significant damage.

2. Escapes must be reported to the board within one working day.

3. The licensee shall recapture or destroy the animal within ten days except where public safety or the health of the domestic or wild population is at risk, in which case the animal may be disposed of immediately. A ten-day extension may be granted by the state veterinarian.

4. The licensee shall notify the board within one working day of the capture or death of an escaped animal.

5. The board or its designated agent may inspect any recaptured animal before it is returned to the nontraditional livestock farm.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-06. Identification.

1. Categories 3, 4, and 5 nontraditional livestock owned by or transferred to any nontraditional livestock premises within the state of North Dakota must be individually identified as prescribed by the board.

2. Tags or identification numbers must be requested from an agent of the board during business hours. Licensees shall record the number and sex of the animals marked. A board representative shall make available the tags or identification to the nontraditional livestock operator.

3. Nontraditional livestock premises that maintain animals for the primary purpose of photography or filming may use another form of identification. The manner in which such animals will be identified must be submitted in writing to the board for approval.

4. When loss of an animal identification is discovered, the licensee shall notify an agent of the board. The animal must be identified with approved identification as soon as reasonably possible or before a license is renewed.

5. Identification assigned to an individual nontraditional livestock animal may not be transferred to any other animal.

6. Any individual identification marker issued by the board which becomes detached from the animal for which it was issued must be returned to a representative of the board.

7. All newborn nontraditional livestock must be individually marked within twelve months of birth, or prior to removal of the animal from the nontraditional livestock premises.

8. Nontraditional livestock acquired from another state or province must be marked with a North Dakota eartag unless it has an official identification tag, or must be marked as prescribed by the board, within thirty days of importation and before commingling with similar animals.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-07. Revocation of license or denial of license application. The board may revoke any license or deny any license application and may dispose of any nontraditional livestock imported, possessed, confined, or transported for failing to comply with these rules or with conditions placed on the permit at the time of issuance. The board may revoke any license or deny any license application if the applicant, or agent, falsified information on the license application or

on the certificate of veterinary inspection, or falsified or failed to keep or submit records as required by this chapter. The revocation of a license or denial of a license application must comply with North Dakota Century Code chapter 28-32.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-08. Term of license. Licenses expire on January first of each year.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-09. License renewal. Any person possessing nontraditional livestock under a license issued pursuant to these rules shall apply for a renewal license to the board. A license is delinquent if not renewed within thirty days after January first. When an application for renewal is received, the board may evaluate the existing holding facility to determine if it is adequate to contain the number and type of nontraditional livestock for which applied and the purpose for which they will be held.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-10. Disposition of nontraditional livestock if license expires. Should a license expire or be revoked, all formerly licensed nontraditional livestock in possession shall be disposed of by the licensee immediately after expiration or revocation of the license. No formerly licensed nontraditional livestock may be abandoned, released, or removed from the holding facility without prior written permission from the board. All formerly licensed nontraditional livestock remaining at the holding facility upon a reasonable period after expiration or revocation of the license may be disposed of by the board.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-11. Fencing requirements.

1. Licensees owning nontraditional livestock shall comply with fencing standards that will assure containment. Conventional perimeter fences must follow the height requirements in this section. The bottom six feet [1.83 meters] must be a mesh of

a size to prevent escape. Any supplemental wires must be at least twelve and one-half gauge and spaced no more than six inches [152.40 millimeters] apart.

a. Electric fencing materials may be used on perimeter fences only as a supplement to conventional fencing materials.

b. All gates in the perimeter fence must be locked.

c. Posts must be of sufficient strength to keep nontraditional livestock securely contained. The posts must extend to the upper limits of the height requirement and be spaced no more than twenty-four feet [7.32 meters] apart.

2. The minimum standards for perimeter fences are as follows:

a. Elk and red deer - seven-foot [2.13-meter] fence.

b. Fallow deer - six-foot [1.83-meter] fence.

c. White-tail and mule deer - eight-foot [2.44-meter] fence.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-12. Categories 3, 4, and 5 nontraditional livestock reporting.

1. Reports must be recorded on the forms provided by the board and must be filled out completely and accurately.

2. Pages in the nontraditional livestock record book may not be discarded. Voided pages must be sent to the board.

3. The annual nontraditional livestock report must be submitted to the board by January thirty-first of each year.

4. Renewal of a nontraditional livestock license is contingent upon timely and accurate completion and submission of required reports.

5. Nontraditional livestock record books and reports must be kept on the premises of the licensed nontraditional livestock premises, residence of the nontraditional livestock operator or manager, or the principal place of business, so long as that location is within the state of North Dakota.

6. Purchase, sales, escapes, recapture, deaths, diseases, or other animal transfers, and births must be reported in the nontraditional livestock records provided by the board.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-13. Nontraditional livestock farm premises description. A category 3, 4, or 5 nontraditional livestock farm operator shall provide a sketch or map of the proposed exterior boundary, holding and handling facilities, location of quarantine area, and proposed location of all gates, at the time of application for a nontraditional livestock license.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-14. Holding and handling facilities. All category 3, 4, or 5 nontraditional livestock operators shall have holding and handling facilities that enable handling, marketing, and individual identification of all nontraditional livestock on the premises. A permanent or portable handling facility must be accessible to the nontraditional livestock farm at all times.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-15. Welfare of animals.

1. A nontraditional livestock operator may not display or house any nontraditional livestock in such a manner as to endanger the health and safety of the public or the nontraditional livestock, as determined by an agent of the board.

2. Persons required to have licenses for holding nontraditional livestock shall meet the animal welfare requirements of this section. The purpose of this section is to ensure that the animals have adequate water, food, and shelter available and that they are held in sanitary conditions.

3. This section applies to persons with stationary and mobile facilities within the state for holding animals in cages or similar enclosures which significantly limit the animals' freedom of movement, and which, because of the limited size of the enclosure, restrict the opportunities for the animals to find food, water, shelter from the environment, and necessary

space for social adjustments relative to other animals in the same enclosure.

4. The possession of a valid license from the United States department of agriculture, issued pursuant to the Animal Welfare Act, is evidence of compliance with this section. Representatives of the board may require production of the United State department of agriculture license and the most recent inspection report issued by the United States department of agriculture. If no inspection report has been issued within six months, the representatives may inspect all facilities. The report of such an inspection by a representative of the board must be filed immediately with the United States department of agriculture for species under the federal Animal Welfare Act, and a copy must be given to the owner or manager of the facility. In these instances, problems noted by the representative shall be reported to the United States department of agriculture and no state action will be taken unless the United States department of agriculture finds failure to comply with United States department of agriculture standards.

5. Persons or facilities not licensed under the federal Animal Welfare Act must meet the animal welfare requirements equivalent to the federal Animal Welfare Act. Authorized representatives of the board will perform inspections and ensure compliance. This subsection applies to category 4 animals only.

6. Humane care and housing.

   a. A license or permit may not be granted by the board until it is satisfied that the provisions for housing and caring for such nontraditional livestock and for protecting the public are proper and adequate and in accordance with the standards established by the board.

   b. The board may examine all lands, with the buildings, licensed as game bird and animal farms, deer farms, or fur farms to determine whether all nontraditional livestock held on licensed farms are treated in a humane manner and confined under sanitary conditions with proper and adequate housing, care, and food.

   c. The board may order any licensee to comply within ten days with standards prescribed in such order for the housing, care, treatment, feeding, and sanitation of nontraditional livestock by the licensee.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08, 36-21.1-12
Law Implemented: NDCC 36-01-08, 36-01-12, 36-21.1-12

48-12-01-16. Waiver. The board may waive any rule that constitutes an undue hardship to an individual nontraditional livestock operator. A nontraditional livestock operator wishing to receive a waiver of any rule shall apply to the board stating specifically why there is a compelling need to have a rule waived and showing that the grant of waiver will not threaten or adversely affect any domestic or wild animal.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-17. Confiscation procedures. The board may seize any illegally obtained or captured native species categories 3, 4, and 5 animal and the costs may be charged to the possessor of the animals.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-18. Auction sales.

1. A nontraditional livestock auction permit is required to conduct auctions as a business where categories 3, 4, and 5 animals are offered for sale or trade.

2. The application for an auction permit must be submitted to the board at least sixty days prior to the date of auction. Once issued, the permit is valid for that date and an alternate date.

3. Information concerning possession permits, disease testing, certificates of veterinary inspection, and animal welfare must be clearly stated in the auction announcement.

4. All potential buyers and sellers shall register at the auction and provide their state and federal permit numbers, if applicable.

5. All migratory waterfowl must be accompanied by a federal waterfowl sale and disposal permit. Original copies must be submitted to the auction office or check-in crew prior to sale and cages containing such birds must be marked with permit number and species of bird.

6. An interstate sale or offer of sale of any endangered or threatened species may not be consummated until a captive-bred wildlife permit or endangered species permit has been obtained from the United States fish and wildlife service by all parties involved.

7. Sellers of category 4 animals shall have a state permit, if required by the state of origin, and applicable federal permits.

8. Buyers of category 4 animals shall have applicable federal permits and a state permit if required by the state of residence.

9. Nonresidents purchasing nontraditional livestock at an auction, which require a state license, may possess such animals in this state for not more than ten days without permit once the animals are removed from the auction grounds.

10. Species of nontraditional livestock native to the state which require a license for possession may be shipped or transported into this state for consignment at an auction. Such animals must be accompanied by the appropriate permit from the state of origin or, when a permit is not required, another document such as a certificate of veterinary inspection indicating the state of origin.

11. All nontraditional livestock entering the state must be shipped in accordance with the disease prevention guidelines. Shipping must also conform to the requirements of the federal Animal Welfare Act and the Lacey Act.

12. An attending veterinarian shall be available during the auction. Sick or injured animals must receive veterinary care.

13. All animals present at the auction must be maintained in accordance with the animal welfare guidelines.

14. Auction sale operators shall maintain records on each animal consigned for the auction in accordance with the federal Animal Welfare Act.

15. Facilities and records may be inspected by the board to the standards of this rule, during standard working hours. Records kept in accordance with the federal Animal Welfare Act are sufficient if applicable to the species involved. Inspections made by the United States department of agriculture inspectors may be substituted for state inspection.

16. Any animal consigned to a particular sale may be sold only by the auction permittee. Private sales on the auction grounds on dates of auction are prohibited.

17. Access to the auction ground must be controlled at all times. All animals must be checked in and out by auction personnel.

18. The permittee shall notify the board within twenty-four hours of the occurrence of any unexplained diseases or deaths occurring in animals held under this permit.

19. Any documents required by the North Dakota department of agriculture must be obtained.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-19. Quarantine area.

1. Every category 3, 4, or 5 nontraditional livestock premises must have an approved quarantine facility within its exterior boundary or submit an action plan to the board that guarantees access to an approved quarantine facility within the state of North Dakota.

2. The quarantine area must meet the tests of isolation, separate feed and water, escape security, and allowance for the humane holding and care of its occupants for extended periods of time.

3. Should the imposition for a quarantine become necessary, the nontraditional livestock owner shall provide an onsite quarantine facility or make arrangements at the owner's expense to transport the animals to the approved quarantine facility named in the quarantine action plan.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-20. Bill of sale and transportation.

1. Categories 3, 4, and 5 nontraditional livestock to be transferred, bought, or sold must have a bill of sale or manifest duly witnessed prior to movement to show proof of ownership.

2. A transaction must be recorded in the record book of the affected nontraditional livestock license within five days of the transaction.

3. Nontraditional livestock may be transported from out of state through North Dakota if:

   a. Animals proceed directly through North Dakota and the owner or transporter has no intent to unload the animals.

b. Animals are not sold, bartered, traded, or otherwise transferred while in the state. Transfer does not include moving animals to another transport vehicle.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-21. Inspection by board personnel. Any person issued a license under this rule to import, possess, confine, or transport live nontraditional livestock shall allow inspection of records, holding facilities, and permitted nontraditional livestock by the board during the term of the license and during normal working hours. The licensee shall accompany the person conducting the inspection. The board shall schedule the inspection.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-08, 36-01-12

48-12-01-22. Indemnity. In case of any serious outbreak of any contagious, infectious, or epizootic diseases among domestic animals or nontraditional livestock which cannot be controlled with the funds at the disposal of the board, the board shall notify the governor immediately, and the governor shall call a meeting of the emergency commission, which may authorize money to be drawn from the state treasury to meet the emergency.

History: Effective March 1, 1994.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-19

TITLE 54

Nursing, Board of

JANUARY 1994

CHAPTER 54-02-01

54-02-01-03. Testing dates. The examination dates shall coincide with the national testing dates set by the national council of state boards of nursing for the use of the national council licensure examination. Notice of the ~~examination dates and the deadline~~ requirement for filing the application shall be sent to all board-approved nursing education programs in North Dakota at least ~~three months before each examination~~ yearly.

History: Amended effective June 1, 1982; January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(9)

54-02-01-04. Examination material. ~~Examination material for each candidate shall be sent for scoring, as provided by the contract. In the event that the material is lost or destroyed through circumstances beyond control of the board, the candidate will be required to rewrite the examination in order to meet requirements for licensure. The candidate must assume the cost of rewriting the examination.~~ Repealed effective January 1, 1994.

History: ~~Amended effective June 1, 1982; March 1, 1986.~~
General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-08(10)~~

54-02-01-04.1. Board authorization to write examination. Candidates must complete application to the board for licensure by examination. Eligibility for testing will be forwarded to the test

center by the board when notification is received that all academic requirements have been met.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10

54-02-01-05. Examination results. Examination results will be reported by mail to individual candidates and recorded on the candidate's permanent record in the board office. The examination results for the successful candidate ~~who has completed the nursing education program~~ will include the number of the permanent license that shall be issued to the candidate and a notice that these results constitute permission to continue in the practice of nursing until the permanent license has been issued. ~~Candidates who have not completed the nursing education program will receive the examination results but will not be issued a permanent license number until all requirements for license by examination have been met.~~

History: Amended effective November 1, 1979; October 1, 1989; December 1, 1991; January 1, 1994.
General Authority: NDCC 43-12.1-08(18)
Law Implemented: NDCC 43-12.1-10

54-02-01-06. Examination fees. The board shall set the fee for licensure by examination. The fee for ~~each applicant desiring to take the licensing~~ licensure by examination shall be seventy-five dollars. The fee ~~will not be refunded after the deadline date for filing the application~~ is nonrefundable. The candidate shall be responsible for any payment of fees charged by the national council of state boards of nursing for use of the national council licensure examination.

History: Amended effective November 1, 1979; March 1, 1986; March 1, 1992; January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(3)

54-02-01-07. Transcript. An official completed transcript, sent directly from the nursing education program to the board office, will be required to provide the board with proof of satisfactory completion of the appropriate nursing education program. An English translated certified copy of the transcript, providing evidence of ~~instruction and experience in medical nursing, surgical nursing, obstetric nursing, nursing of children, and psychiatric nursing,~~ completion of the appropriate nursing education program will be required from nursing education programs in another country. A copy of the transcript submitted to the commission on graduates of foreign nursing schools will be accepted if sent directly from the commission.

History: Amended effective June 1, 1982; January 1, 1994.

General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(3)

54-02-01-12. Early admission to the licensing examination. ~~Students enrolled in nursing programs approved by the board of nursing may apply for early admission to the licensing examination if the examination is scheduled within the final academic term of the nursing program and authorization from the nursing program for early admission to the licensing examination is included with the application. Candidates admitted to the licensing examination prior to the completion of the nursing program must meet all requirements for licensure by examination before a license to practice is issued.~~ Repealed effective January 1, 1994.

History: ~~Effective October 1, 1989.~~
General Authority: ~~NDCC 43-12.1-08(18)~~
Law Implemented: ~~NDCC 43-12.1-10~~

54-02-01-13. Authorization to practice nursing. Authorization to practice nursing between the dates of program completion and notification of results of the licensing examination will be issued to individuals accepted as candidates for the first licensing examination after program completion for which the candidate is eligible. Eligibility will be determined by the following criteria:

1. The applicant has submitted a completed application, the appropriate fee, and official transcript verifying program completion to the board office.

2. The applicant is a North Dakota resident or has accepted employment in North Dakota or the federal government.

3. The applicant's registration with the testing center has been reported to the board office.

Upon receipt of the work authorization, the applicant may use the appropriate title of graduate nurse or graduate practical nurse or the appropriate abbreviation of "G.N." or "G.P.N.". The applicant must practice under the supervision of a registered nurse while the authorization to practice is valid. The work authorization to practice will expire in sixty days or upon notification of the testing results, whichever occurs first. The work authorization is nonrenewable and available only to graduates who complete application for licensure within sixty days of graduation.

History: Effective October 1, 1989; amended effective December 1, 1991; January 1, 1994.
General Authority: NDCC 43-12.1-08(18)
Law Implemented: NDCC 43-12.1-10

54-02-02-03. Failure of licensing examination. Candidates who fail the licensing examination shall file an application to rewrite the licensing examination and ~~submit the proper fee. The candidate~~ shall be responsible for payment of any fees charged by the national council of state boards for use of the national council licensure examination. ~~Candidates who fail the licensing examination two times will not be permitted to rewrite the examination until they present evidence to the board of having had planned directed instruction in an approved nursing education program or by a registered nurse tutor. Guidelines are provided by the board.~~ The candidate's application to rewrite the examination will be accepted dependent upon the timeframes established by the national council of state boards for use of the item pool.

History: Amended effective March 1, 1986; January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10

54-02-02-07. Failure of licensing examination in another state. ~~Any qualified applicant for license by examination, who has written the practical nurse licensing examination or the registered nurse licensing examination in another state of the United States or its territories and failed, must meet North Dakota requirements for rewriting that examination before being admitted to the North Dakota licensing examination.~~ Repealed effective January 1, 1994.

History: ~~Amended effective June 1, 1982.~~
General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-10~~

54-02-02-09. Maximum number of attempts to write the licensing examination. Candidates will have a maximum number of five attempts to pass the licensing examination. The candidate must have completed the nursing education program within five years of the scheduled appointment to write the examination.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10

CHAPTER 54-02-03

54-02-03-01. Proctoring service in North Dakota. ~~The North Dakota board of nursing will proctor the licensing examination for a board of nursing, upon its authorization, of a candidate who is residing in North Dakota and is seeking licensure in the other state.~~ Repealed effective January 1, 1994.

General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-10~~

54-02-03-02. Time of proctoring. ~~Proctoring services will be provided at a regularly scheduled examination session provided space is available.~~ Repealed effective January 1, 1994.

General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-10~~

54-02-03-03. Proctoring fee. ~~A proctoring service fee shall be paid by the candidate to the North Dakota board of nursing prior to the examination and shall not exceed twenty-five dollars.~~ Repealed effective January 1, 1994.

General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-08(3)~~

CHAPTER 54-04.1-03

54-04.1-03-02. Note required. Before the loan is disbursed, recipients and their board-approved cosigner must sign a note to the North Dakota board of nursing for repayment of the loan. Interest will accrue at the rate of nine percent per annum or the maximum contract rate of interest established under the provisions of North Dakota Century Code section 47-14-09, whichever is the lesser.

History: Effective October 1, 1987; amended effective March 1, 1992; January 1, 1994.
General Authority: NDCC 43-12-27
Law Implemented: NDCC 43-12-27

CHAPTER 54-04.1-05

54-04.1-05-01. Repayment requirements. Repayment of the loan must meet the following requirements:

1. Payments must begin within sixty days after graduation or withdrawal from the nursing program unless such period is extended by the board.

2. ~~A rate of nine percent annual interest will accrue on the unpaid balance until the note is canceled.~~

~~3.~~ Payments of at least fifty dollars per month or ~~a specific~~ other amount determined by the board must be made to the North Dakota board of nursing by the fifth day of each month until the note is canceled.

History: Effective October 1, 1987; amended effective March 1, 1992; January 1, 1994.
General Authority: NDCC 43-12-27
Law Implemented: NDCC 43-12-27

CHAPTER 54-05-01

54-05-01-01. Statement of intent. ~~Traditionally the practical nurse acted as an extension of the registered nurse, giving physical care to chronic and stable patients under the direction of the registered nurse. While nursing care remains under the purview of the registered nurse, the licensed practical nurse is prepared to participate in each phase of the nursing process in caring for selected patients in a variety of settings.~~

~~The licensed practical nurse exercises nursing judgments based upon knowledge of biological science and technical skills acquired through educational preparation and supervised experience. The licensed practical nurse knows what nursing actions the licensed practical nurse may perform safely, as well as the licensed practical nurse's limitations, and is accountable for any responsibilities the licensed practical nurse accepts. All licensed practical nurses have the obligation to meet each standard.~~

The role of the licensed practical nurse in health care is to give holistic nursing care to clients in nursing practice settings under the direction of the registered nurse, licensed physician, or dentist. The knowledge, skills, and abilities of the licensed practical nurse are based on the nurse's educational preparation and nursing experience.

Each licensed practical nurse is responsible and accountable to practice according to standards of practice prescribed by the board and the profession. The licensed practical nurse is responsible and accountable for the care provided and assuring the safety and well-being of the clients and significant others. The licensed practical nurse's acceptance of assigned nursing responsibilities must be based upon client care needs, the knowledge, skills, and abilities of the practical nurse, and agency policy. The nursing care remains the responsibility of both the delegator and the licensed practical nurse.

History: Effective June 1, 1979; amended effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15)

54-05-01-02. Standards of practice. The licensed practical nurse assists in implementing the nursing process. The components are assessment, planning, implementation, and evaluation. Written and verbal communication is essential to the nursing process. The licensed practical nurse will:

1. ~~Collects, reports, and records data about the health status of the patient.~~ Collect relevant health care data.

2. ~~Identifies, reports, and records evidence of patient needs.~~ Organize data and contribute to the development of an

individualized nursing plan of care based upon the nursing diagnosis.

3. ~~Participates in the development of the nursing care plan.~~ Implement the individualized nursing plan of care to achieve the expected outcomes.

4. ~~Implements assigned components of the nursing care plan.~~ Collaborate in the evaluation of the client's response toward the achievement of the expected outcomes.

~~5. Provides for patient safety and comfort.~~

~~6. Involves the patient in the patient's own health restoration, promotion, and maintenance.~~

~~7. Identifies, records, and reports patient responses to health care.~~

~~8. Implements assigned portions of the teaching plan.~~

History: Effective June 1, 1979; amended effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15)

54-05-01-03. Role of the licensed practical nurse. The licensed practical nurse under the direction of the registered nurse, licensed physician, or dentist will:

1. Involve the client and significant others in the client's health restoration, promotion, and maintenance.

2. Utilize established lines of authority and communication to provide care to clients with actual or potential responses to health problems.

3. Participate in client teaching specific to the actual or potential learning needs by implementing or modifying standard teaching plans.

4. Manage the environment and resources effectively and efficiently to attain goals specific to clients with actual or potential responses to health.

5. Recognize and utilize the knowledge base of nursing practice acquired through nursing research.

6. Recognize client rights and seek appropriate resources to protect those rights.

7. Practice within the ethical frameworks of the nursing profession.

8. Evaluate own nursing practice in relation to professional nursing practice standards and relevant statutes and regulations.

9. Acquire and maintain current knowledge in nursing practice.

10. Maximize the client's health care through the appropriate delegation of nursing tasks and nursing functions to the nurse assistant.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15)

54-05-01-04. Criteria for delegation to licensed practical nurses. Delegation of nursing care to licensed practical nurses shall comply with the following criteria:

1. The registered nurse, licensed physician, or dentist must make an assessment of the client's nursing care needs prior to delegating the responsibilities.

2. The responsibilities must be within the scope of practice delineated by the board and described within agency written policy.

3. The delegating registered nurse, licensed physician, or dentist must determine the responsibilities that can be properly and safely performed by the licensed practical nurse.

4. The registered nurse, licensed physician, or dentist shall supervise the performance and documentation of the delegated responsibilities by the licensed practical nurse.

5. The nursing care remains the responsibility of both the delegator and the licensed practical nurse.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15)

54-05-01-05. Criteria for delegation of specialized nursing care to the licensed practical nurse. The licensed practical nurse providing specialized nursing care is a licensed practical nurse with additional preparation and experience who is qualified to assume greater responsibility in specialized care areas or in patient care management, or both, according to designated written policies of the employing institution. The registered nurse, licensed physician, or dentist shall determine that the licensed practical nurse providing specialized nursing care meets the following qualifications:

1. Has a minimum of one year's experience in nursing practice at the staff level.

2. Provides verification of having acquired additional knowledge, skills, and abilities necessary to assume the greater responsibility in specialized nursing care areas.

3. Practices according to the employing institution written policies that address the licensed practical nurse's preparation and role in specialized nursing care.

4. The nursing care remains the responsibility of both the delegator and the licensed practical nurse.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15)

CHAPTER 54-05-01.1

STANDARDS OF PRACTICE FOR LICENSED PRACTICAL NURSES PROVIDING SPECIALIZED NURSING CARE

[Repealed effective January 1, 1994]

CHAPTER 54-05-02

54-05-02-01. Statement of intent. The practice of the registered nurse is determined ~~both~~ by the educational program completed and the knowledge, technical skills, and process skills the nurse acquires ~~for facilitating a positive alteration in the health status of the client/patient. A working knowledge of the nursing process is the standard by which nursing practice is currently measured, a standard that can be applied to the care given by the graduates of all nursing programs. Ultimately, the standard must be the client's/patient's response to this care~~ to facilitate positive responses in the health status of the client. The registered nurse uses a variety of scientific principles to synthesize relevant information and make clinical inferences. The registered nurse applies nursing theory to the assessment, diagnosis, outcome criteria, planning, interventions, and evaluation of human responses in nursing practice settings to provide holistic nursing care.

The registered nurse ~~role includes independent, collaborative, dependent, and managerial functions~~ in clinical practice functions as a direct caregiver in both institutional and community settings. In addition, the registered nurse functions as a client care manager, educator, researcher, and as case manager or coordinator of client care services within the broader health service system. Each function is to be carried out with consideration for optimum health care and client~~/patient~~ safety. The registered nurse is accountable for all nursing responsibilities the registered nurse accepts.

~~All~~ The registered ~~nurses have the obligation to meet each standard~~ nurse is responsible and accountable to practice according to the standards of practice prescribed by the board and the profession. Registered nurses established the standards of practice for nursing care for all client populations in all practice settings. The extent to which the standard will be met is relative to the nurse's academic preparation and experience.

History: Effective June 1, 1979; amended effective March 1, 1986; January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15)

54-05-02-02. Standards of practice. The registered nurse utilizes the nursing process to assess, diagnose, establish outcome criteria, intervene, evaluate, and document human responses to actual or potential health problems in nursing practice settings. The nurse will:

1. ~~Collects data about the health status of the client/patient systematically and continuously. The data is accessible, communicated, and recorded.~~ Collect and assess relevant health data.

2. ~~Formulates nursing diagnoses. The nursing diagnosis, defined as the identification of the client's/patient's response to the client's/patient's condition as assessed by a nurse, is derived from health status data.~~ Analyze the client data base to establish the nursing diagnoses.

3. ~~Develops a nursing care plan that includes goals derived from the nursing diagnoses.~~ Identify expected outcomes individualized to the client.

4. ~~Includes priorities and measures to achieve the goals derived from the nursing diagnoses in the nursing care plan. The nursing care plan is recorded and accessible to the health team.~~ Develop a nursing plan of care that prescribes interventions to attain expected outcomes.

5. ~~Provides for client/patient participation in health promotion, maintenance, and restoration.~~ Implement the nursing plan of care.

6. ~~Assists the client/patient maximize the client's/patient's health capabilities through the implementation of the developed plan of care by direct intervention, health counseling, teaching, and appropriate delegation of components of the nursing care plan.~~ Evaluate the client's responses toward attainment of the expected outcomes and modify the plan as indicated.

~~7. Determines the client's/patient's progress or lack of progress toward goal achievement with the client/patient, or significant others, or both.~~

~~8. Reassesses, reorders priorities, sets new goals, and revises the plan of nursing care as directed by the client's/patient's progress or lack of progress.~~

~~9. Cares for clients/patients under written policies and statutory laws.~~

History: Effective June 1, 1979; amended effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15)

54-05-02-03. Role of the registered nurse. The registered nurse will:

1. Assist the client to maximize the client's health through the direct implementation of the nursing plan of care.

2. Maximize the client's health through the appropriate delegation of components of the nursing plan of care.

3. Facilitate communication between the client, significant others, and health care team.

4. Design and implement a teaching plan specific to the actual or potential learning needs of the client.

5. Manage resources, environments, and programs to maximize client outcomes.

6. Utilize research findings appropriate to nursing practice.

7. Advocate for client rights.

8. Practice within the ethical frameworks of the nursing profession.

9. Assume a leadership role in health care management.

10. Evaluate the nurse's own nursing practice in relation to professional practice standards and relevant statutes and regulations.

11. Acquire and maintain current knowledge in nursing practice.

12. Participate in quality of care activities as appropriate to position, education, and practice environment.

13. Collaborate with the client, significant others, and health care providers in providing client care.

14. Contribute to the professional development of peers, colleagues, and others.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15)

CHAPTER 54-07-03

54-07-03-03. Delegation of global nursing tasks and nursing functions. The following nursing tasks and nursing functions are ones that are within the scope of sound nursing practice to be delegated to ~~an assistant to the~~ a nurse assistant.

1. The collecting, reporting, and documentation of data including, but not limited to:

   a. Vital signs, height, weight, intake, and output;

   b. Changes from baseline data established by the licensed nurse;

   c. Environmental situations;

   d. ~~Patient~~ Client and family comments relating to the ~~patient's~~ client's care; and

   e. Behaviors related to the plan of care.

2. Ambulation, positioning, and turning.

3. Transportation of the ~~patient~~ client.

4. Personal hygiene and elimination~~, including cleansing enemas~~.

5. Feeding, cutting up food, placement of meal trays.

6. Socialization activities.

7. Activities of daily living.

History: Effective November 1, 1992; amended effective January 1, 1994.
General Authority: NDCC 43-12.1-08(18)
Law Implemented: NDCC 43-12.1-08(21)

STAFF COMMENT: Chapter 54-07-04 contains all new material but is not underscored so as to improve readability.

CHAPTER 54-07-04
NURSE ASSISTANT DISCIPLINARY ACTION

54-07-04-01. Definitions. The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 43-12.1, except:

1. "Abuse" means mental, physical, sexual, or verbal behavior demonstrated while administering nursing tasks or functions in a manner that is harmful or done with the intent to do harm to the client.

2. "Denial" means the board's refusal to issue a current registry card.

3. "Incompetent" means administering nursing tasks or functions in an inaccurate manner or a manner inconsistent with acceptable nursing standards.

4. "Neglect" means failure to fulfill an assignment or leaving an assignment without notifying the proper authorities in a manner that endangers the health, safety, and welfare of the individuals entrusted to the nurse assistant's care.

5. "Nurse assistant" means the assistant to the nurse as defined in subsection 1 of North Dakota Century Code section 43-12.1-02.

6. "Revocation" means the removal of a current registry listing on the nurse assistant registry for cause. The individual's name and supporting data remain on the registry with the notation of revocation and the date.

7. "Suspension" means the withholding by the board of a current registry card for a specified length of time.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

54-07-04-02. Nurse assistants on board-recognized registries. Individuals listed on a board-recognized registry shall be considered to be on the board's registry for purposes of investigation of a nurse assistant and any board action that may result.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

54-07-04-03. Registry applicant statement. If an applicant for registry status reports an arrest, charge, or prior conviction of a crime other than a minor traffic violation, the applicant must provide the necessary information to determine the bearing upon that person's ability to serve as a nurse assistant. Upon receipt of evidence of sufficient rehabilitation as outlined in North Dakota Century Code section 12.1-33-02.1, the registry listing may be issued. If the information does not substantiate the rehabilitation, the applicant may ask for a hearing pursuant to North Dakota Century Code chapter 28-32.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

54-07-04-04. Complaints. Any individual having personal knowledge or information concerning an alleged violation of North Dakota Century Code chapter 43-12.1 constituting abuse, neglect, or incompetence by a nurse assistant may initiate the disciplinary process by filing a written request for investigation with the board. The request must include:

1. The full name, address, and telephone number (if available) of the complainant.

2. The name, address, and telephone number (if known) of the nurse assistant.

3. A statement of the facts concerning the alleged violation.

Board staff shall be available to assist individuals in submitting the request for investigation. If the required information cannot be elicited with assistance of the board staff, the request for

investigation shall be forwarded to the appropriate agency involved. Anonymous requests for investigation shall not be accepted.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

54-07-04-05. Investigation. The request for investigation must be reviewed to determine the regulatory authority of the board. If the allegations indicate that nursing care has been compromised or harm to the client has occurred, the board staff shall investigate and determine whether sufficient grounds exist to believe a violation of applicable law or rule has occurred. The request for investigation must result in one of the following:

1. For matters concerning allegations of abuse, incompetency, or neglect, filing of a formal complaint and scheduling a disciplinary hearing pursuant to North Dakota Century Code chapter 28-32. The disciplinary hearing shall be conducted by an administrative hearings officer, and the recommended findings of fact, conclusions of law, and order shall be presented to the board for consideration. The board shall consider the recommended findings of fact, conclusions of law, and order and issue the order regarding the individual's registry status as recommended by the hearings officer, or issue its own findings of fact, conclusions of law, and order.

2. For matters concerning allegations of theft of property, the information shall be forwarded to the appropriate law enforcement agency with a request for a report when action is taken.

3. For matters concerning sufficient rehabilitation from a prior conviction of an offense, or an arrest or charge regarding an offense, a disciplinary hearing may be held pursuant to North Dakota Century Code chapter 28-32 to determine if the offense has a direct bearing on the individual's ability to serve the public as a nurse assistant.

4. Negotiation of a stipulated settlement with the registrant for revocation or suspension of the registry status if the allegations are not contested. The settlement shall be presented to the board for review and acceptance, and if accepted by the board, the board's order shall be issued accordingly.

5. Negotiation of a plan of corrective action with the nurse assistant and nurse assistant's employer for ratification by the board. The plan of corrective action must include grounds for registry revocation if the nurse assistant does not complete the plan as outlined.

6. Dismissal for failure to substantiate the allegations or insufficient evidence to proceed.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

54-07-04-06. Board decision - Revocation - Suspension - Denial. The final decision must be adopted by a simple majority of the board and must include findings of fact, conclusions of law, and order. The decision of the board must be communicated to the nurse assistant in the form of a board order.

1. If the board issues a revocation order, it may also indicate in the order the specific action necessary for the reinstatement of the registry listing.

2. If the board issues a suspension order, it may also indicate the specific action necessary for the reinstatement of the registry listing.

3. If the board denies registry listing, it may also indicate the specific action necessary for reconsideration of the registry application.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

54-07-04-07. Application for reinstatement. Any person whose registry listing has been suspended or revoked by the board may apply in writing for reinstatement at the conclusion of the time period specified in the order. The burden of proof is on the individual to prove to the satisfaction of the board that the conditions that led to the sanction no longer exist or no longer has a material bearing on the individual's ability to perform nursing tasks or nursing functions. Applications for reinstatement shall be reviewed by board staff and necessary information requested prior to scheduling board review. If the board denies reinstatement, reasons for denial must be communicated to the individual.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

54-07-04-08. Public notification. The names and addresses of persons whose registry listing have been suspended or revoked by the

board shall be communicated in writing to all North Dakota health care facilities and other registries recognized by the board.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

54-07-04-09. Providing assistance to the nurse without current registry status. All persons who provide assistance to the nurse and carry out legally delegated nursing tasks or nursing functions must hold current registry status. Individuals holding current registry status on a board-recognized registry meet this requirement. Individuals who are employed to perform nursing tasks or nursing functions delegated by a licensed nurse who have never held registry status have four months from the date of initial employment to achieve registry status. A lapsed registry status may be reinstated by submission of the required competency verification by the employer and payment of the required fee.

History: Effective January 1, 1994.
General Authority: NDCC 43-12.1-08(21)
Law Implemented: NDCC 43-12.1-14.1

TITLE 62

Plumbing, Board of

FEBRUARY 1994

CHAPTER 62-02-01

62-02-01-01. Application for journeyman or master plumber license. No applicant shall be entitled to take the examination for either the master or journeyman plumber's certificate and license unless and until the applicant furnishes to the board satisfactory evidence that the applicant possesses sufficient practical experience to enable the applicant to perform satisfactorily the duties of the classification for which the applicant has made application.

1. Applicants for a journeyman plumber's examination and license shall have had four years' experience as an apprentice plumber under a licensed master plumber. ~~A four-year term of apprenticeship is defined as not less than one thousand nine hundred hours per year with a total of not less than seven thousand six hundred hours for a four-year term.~~

   ~~a. Graduates of the plumbing course of an accredited trade school having at least a nine-month (one thousand twenty hours) course in plumbing shall receive the following number of hours credit for each hour of the course according to the graduating grade average they received:~~

      ~~A average - two hours.~~
      ~~B average - one and three-quarter hours.~~
      ~~C average - one and one-half hours.~~
      ~~D average - one hour.~~

   ~~b. Apprentice plumbers who have had three years (five thousand seven hundred hours) experience in learning and assisting in the installation, alteration, and repair of plumbing working for a master plumber may work during~~

~~their fourth year of apprenticeship by themselves without being under the direct supervision of a master or journeyman plumber.~~

~~c.~~ Applicants who are working at the plumbing trade in localities where state licenses are not required, who have had five years of experience (one thousand nine hundred hours per year and a total of nine thousand five hundred hours) and who furnish four affidavits verifying years of experience, may make application for a journeyman examination screening test. The screening test is defined as an oral and written test given by the state plumbing board and a plumbing inspection report, signed by a state plumbing inspector, of an installation installed by the applicant to determine the applicant's qualifications for writing the journeyman examination.

2. Applicants who are journeyman plumbers in other states who desire to work in this state in localities where a state journeyman license is required may make application for a journeyman examination and license. Proof of such journeyman license from another state shall be vouched for as provided on the application blank furnished by the North Dakota state plumbing board.

3. All applicants for a master plumber's license must be twenty-one years of age and must have had two years' (three thousand four hundred hours) experience as a journeyman plumber licensed by the state of North Dakota or any other state that has a state licensing law. Proof of such journeyman license from another state shall be vouched for as provided on the application blank furnished by the North Dakota state plumbing board.

4. Applicants who are master plumbers in other states who desire to work in this state in localities where a state master license is required may make application for a master examination and license. Proof of such master license from another state shall be vouched for as provided on the application blank furnished by the North Dakota state plumbing board.

5. All applications will expire and be canceled after a period of six months from date of approval if the applicant fails to appear for examination within the six-month period.

History: Amended effective February 1, 1994.
General Authority: NDCC 43-18-08
Law Implemented: NDCC 43-18-13, 43-18-13.1

STAFF COMMENT: Section 62-02-01-01.1 contains all new material but is not underscored so as to improve readability.

62-02-01-01.1. Application for apprentice plumber - Supervised practice. An applicant for registration as an apprentice must have reached the age of eighteen years. An apprentice shall serve a term of four years, not less than one thousand nine hundred hours per year, with a total of not less than seven thousand six hundred hours.

1. The board may grant hourly credit toward a term of apprenticeship when the applicant furnishes proof of previous practical experience in the trade, or is a graduate of a course in plumbing at an accredited school having at least a nine month, one thousand twenty hours course in plumbing. The number of hours credit for each hour of the course according to the graduating grade average shall be: A average - two hours, B average - one and three-quarter hours, C average - one and one-half hours, and a D average - one hour. Credit for trade-related experience shall be determined by criteria established by the board.

2. A master plumber employing a registered apprentice shall report to the board any changes made in relation to continued employment of such apprentice. It is the employer's duty and responsibility to not permit an apprentice to perform work unless under the direct supervision and in the immediate presence of either a master or journeyman plumber. There shall not be more than five plumber's apprentices under the immediate and personal supervision of either a master plumber or journeyman plumber employed on any installation, alteration, or repair project.

3. Apprentice plumbers who have had three years (five thousand seven hundred hours) experience in learning and assisting in the installation, alteration, and repair of plumbing, and working for a master plumber, may work during their fourth year of apprenticeship by themselves without being under the direct supervision of a master or journeyman plumber.

History: Effective February 1, 1994.
General Authority: NDCC 43-18-08
Law Implemented: NDCC 43-18-21

62-02-01-08. ~~Issuance of journeyman plumber's certificate and license. The board issues a person a journeyman plumber's certificate and license upon and with the understanding that the holder thereof shall not engage in the business of installing plumbing unless at all times a registered and licensed master plumber, who is responsible for the proper installation of the plumbing, is in charge of such work.~~

Application for plumbing installation certificate. All plumbing installations requiring inspection must have a plumbing installation certificate properly executed by the master or journeyman plumber in charge of the installation. The board shall have on hand a supply of certificates for distribution to the person in charge of the installation.

1. Inspection fees for each certificate issued shall be according to the schedule of fees shown on the plumbing installation certificate. If work has commenced prior to submittal of certificate and proper fees, the fee will be double or actual cost incurred to investigate, whichever is less. Requested inspection, reinspection, or inspection for which no fee is specifically indicated shall be charged at twenty-five dollars per hour, plus travel expense.

2. The certificate must be signed by the applicant and original returned to the board along with the proper fees prior to commencement of work. The duplicate copy shall be retained by the plumbing contractor, and the triplicate copy shall be submitted to the building owner. The issuing certificate fee will be charged for each certificate that must be reissued.

History: Amended effective February 1, 1994.
General Authority: NDCC 43-18-08
Law Implemented: NDCC ~~43-18-21~~ 43-18-17.2, 43-18-17.3

62-02-01-09. Licensed master plumber required. ~~In cities of over one thousand population, it shall be unlawful for any plumbing establishment to sell, or offer for sale, services in a permanent location, unless a licensed master plumber is available full time for services at that location.~~ Repealed effective February 1, 1994.

General Authority: ~~NDCC 43-18-08~~
Law Implemented: ~~NDCC 43-18-10~~

62-03-03.1-06. Sanitary drainage and indirect waste systems.

1. **Aboveground piping - Sanitary and indirect drainage.** Soil and waste piping aboveground in buildings must be of brass pipe, copper pipe, copper tube drainage, waste and venting weight or heavier, cast iron soil pipe, galvanized steel pipe, ~~lead pipe,~~ or acrylonitrile-butadiene-styrene, or polyvinyl chloride, drainage, waste and venting, schedule 40 or heavier plastic pipe. When plastic pipe is installed each soil or waste stack (does not include stack vent) may not exceed thirty-five feet [10.67 meters] in height. Horizontal offsets in stacks, horizontal branches connected to stacks and building drains aboveground are limited to a maximum developed length of thirty-five feet [10.67 meters]. If provisions are made for expansion at thirty-five-foot [10.67-meter] intervals, the distance may exceed thirty-five feet [10.67 meters].

2. **Underground building sanitary drains.** All underground building drains must be cast iron soil pipe, hard-temper copper tube type L, or heavier, or acrylonitrile-butadiene-styrene, or polyvinyl chloride, drainage, waste and venting, schedule 40 or heavier plastic pipe. Where ferrous threaded joints are used underground, they must be coal tar coated or equivalent approved protection applied when installed.

3. **Building sanitary sewer.**

   a. In trench separate from water service. If the building sewer is installed in a trench separate from the water service, the sewer pipe material must be bituminized fiber, cast iron, concrete, vitrified clay, copper, acrylonitrile-butadiene-styrene, or polyvinyl chloride, drainage, waste and venting schedule 40 or heavier, or acrylonitrile-butadiene-styrene, or polyvinyl chloride, sewer pipe (SDR 35 or heavier) plastic pipe. Joints must be watertight and rootproof.

   b. In trench with water service. If the building sewer is installed in the same trench as the water service, the sewer pipe material must be cast iron, acrylonitrile-butadiene-styrene, or polyvinyl chloride, drainage, waste and venting, schedule 40 or heavier. The conditions in subsection 1 of section 62-03-10-06 must also be met.

4. **Fittings.** The materials of which drainage system pipe fittings are made must conform to the type of piping materials

used in the drainage system. The fittings may have no ledges, shoulders, or reductions which can retard or obstruct flow in the piping. Threaded drainage pipe fittings must be of the recessed drainage type, black or galvanized.

History: Effective July 1, 1985; amended effective October 1, 1989; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-03.1-09. Storm drainage systems.

1. Interior conductors. Interior conductors installed aboveground in buildings must be of brass pipe, copper pipe, copper tube, drainage, waste and venting weight or heavier, cast iron soil pipe, galvanized steel pipe, lead pipe, acrylonitrile-butadiene-styrene or polyvinyl chloride, drainage, waste and venting schedule 40 or heavier plastic pipe, or acrylonitrile-butadiene-styrene or polyvinyl chloride sewer pipe SDR 35 or heavier for interior conductors six inches [15.24 centimeters] in diameter or larger. When plastic pipe is installed for interior conductors, and the vertical or horizontal length exceeds thirty-five feet [10.67 meters], provisions for expansion must be made at thirty-five-foot [10.67-meter] intervals.

2. Exterior leaders. Exterior leaders must be of approved sheet metal or other acceptable material.

3. Underground building storm drains. All underground building storm drains must be cast iron soil pipe, hard-temper copper tube type drainage, waste and venting, or heavier, acrylonitrile-butadiene-styrene or polyvinyl chloride drainage, waste and venting, schedule 40 or heavier plastic pipe or acrylonitrile-butadiene-styrene or polyvinyl chloride sewer pipe SDR 35 for building drains six inches [15.24 centimeters] in diameter or larger. Where ferrous threaded joints are used underground, they must be coal tar coated or equivalent approved protection applied when installed.

4. Building storm sewer. The building storm sewer must be of asbestos cement, bituminized fiber, cast iron soil pipe, concrete, vitrified clay, copper tube type drainage, waste and venting, acrylonitrile-butadiene-styrene, or polyvinyl chloride drainage, waste and venting schedule 40 or heavier plastic pipe, or acrylonitrile-butadiene-styrene, or polyvinyl chloride sewer pipe SDR 35 or heavier.

History: Effective July 1, 1985; amended effective October 1, 1989; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-07-24. Minimum plumbing facilities.

1. Minimum number of fixtures. Plumbing fixtures shall be provided for the type of building occupancy and in the minimum number shown in table ~~62-03-07.1~~ 62-03-07. ~~Types of building occupancy not shown in Table 62-03-07.1 will be considered individually by the administrative authority.~~ The number of fixtures is the minimum required as shown in the table and is assumed to be based on fifty percent male and fifty percent female. The number of plumbing fixtures must be based on the number of persons to be served by the fixture. If occupancies are not established, the occupant load factors must be as shown in the table.

2. Separate facilities. In other than residential installations where toilet and bathing facilities are provided to serve members of both sexes and are designed for use by more than one person at a time, separate facilities shall be installed for each sex, except as allowed in table 62-03-07.

History: Amended effective April 1, 1984; July 1, 1985; January 1, 1992; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-07-25. Facilities for ~~the handicapped~~ persons with disabilities.

~~1. In newly constructed or remodeled buildings and facilities used by the public,~~ Plumbing fixtures in toilet rooms ~~shall be made accessible to, and usable by, the physically handicapped~~ in newly constructed or remodeled buildings and facilities subject to the federal Americans with Disabilities Act of 1990 [Pub. L. 101-336; 104 Stat. 317] must conform to the accessibility standards of the Americans with Disabilities Act Accessibility Guidelines for Buildings and Facilities as contained in the appendix to title 28, Code of Federal Regulations, part 36, [28 CFR 36], and in accordance with North Dakota Century Code section 54-21.3-04.1.

NOTE: Drawings in diagram 62-03-07 and on the following pages may be used in part as a guideline for specifications and clear floor spaces for plumbing fixtures.

~~2. It is essential that an appropriate number (note 5) of toilet rooms, in accordance with the nature and use of a specific building or facility, be made accessible to, and usable by, the physically handicapped.~~

3. Toilet rooms for the handicapped shall conform to the requirements of the administrative authority.

4. Toilet rooms shall have at least one toilet stall that:

a. Is forty-two inches [106.68 centimeters] wide.

b. Is at least five feet [152.4 centimeters] deep.

c. Has a door (where doors are used) with thirty-two inches [81.28 centimeters] clear space and swings out.

d. Has two handrails, thirty-three to thirty-six inches [83.82 to 91.44 centimeters] high and parallel to the floor, one and one-half inches [38.1 millimeters] in outside diameter, with one and one-half inches [38.1 millimeters] clearance between rail and wall, and fastened securely.

e. Has a water closet with the seat seventeen to nineteen inches [43.18 to 45.72 centimeters] from the floor (standard height bowls with seat that raise bowl height are permissible).

Note: The design and mounting of the water closet is of considerable importance. A wall-mounted water closet with a narrow understructure that recedes sharply is most desirable. If a floor-mounted water closet must be used, it should not have a front that is wide and perpendicular to the floor at the front of the seat. The bowl should be shallow at the front of the seat and turn backward more than downward to allow the individual in a wheelchair to get close to the water closet with the seat of the wheelchair.

5. Toilet rooms shall have at least one lavatory with twenty-nine inch [73.66 centimeter] clearance below apron, which when mounted at standard height is usable by individuals in wheelchairs or shall have lavatories mounted higher, when particular designs demand, so that they are usable by individuals in wheelchairs.

Note: It is important that drainpipes and hot water pipes under a lavatory be covered or insulated so that a wheelchair individual without sensation will not burn oneself.

6. Mirrors and shelves shall be provided above lavatories at a height as low as possible and no higher than forty inches [101.6 centimeters] above the floor, measured from the top of the shelf and the bottom of the mirror.

7. Toilet rooms in which more than one urinal is provided shall have one wall-mounted urinal with the opening of the basin seventeen inches [43.18 centimeters] from the floor.

8. Toilet rooms shall have an appropriate number (note 5) of towel racks, towel dispensers, and other dispensers and disposal units mounted no higher than forty inches [101.6 centimeters] from the floor.

9. Water fountains. An appropriate number (note 5) of water fountains or other water dispensing means shall be accessible to, and usable by, the physically disabled.

10. Water fountains or coolers shall have up-front spouts and controls.

11. Water fountains or coolers shall be hand-operated or hand-and-foot operated. (See also American Standard Specifications for Drinking Fountains, Z4.2-1942.)

Note 1. Conventional floor-mounted water coolers can be serviceable to individuals in wheelchairs if a small fountain is mounted on the side of the cooler thirty inches [76.2 centimeters] above the floor.

Note 2. Wall-mounted, hand-operated coolers of the latest design, manufactured by many companies, can serve the able-bodied and the physically disabled equally well when the cooler is mounted with the basin thirty-six inches [91.44 centimeters] from the floor.

Note 3. Fully recessed water fountains are not recommended.

Note 4. Water fountains should not be set into an alcove unless the alcove is wider than a wheelchair.

Note 5. As used in this section, appropriate number means the number of a specific item that would be necessary, in accord with the purpose and function of a building or facility, to accommodate individuals with specific disabilities in proportion to the anticipated number of individuals with disabilities who would use a particular building or facility.

Example: Although these specifications shall apply to all buildings and facilities used by the public, the numerical need for a specific item would differ, for example, between a major transportation terminal, where many individuals with diverse disabilities would be continually coming and going, an office building or factory, where varying numbers of individuals with disabilities of varying manifestations (in many instances, very large numbers) might be employed or have reason for frequent visits, a school or church, where the number of individuals may be fixed and activities more

~~definitive; and many other buildings and facilities dedicated to specific functions and purposes.~~

~~Note. Disabilities are specific and where the individual has been properly evaluated and properly oriented and where architectural barriers have been eliminated, a specific disability does not constitute a handicap. It should be emphasized that more and more of those physically disabled are becoming participants, rather than spectators, in the fullest meaning of the word.~~

History: Amended effective April 1, 1984; January 1, 1992; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

~~NOTES:~~

~~1. This table shall be used in the absence of local building code requirements. Fire codes may also be consulted for assembly values. For handicap requirements see local, state and national ordinances. Additional fixtures may be required where environmental conditions or special activities may be encountered.~~

~~2. In food preparation areas, fixture requirements may be dictated by local health codes.~~

~~3. Whenever both sexes are present in approximately equal numbers, multiply the total census by 50 percent to determine the number of persons for each sex to be provided for. This regulation only applies when specific information, which would otherwise affect the fixture count, is not provided.~~

~~4. Not more than 50 percent of the required number of water closets may be urinals. When additional water closets or urinals are provided the appropriate number of lavatories must also be provided.~~

~~5. In buildings constructed with multiple floors, accessibility to the fixtures shall not exceed one vertical story.~~

~~6. Fixtures for public uses as required by this section may be met by providing a centrally located facility accessible to several stores. The maximum distance from entry to any store to this facility shall not exceed 500 feet.~~

~~7. In stores with floor area of 150 square feet or less, the requirements of this section to provide facilities for uses by employees may be met by providing a centrally located facility~~

~~accessible to several stores. The maximum distance from entry to any store to this facility shall not exceed 300 feet.~~

~~8. Fixtures accessible only to private offices shall not be counted to determine compliance with this section.~~

~~9. Multiple dwelling units or boarding houses without public laundry rooms, shall have one laundry tray or one automatic washer standpipe for each dwelling unit. When public laundry rooms are provided, one laundry tray or automatic washer standpipe shall be required for each four apartments. For multiple dwelling units over twelve, add one laundry tray or one automatic washer standpipe for each additional eight units.~~

~~10. Where the total number of persons do not exceed eight, one toilet facility with one water closet and one urinal with a lockable door is permitted.~~

~~11. Requirements for employees and customers may be met with a single set of restrooms. The required number of fixtures shall be the greater of the required number for employees, or the required number for customers.~~

NOTES:

1. The figures shown are based on one fixture being the minimum required for the number of persons indicated or any fraction thereof.

2. Any category not mentioned specifically or about which there are any questions shall be classified by the administrative authority, and included in the category which it most nearly resembles, based on the expected use of the plumbing facilities.

3. When urinals are provided, one water closet less than the number specified may be provided for each urinal installed, except the number of water closets in such cases shall not be reduced to less than one-half of the minimum specified. When additional water closets or urinals are provided, the appropriate number of lavatories must also be provided.

4. Drinking fountains shall not be installed in toilet rooms.

5. Twenty-four inches [609.60 millimeters] of wash sink or eighteen inches [457.20 millimeters] of circular basin, when provided with water outlets for such space, shall be considered equivalent to one lavatory.

6. When the design occupant load is less than ten persons, a facility with a lockable door, usable by either sex, may be approved by the administrative authority. When occupancy exceeds four persons, and both sexes are served by this facility, a urinal shall also be required.

7. Multiple dwelling units or boarding houses without public laundry rooms shall have one laundry tray or one automatic washer standpipe for each dwelling unit. When public laundry rooms are provided, one laundry tray or automatic washer standpipe shall be required for each four apartments. For multiple dwelling units over twelve, add one laundry tray or one automatic washer standpipe for each additional eight units.

8. A restaurant is defined as a business which sells food to be consumed on the premises. The number of occupants for a drive-in restaurant shall be considered as equal to the number of parking stalls.

Special notes:

A. Occupant loads over thirty shall have one drinking fountain for each one hundred fifty occupants. Drinking fountains are not required in restaurants or other food service establishments if drinking water service is available.

B. In buildings constructed with multiple floors, accessibility to the fixtures shall not exceed one adjacent story.

C. Fixtures for public use as required by this section may be met by providing a centrally located facility accessible to several stores. The maximum distance from entry to any store to this facility shall not exceed five hundred feet [152.40 meters].

D. In stores with floor area of one hundred fifty square feet [45.72 square meters] or less, the requirements of this section to provide facilities for use by employees may be met by providing a centrally located facility accessible to several stores. The maximum distance from entry to any store to this facility shall not exceed three hundred feet [91.44 meters].

E. Fixtures accessible only to private offices shall not be counted to determine compliance with this section. Requirements for employees and occupants may be met with a single set of toilet rooms. The required number of fixtures shall be the greater of the required number for employees, or

the required number of occupants. Employee facilities must be made accessible to the public.

History: Effective July 1, 1985; amended effective October 1, 1989; January 1, 1992; February 1, 1994.

62-03-10-05. Protection against backflow and backsiphonage.

1. Water outlets. A potable water system shall be protected against backflow and backsiphonage by providing at each outlet by the following:

   a. An airgap as specified herein between the potable water outlet and the flood level rim of the fixture it supplies or between the outlet and any other source of contamination.

   b. Where an airgap is impracticable, a backflow preventer device or vacuum breaker approved as hereinafter provided.

2. Minimum required airgap.

   a. How measured. The minimum required airgap shall be measured vertically from the lowest end of a potable water outlet to the flood rim or line of the fixture or receptacle into which it discharges.

   b. Size. The minimum required airgap shall be twice the effective opening of a potable water outlet unless the outlet is a distance less than three times the effective opening away from a wall or similar vertical surface in which cases the minimum required airgap shall be three times the effective opening of the outlet. In no case shall the minimum required airgap be less than shown in the following table:

MINIMUM AIRGAPS FOR PLUMBING FIXTURES

Fixture	Minimum Airgap	
	When Not Affected By Near Wall * (Inches)	When Affected By Near Wall ** (Inches)
Lavatories and other fixtures with effective opening not greater than 1/2 inch diameter	1	1 1/2
Sink, laundry trays, gooseneck bath faucets and other fixtures with effective openings not greater than 3/4 inch diameter	1 1/2	2 1/4
Over rim bath fillers	2	3

and other fixtures with effective openings not greater than 1 inch diameter		
Drinking water fountains - single orifice not greater than 7/16 (0.437) inch diameter or multiple orifices having total area of 0.150 square inches (area of circle 7/16 inch diameter)	1	1 1/2
Effective openings greater than one inch	2X Diameter of effective opening	3X Diameter of effective opening

* Side walls, ribs, or similar obstructions do not affect airgaps when spaced from inside edge of spout opening a distance greater than three times the diameter of the effective opening for a single wall, or a distance greater than four times the diameter of the effective opening for two intersecting walls.

** Vertical walls, ribs, or similar obstructions extending from the water surface to or above the horizontal plane of the spout opening require a greater airgap when spaced closer to the nearest inside edge of spout opening than specified in Note 1, above. The effect of three or more such vertical walls or ribs has not been determined. In such cases, the airgap shall be measured from the top of the wall.

3. **Devices for the protection of the potable water supply.** When plumbing fixtures and equipment are subject to backflow conditions, approved backflow preventers or vacuum breakers must be used. Connection to the potable water supply system, for the following fixtures or equipment, must be protected against backflow with any one or more of the devices as indicated.

   a. Low inlet to receptacles containing toxic substances (vats, storage containers, plumbing fixtures).

      (1) An approved airgap.

      (2) Reduced pressure principle backflow preventer.

      (3) Pressure vacuum breaker unit.

      (4) Atmospheric vacuum breaker unit.

   b. Low inlet to receptors containing nontoxic substances (steam, air, food, beverages, etc.)

      (1) An approved airgap.

(2) Reduced pressure principle backflow preventer.

(3) Pressure vacuum breaker unit.

(4) Atmospheric vacuum breaker unit.

(5) Approved doublecheck valve assembly.

c. Outlets with hose attachments which may constitute a cross connection.

(1) An approved airgap.

(2) Reduced pressure principle backflow preventer.

(3) Pressure vacuum breaker unit.

(4) Atmospheric vacuum breaker unit.

d. Coils or jackets used as heat exchangers in compressors, degreasers, and other such equipment involving toxic substances.

(1) An approved airgap.

(2) Reduced pressure principle backflow preventer.

(3) Pressure vacuum breaker unit.

e. Heat exchangers for potable hot water supply which utilize heat recovery or solar recovery.

(1) Heat exchangers with a pressure on the transfer fluid side above the potable hot water side must be separated from the potable water by a double wall construction. A space open to atmosphere must be provided between the two walls.

(2) Exception: Heat exchangers with a pressure on the transfer fluid side lower than the pressure on the potable water side and the heating system is equipped with an approved pressure relief valve set at a minimum of ten pounds per square inch lower than the potable water operating pressure may be of single wall construction.

f. Systems subject to back pressure.

(1) Nontoxic substances.

(a) An approved airgap.

(b) Reduced pressure principle backflow preventer.

(c) Approved doublecheck valve assembly.

(2) Toxic substances.

(a) An approved airgap.

(b) Reduced pressure principle backflow preventer.

(3) Sewage. An approved airgap.

g. Lawn sprinkler or irrigation systems.

(1) Systems without pumps or connections for fertilizer or chemical attachments.

(a) Reduced pressure principle backflow preventer.

(b) Approved double check valve assembly.

(c) Pressure vacuum breaker.

(d) Atmospheric vacuum breaker.

(2) Systems with connections for fertilizer or chemical attachments. Reduced pressure principle backflow preventer.

h. Fire protection systems.

(1) Systems with piping connected to potable water.

(a) Reduced pressure principle backflow preventer.

(b) Approved double check valve assembly,

(2) Systems with direct connections to nonpotable sources or with toxic chemical additives or antifreeze. Reduced pressure principle backflow preventer.

4. **Approval of devices.** Before any device for the prevention of backflow or backsiphonage is installed, it shall have first been certified by a recognized testing laboratory acceptable to the administrative authority. Devices installed in a building potable water supply distribution system for protection against backflow shall be maintained in good working condition by the person or persons responsible for the maintenance of the system.

5. **Installation of backflow preventers.**

a. Atmospheric vacuum breakers. Atmospheric vacuum breakers shall be installed with the critical level at least six inches [15.24 centimeters] above the flood level rim of

the fixture they serve and on the discharge side of the last control valve to the fixture. No shutoff valve or faucet shall be installed beyond the vacuum breaker. Where C-L mark is not shown on the preventer, the bottom of the device shall be the C-L reference.

b. Pressure type vacuum breakers. Pressure type vacuum breakers must be installed at a height of at least twelve inches [30.48 centimeters] above the flood level rim of the fixture, tank, or similar device.

c. Doublecheck valves and reduced pressure principle valves. Such devices must be installed at not less than twelve inches [30.48 centimeters] above the floor. A reduced pressure zone type backflow preventer must be installed where there is a high potential health hazard.

d. Devices of all types. Backflow and backsiphonage prevention devices shall be accessibly located. Backflow prevention devices may not be installed in pits or similar potentially submerged locations. All devices with a vent to atmosphere may not be located within a fuel hood.

6. Tanks and vats - Below rim supply.

a. Where a potable water outlet terminates below the rim of a tank or vat and the tank or vat has an overflow of diameter not less than given in the table in subsection 3 of section 62-03-10-08, the overflow pipe shall be provided with an airgap as close to the tank as possible.

b. The potable water outlet to the tank or vat shall terminate a distance not less than one and one-half times the height to which water can rise in the tank above the top of the overflow. This level shall be established at the maximum flow rate of the supply to the tank or vat and with all outlets closed except the airgapped overflow outlet.

c. The distance from the outlet to the high water level shall be measured from the critical point of the potable water supply outlet.

7. Connections to boilers. Potable water connections to boiler feed water systems must be made through an airgap or provided with an approved ~~doublecheck~~ reduced pressure principle backflow preventer ~~with atmospheric vent and appropriate testing arrangements. If toxic materials are to be used in the boiler, additional protection must be installed~~.

8. Refrigeration unit condensers and cooling jackets. Except where potable water provided for a refrigeration condenser or cooling jacket is entirely outside the piping or tank

containing a toxic or flammable refrigerant as listed in American national standards institute B9.1-1964 Par. 5.1.2 and 5.1.3 or with two separate thicknesses of metal separating the refrigerant from the potable water supply, inlet connection must be provided with an approved doublecheck valve assembly. Also, adjacent to and at the outlet side of the doublecheck valve, an approved pressure relief valve set to relieve at five pounds per square inch [2.27 kilograms per 6.45 square centimeters] above the maximum water pressure at the point of installation must be provided if the refrigeration units contain more than twenty pounds [9.07 kilograms] of refrigerants.

9. Connections to carbonated beverage dispensers.

   a. Water supply connections to a carbonated beverage dispenser must be made with ~~a~~ an approved stainless steel doublecheck valve with atmospheric vent ~~or equivalent protection~~. The doublecheck valve with atmospheric vent devices must be located within twelve inches [30.48 centimeters] of the equipment.

   b. The piping downstream of this backflow preventer shall not be affected by carbon dioxide gas. There must be no copper piping after the backflow preventer.

10. Barometric loop. Water connections not subject to back pressure where an actual or potential backflow or backsiphonage hazard exists may in lieu of devices specified in subsection 5 be provided with a barometric loop. Barometric loops shall precede the point of connection.

~~11. Lawn sprinklers. Lawn sprinkler systems when connected to a potable water system shall be installed in accordance with this section. Adequate and proper provision shall be made for control and drainage, and to prevent backsiphonage. The water supply lines may be laid at a depth less than three and one-half feet [106.68 centimeters], if and when approved by the administrative authority. Detailed plans of lawn sprinkler systems shall be submitted with the application for a permit to make the installation. Water shall not be turned on to any lawn sprinkler system until it has been inspected and approved. The administrative authority shall give approval on the materials used in the installation of lawn sprinkler systems.~~

History: Amended effective October 1, 1989; January 1, 1992; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-06. Water service.

1. Separation of water service and building sewer. Except as permitted below, the underground water service pipe and the building drain or building sewer shall be not less than ten feet [3.05 meters] apart horizontally and shall be separated by undisturbed or compacted earth.

   When conditions prevent reasonable separation, the water service pipe may be placed in the same trench with the building drain and building sewer provided approval is given on a case-by-case basis by the administrative authority and the following conditions are met:

   a. The bottom of the water service pipe at all points shall be level with or above the top of the sewerline, and must have not less than one foot [0.305 meters] horizontal distance between the piping.

   b. The number of joints in the water service pipe shall be kept to a minimum.

   c. The water service pipe material shall comply with subsection 1 of section 62-03-03.1-08 and conditions in section 62-03-03.1-06, and section 62-03-02-16 shall also be met.

   d. The building sewer shall be rootproof and watertight and tested with a ten-foot head of water or equivalent.

2. Water service near sources of pollution. Potable water service pipes shall not be located in, under, or above cesspools, septic tanks, septic tank drainage, fields, or seepage pits. A separation of ten feet [3.05 meters] shall be maintained. Where the water service must cross the existing sewerline, ~~the bottom of the water service~~ no joints are permitted in the water service within ten feet [3.05 meters] on both sides of the ~~point of~~ crossing ~~shall be~~, and at least twelve inches [30.48 centimeters] ~~above the top of the sewerline. The~~ separation must be maintained. Where the sewer is exposed or on new installations, the sewerline shall be of cast iron, schedule 40 acrylonitrile-butadiene-styrene or polyvinyl chloride plastic pipe, at least ten feet [3.05 meters] on both sides of the crossing.

3. Stop and waste valves. Combination stop and waste valves or cocks may be installed in an underground water service pipe only when not less than ten feet [3.05 meters] apart horizontally from the building sewer, and shall be separated by undisturbed or compacted earth.

4. Water service pipe through wall or floor. Clearance shall be provided around a water service pipe passing through wall or floor to protect it against (a) chemical action from direct contact with concrete, (b) distortion or rupture of water

service pipe from shearing action due to settlement, (c) distortion or rupture of the water service pipe caused by expansion or contraction. Clearance shall be not less than one-half inch [12.7 millimeters] between the outside of the pipe and the wall or floor. Sleeves or arches may be used to provide the wall opening. The space between the pipe and wall structure or floor shall be carefully packed or caulked with lead or waterproof and vermin-resistant, rodent-resistant, and fire-resistant material.

History: Amended effective November 1, 1982; April 1, 1984; July 1, 1985; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-12. Water supply control valves.

1. **Curb valve.** On each water service from a street main to a building, an approved gate valve or ground key stopcock or ball valve shall be installed near the curbline between the property line and the curb. This valve or stopcock shall be provided with an approved curb valve box and may not be under a driveway.

2. **Building valve.** Each building water service up to two inches [5.08 centimeters] shall be provided with a ball valve of same nominal size. For water service over two inches [5.08 centimeters], a gate valve of same nominal size may be used. The valve must be located inside the building near the point where the water service enters. Where there are two or more water services serving one building, a check valve shall be installed on each service in addition to the above valves.

3. **Tank controls.** Supply lines from pressure or gravity tanks shall be valved at or near the tanks.

4. **Valves in dwelling units.** All water closets and kitchen sinks shall have individual fixture valves installed. Valves must also be installed for each bath, shower, powder room, or fixture group. A group of fixtures means two or more fixtures adjacent to each other in the same family unit, but not necessarily in the same room. In a one family unit, one or two bathrooms back to back or one over the other may be considered a group. However, in each dwelling unit with two or more bathroom groups not adjacent to each other, one or more control valves or individual fixture valves shall be provided so that each group may be isolated from the other.

   In more than single family dwelling units, one or more control valves shall be provided so that the water to any plumbing fixture or group of fixtures in any one dwelling unit may be shut off without stopping flow of water to fixtures in other

dwelling units. These valves shall be accessible inside the building unit controlled.

5. **Riser valves.** Except in single family dwellings, a valve shall be installed at the foot of each water supply riser. In multistory buildings, a valve shall be installed at the top of each water supply downfeed pipe and also at the base where required to isolate this riser for servicing.

6. **Individual fixture valves.** In occupied buildings other than dwellings, the water distribution line to each fixture or other piece of equipment shall be provided with a valve or fixture stop to shut off the water to the fixture or the room in which it is located. Except in single family dwellings, sill cocks and wall hydrants shall be separately controlled within eight feet [2.438 meters] by an accessible valve inside the building.

7. **Water heating equipment valve.** The cold water branch to each hot water storage tank or water heater shall be provided with a valve located near the equipment and only serving this equipment. The hot water line from each hot water storage tank or water heater shall be provided with a valve when the line is one inch [2.54 centimeters] or larger. Each tank or heater shall be equipped with an approved automatic relief valve as specified in subsection 1 of section 62-03-10-16.

8. **Meter valve.** A gate valve or ball valve shall be installed in the line on the discharge side of each water meter.

9. **Valves to be accessible.** All water supply control valves shall be placed so as to be accessible for service and maintenance.

10. **Control valve design.** Except to single fixtures, control valves on all waterlines shall, when fully opened, have a cross-sectional area not less than eighty-five percent of the cross-sectional area of the line in which they are installed.

11. **Wall hydrants.** Wall hydrants subject to freezing must be of the frostproof self-draining type with integral backflow protection ~~and automatic draining with hose attached~~.

History: Amended effective November 1, 1979; July 1, 1985; January 1, 1992; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-15. Hot water distribution.

1. **Hot water supply system.** In residences and buildings intended for human occupancy, hot water shall be supplied to all

plumbing fixtures and equipment used for bathing, washing, culinary purpose, cleansing, laundry, or building maintenance, at a minimum temperature of one hundred ten degrees Fahrenheit [43 degrees Celsius] and a maximum leaving temperature of one hundred forty degrees Fahrenheit [60 degrees Celsius].

2. ~~**Return circulation**~~ Temperature maintenance - **where required.** Hot water supply systems in buildings four or more stories high or in buildings where developed length of hot water piping from the source of hot water supply to the farthest fixture supplied exceeds one hundred feet [30.48 meters] shall be of the return circulation type, or other alternative method.

3. **Minimum requirements for hot water storage tanks.** Hot water storage tanks shall be adequate in size, when combined with the British thermal unit input of the water heating equipment to provide the rise in temperature necessary.

   The water heater and storage tank shall be sized to provide sufficient hot water to provide both daily requirements and hourly peak loads of the occupants of the building.

   Hot water storage tanks shall meet construction requirements of the American society of mechanical engineers, American gas association, or underwriters' laboratories as appropriate.

   Storage tanks less in volume than those requirements specified by the American society of mechanical engineers shall be of durable materials and constructed to withstand one hundred twenty-five pounds per square inch [56.70 kilograms per 6.45 square centimeters] with a safety factor of two.

   The water inlets and outlets of a hot water storage tank shall be not less than the hot water distribution pipe served.

   All storage tanks shall be protected against excessive temperatures and pressure conditions as specified in this article.

4. **Drain cocks or valves for hot water storage tanks.** Drain cocks or valves for emptying shall be installed at the lowest point of each hot water storage tank.

5. **Mixed water temperature control.**

   a. The temperature of mixed water to multiple or gang showers must be controlled by a master thermostatic blender or such showers may be individually regulated by balanced pressure mixing valves.

   b. Showers and bathtub/shower combinations in buildings other than single dwelling units must be protected with water

temperature control valves of the balanced pressure mixing type or the thermostatic mixing valve type, or the combination pressure balance, thermostatic type.

6. **Thermal expansion control.** Whenever a check valve or backflow prevention device is installed, which prevents the expansion of water from a water heater to the building water service, a device for controlling thermal expansion must be installed.

History: Amended effective April 1, 1984; July 1, 1985; October 1, 1989; January 1, 1992; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

CHAPTER 62-03-12

62-03-12-10. Wet venting.

1. Single bathroom groups ~~—— top floor~~. A single bathroom group of fixtures may be installed with the drain from a back-vented lavatory serving as a wet vent for a bathtub or shower stall and for the water closet, provided that:

   a. Not more than one fixture unit is drained into a one and one-half-inch [38.1-millimeter] diameter wet vent or not more than four fixture units drain into a two-inch [5.08-millimeters] diameter wet vent.

   b. The horizontal branch shall be a minimum of two inches [5.08 centimeters] and connect to the stack at the same level as the water closet drain or below the water closet drain when ~~installed on the top floor~~ the water closet is individually vented. It may also connect to the water closet bend above the centerline.

   c. When more than one fixture unit is drained into the horizontal drain, or the wet vent is also venting the water closet, the wet vent extension to the vent stack or stack vent must be two inches [5.08 centimeters].

2. Double bath. Bathroom groups back to back ~~on the top floor~~ consisting of two lavatories and two bathtubs or showers may be installed on the same horizontal branch with a common vent for the lavatories and with no back vent for the bathtubs or showers, provided the fixture drains for the bathtubs or showers connect downstream from the fixture drain for the lavatories, ~~the bathtub traps and supply fittings are accessible, the wet vent is two inches [5.08 centimeters] in diameter,~~ and the length of the fixture drains conform to the table in subsection 1 of section 62-03-12-08.

3. Multistory bathroom groups. ~~On the lower floors of a multistory building, the waste pipe from one or two lavatories may be used as a wet vent for one or two bathtubs or showers provided that:~~

   ~~a. The wet vent and its extension to the vent stack is two inches [5.08 centimeters] in diameter.~~

   ~~b. Each water closet below the top floor is individually back vented.~~

~~4. Exception.~~

~~a.~~ In ~~multistory~~ bathroom groups, wet vented in accordance with subsection ~~3~~ 1, the water closets below the top floor need not be individually vented ~~if the~~ provided that:

a. The two-inch [5.08-centimeter] ~~waste pipe~~ wet vent connects directly into the water closet bend at a forty-five degree angle to the horizontal portion of the bend in the direction of flow.

b. ~~If~~ When a stack fitting is used which consists of one or two 3-inch [7.62-centimeter] or four-inch [10.16-centimeter] water closet openings and one or two side-inlets ~~each~~ two inches [5.08 centimeters] in diameter that have their invert above the center of, but below the top of the water closet opening, and ~~one of the two inch [5.08 centimeter] inlets is~~ the side inlets are used to connect ~~one (if revented) or two~~ vented bathtubs ~~or,~~ showers, ~~and the other two inch [5.08 centimeter] inlet is used to connect one~~ or ~~two~~ lavatories.

~~c. In lieu of the special stack fitting in subdivision b, a four inch [10.16 centimeter] closet bend with two 2 inch [5.08 centimeter] wye taps may be used.~~

~~5.~~ 4. Waste stacks serving kitchen sinks. When a waste stack receives the discharge of a kitchen type sink or three-fixture units, it may also serve as a wet vent for two 3-fixture units independently connected to the stack at the floor below; provided the horizontal branch serving the waste stack and the waste stack up to the branch connections is three inches [7.62 centimeters]. The minimum size of the waste stack (wet vent) and trap arm to the connections at the floor above must be two inches [5.08 centimeters] in diameter.

History: Amended effective April 1, 1984; July 1, 1985; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-12-16. Size and length of vents.

1. Length of vent stacks. The length of the vent stack or main vent shall be its developed length from the lowest connection of the vent system with the soil stack, waste stack, or building drain to the vent stack terminal, if it terminates separately in the open air, or to the connection of the vent stack with the stack vent, plus the developed length of the stack vent from the connection to the terminal in the open air, if the two vents are connected together with a single extension to the open air.

2. Size of individual vents. The diameter of an individual vent may be not less than one and one-fourth inches [31.75 millimeters], nor less than one-half the diameter of the drain to which it is connected.

3. Size of relief vent. The diameter of a relief vent may be not less than one-half the diameter of the soil or waste branch to which it is connected.

4. Stacks of more than ten branch intervals. Soil and waste stacks in buildings having more than ten branch intervals shall be provided with a relief vent at each tenth interval installed, beginning with the top floor. The size of the relief vent shall be equal to the size of the vent stack to which it connects. The lower end of each relief vent shall connect to the soil or waste stack through a wye below the horizontal branch serving the floor and the upper end shall connect to the vent stack through a wye not less than three feet [91.44 centimeters] above the floor level.

5. Size of circuit or loop vent. The diameter of a circuit loop vent may be not less than the size of the diameter of the vent stack or one-half the size of the diameter of the horizontal soil or waste branch, whichever is smaller.

6. Size of vent piping. The size of vent piping must be determined from its length and the total number of fixture units connected thereto, as set forth in the following table. In addition, the drainage piping of each building and each connection to a public sewer or a private sewage disposal system shall be vented by means of one or more vent pipes, the aggregate cross-sectional area of which shall not be less than that of the largest required building drain as determined from the Building Drains and Sewers Table in subsection 1 of section 62-03-11-05.

SIZE AND LENGTH OF VENTS

~~Size of Soil or Waste Stack~~	Fixture Units Connected	Diameter of Vent Required (Inches)								
		1-1/4	1-1/2*	2	2-1/2	3	4	5	6	8
		Maximum Length of Vent (Feet)								
~~Inches~~	4	40	200							
~~1-1/2~~	8	~~50~~	150	250						
~~1-1/2~~	10	~~30~~	100	200						
~~2~~	12	~~30~~	75	200						
~~2~~	24	~~26~~	50	150	400					
~~2-1/2~~	42		30	100	300	500				
~~3~~	~~10~~		~~30~~	~~100~~	~~200~~	~~600~~				
~~3~~	~~30~~			~~60~~	~~200~~	~~500~~				

~~3~~	60	50	80	400				
~~4~~	100	35	100	260	1000			
~~4~~	200	~~30~~	90	250	900			
~~4~~	500	~~20~~	~~70~~	180	700			
~~5~~	~~200~~		~~35~~	~~80~~	~~350~~	~~1000~~		
~~5~~	~~500~~		~~30~~	~~70~~	~~300~~	~~900~~		
~~5~~	1100		~~20~~	50	200	700		
~~6~~	~~350~~		~~25~~	~~50~~	~~200~~	~~400~~	~~1300~~	
~~6~~	~~620~~		~~15~~	~~30~~	~~125~~	~~300~~	~~1100~~	
~~6~~	~~960~~			~~24~~	~~100~~	~~250~~	~~1000~~	
~~6~~	1900			20	70	200	700	
~~8~~	~~600~~				~~50~~	~~150~~	~~500~~	~~1300~~
~~8~~	~~1400~~				~~40~~	~~100~~	~~400~~	~~1200~~
~~8~~	2200				30	80	350	1100
~~8~~	3600				25	60	250	800
~~10~~	~~1000~~					~~75~~	~~125~~	~~1000~~
~~10~~	~~2500~~					~~50~~	~~100~~	~~500~~
~~10~~	~~3800~~					~~30~~	~~80~~	~~350~~
~~10~~	~~5600~~					~~25~~	~~60~~	~~250~~

*except 6 fixture unit fixtures

History: Amended effective August 1, 1981; July 1, 1985; February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

CHAPTER 62-03-13

62-03-13-01. General.

1. **Where required.** All roofs, paved areas, yards, courts, and courtyards shall be drained into a separate storm-sewer system, or a combined-sewer system where such systems are available, or to a place of disposal satisfactory to the administrative authority. In the case of ~~one~~ one-family and two-family dwellings, storm water may be discharged on flat areas such as streets or lawns so long as the storm water will flow away from the building. In no case shall water from roofs be allowed to flow upon the public sidewalk.

2. **Storm water drainage to sewer prohibited.** Storm water shall not be drained into sewers intended for sewage only.

3. **Sanitary and storm sewers.** Where separate systems of sanitary drainage and storm water are installed in the same property, the storm and sanitary building sewers and drains may be laid side by side in the same trench.

4. **Expansion joints required.** Expansion joints or sleeves shall be provided where warranted by temperature variations or physical conditions. When plastic pipe is installed for interior conductors, and the vertical or horizontal length exceeds thirty-five feet [10.67 meters], provisions for expansion must be made at thirty-five-foot [10.67-meter] intervals.

5. **Subsoil drains.** Where subsoil drains are placed under the cellar or basement floor or are used to surround the outer walls of a building, they shall be made of open-jointed or horizontally split or perforated clay tile, or perforated bituminized fiber pipe, asbestos cement pipe, or plastic pipe, not less than four inches [10.16 centimeters] in diameter. The subsoil drain shall be protected by an accessibly located backwater valve. Subsoil drains may discharge into a properly trapped area drain or sump. Such sumps do not require vents.

6. **Areaway drains.** All open subsurface space adjacent to a building serving as an entrance to the basement or cellar of a building must be provided with a drain or drains. Such areaway drain shall be of cast iron pipe, or schedule 40 plastic pipe, two inches [5.08 centimeters] minimum in diameter for areaway, not to exceed one hundred square feet [9.29 square meters] in area. No areaway drain can discharge into a subsoil drain. Areaway drains for areas exceeding one hundred square feet [9.29 square meters] shall be sized according to the table in subsection 2 of section 62-03-13-06.

7. **Window well drains.** Window areaways not greater than ten square feet [.93 square meters] in area may discharge to subsoil drains through a two-inch [5.08-centimeter] cast iron pipe or schedule 40 plastic pipe. However, in the case of window areaways greater than ten square feet [.93 square meters] in area, such areaways must be handled in the manner provided for entrance areaways.

8. **Filling stations and motor vehicle washing.** Public filling stations and motor vehicle washing establishments shall have the paved area sloped toward sumps or gratings within the property lines. Curbs not less than six inches [15.24 centimeters] high shall be placed where required to direct water to gratings or sumps.

9. **Paved areas.** Where the occupant creates surface water drainage, the sumps, gratings, or floor drains shall be piped to a storm drain or an approved water course.

History: Amended effective February 1, 1994.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

TITLE 67

Public Instruction, Superintendent of

MARCH 1994

CHAPTER 67-06-01-01

67-06-01-01. Definitions. For the purposes of this ~~chapter~~ article, unless the ~~following terms mean~~ context otherwise requires:

1. "Appropriately licensed professional" means a state-approved school psychologist or clinical psychologist.

2. "Assessment plan" means the written document which:

   a. Identifies the members of the mutidisciplinary assessment team;

   b. States the purpose of the assessment;

   c. Outlines the procedures to be followed; and

   d. Identifies the information which is to be gathered.

3. "Cumulative folder":

   a. "District cumulative folder" means the student file kept by the local superintendent which contains the student's nationally standardized achievement test results~~, nationally standardized academic aptitude test results,~~ along with supporting documentation and evidence of the work and progress of the student.

   b. "Parent cumulative folder" means the student file which is maintained by the parent on an ongoing basis to show academic progress which contains nationally standardized achievement test results, ~~nationally standardized academic~~

~~aptitude test results,~~ subject area test documentation, products of subject area work, anecdotal records, and any other relevant information.

4. "Developmentally disabled" means the condition of a person who has a severe, chronic disability which:

   a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

   b. Is manifested before the person attains age twenty-two;

   c. Is likely to continue indefinitely;

   d. Results in substantial functional limitations in three or more of the following areas of major life activity:

      (1) Self-care;

      (2) Receptive and expressive language;

      (3) Learning;

      (4) Mobility;

      (5) Self-direction;

      (6) Capacity for independent living; and

      (7) Economic sufficiency; and

   e. Reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

5. "Empirical norming period" means the period of time during which a nationally normed standardized achievement test is given for the purpose of collecting grade level national norms.

6. "Independent educational evaluation" means an evaluation conducted by a qualified examiner who is not employed by the public agency responsible for the education of the student in question.

7. "Individual education program" means a written statement for a handicapped child developed in a meeting by the individual education program team which includes:

   a. A statement of the present levels of educational performance of the child;

b. A statement of annual goals, including short-term objectives;

c. A statement of the specific educational services to be provided to the child;

d. The projected date for initiation and anticipated duration of such services; and

e. Appropriate criteria and evaluation procedures and schedules for determining, on an annual basis, whether instructional objectives are being achieved.

8. "Individual education program team" means the group of people assembled to develop a written statement for a handicapped child which will determine the educational programming to be provided including:

a. The local director of special education who will serve as team chairperson;

b. The local school superintendent;

c. The parents;

d. The ~~supervising~~ monitoring teacher, in ~~supervised~~ monitored programs;

e. The child, when appropriate; and

f. Additional members at the discretion of the team.

9. "Local superintendent" means the superintendent of the public school district in which the student resides or, in the absence of one, the county superintendent of schools in the student's county of residence.

10. "Monitored program" means a program of home-based instruction in which the supervising parent meets the statutory requirements to supervise by being monitored by a certified teacher.

11. "Multidisciplinary assessment team" means a group including:

a. The local director of special education who will serve as team chairperson;

b. At least one specific learning disabilities teacher or other specialist with knowledge in the area of suspected disability;

c. The parents;

d. A state-approved school psychologist or clinical psychologist;

e. The ~~supervising~~ monitoring teacher in ~~supervised~~ monitored programs or, in ~~unsupervised~~ unmonitored programs, the parent's or parents' choice of a classroom teacher from a state-approved public~~, private, or parochial~~ nonpublic school currently teaching in a grade equivalent to the grade the student is in; and

f. Additional members at the discretion of the team.

~~11.~~ 12. "Nationally standardized test" means a test developed by subjecting items and subtests to a norming process involving stratified samples of students by grade, geographical distribution, grade level, sex, etc., and administered according to identical instructions.

~~a. "Nationally standardized academic aptitude test" means a test which is designed to measure a student's academic aptitude and thereby predict the level of achievement to be anticipated in school.~~

~~b.~~ 13. "Nationally standardized achievement test" means a test which is designed to measure a student's knowledge and skills acquired in specific content areas at a certain time.

~~12.~~ 14. "Reasonable academic progress" means performance at the expected competency level established for the student's grade and age level ~~and commensurate with the student's academic aptitude~~.

~~13.~~ 15. "Statement of intent" means the document provided by the local superintendent which the parent intending to supervise home-based instruction files for each student for which instruction is intended with the local superintendent at least thirty days prior to the beginning of the school semester for which the parent requests the exemption. ~~The statement must include:~~

~~a. The name and address of the parent who will supervise and the student who will receive home-based instruction;~~

~~b. The date of birth and grade level of each student;~~

~~c. The intention of the parent to supervise home-based instruction;~~

~~d. The qualifications of the parent who will supervise the home-based instruction;~~

~~e. A list of courses or extracurricular activities in which the student intends to participate in the public school district; and~~

~~f. An oath or affirmation that the parent will comply with all provisions of North Dakota Century Code chapter 15-34.1.~~

~~14. "Supervised program" means a program of home-based instruction in which the parent does not meet the statutory requirements which would allow the parent to teach and, therefore, must be supervised by a certificated teacher employed by the local school district or, if requested by the parent, a certificated teacher employed by a state-approved private or parochial school.~~

~~15.~~ 16. "Test administrator" means a ~~certificated~~ certified teacher ~~employed by the district, or if requested by the parent, a certificated teacher employed by a state-approved private or parochial school,~~ who administers the nationally standardized achievement test ~~and the nationally standardized academic aptitude test to students receiving home-based instruction~~.

~~16.~~ 17. "~~Unsupervised~~ Unmonitored program" means a program of home-based instruction in which the parent ~~meets the statutory requirements~~ qualifies to supervise either by being certified to teach in North Dakota or by meeting or exceeding the cutoff scores of the national teacher exam, and ~~thus, can teach~~ therefore may supervise without ~~the supervision of~~ being monitored by a ~~certificated~~ certified teacher.

History: Effective September 1, 1990; amended effective March 1, 1994.
General Authority: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07
Law Implemented: ~~S.L. 1989, Ch. 198, §§ 4, 5~~ NDCC 15-34.1-06, 15-34.1-07

67-06-02-02. Transfer to a public~~, private,~~ or ~~parochial~~ nonpublic school. Documentation of courses taken and academic progress assessments, including nationally standardized achievement test results ~~and nationally standardized academic aptitude test results~~, must be furnished upon request of the local superintendent in the event a student transfers to a public school or state-approved ~~private or parochial~~ nonpublic school.

History: Effective September 1, 1990; amended effective March 1, 1994.
General Authority: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07
Law Implemented: ~~S.L. 1989, Ch. 198, § 4~~ NDCC 15-34.1-06, 15-34.1-07

67-06-02-03. Responsibilities of the parent. It is the responsibility of the parent to:

1. File a statement of intent annually with the local superintendent for each student who is to receive home-based instruction;

2. ~~Teach~~ Supervise the courses required by statute;

3. Conduct classes for the required length of time and number of days;

4. Maintain a parent cumulative folder for each student receiving home-based instruction;

5. Arrange for annual testing using a nationally standardized achievement testing instrument ~~and a nationally standardized academic aptitude testing instrument~~ as required by statute;

6. Serve on a multidisciplinary assessment team for the purpose of evaluating the student who scores below the thirtieth percentile on the nationally standardized achievement test; and

7. ~~Develop and implement a plan of program adaptation for the student who is not handicapped but whose nationally standardized achievement test score falls five points below the nationally standardized academic aptitude score; and~~

~~8.~~ Transfer the parent cumulative folder, upon request of the local superintendent, if the student enrolls in a public~~, private,~~ or ~~parochial~~ nonpublic school.

History: Effective September 1, 1990; amended effective March 1, 1994.
General Authority: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07

Law Implemented: ~~S.L. 1989, Ch. 198, §§ 4,~~ 5 NDCC 15-34.1-06, 15-34.1-07

67-06-03-01. Provision of information to parent. Upon receipt of a statement of intent, the local superintendent shall provide information to the parent, ~~including~~ relating to the following:

1. ~~The supervising teacher of a supervised program who shall:~~

   ~~a. Be a certificated teacher employed by the school district, or if requested by the parent, a certificated teacher employed by a state-approved private or parochial school; and~~

   ~~b. Provide the minimum amount of student supervision required by law.~~

~~2.~~ ~~Each~~ The responsibility of the parent is responsible for maintaining a ~~parent~~ cumulative folder for each student which contains a list of the courses taken and documentation of academic progress, including nationally standardized achievement test results ~~for each year the student receives home-based instruction and nationally standardized academic aptitude test results for tests administered twice in the span of grades one through six and once in grade seven or eight.~~

2. The availability of resources and support for the students who are experiencing learning difficulties and may be in need of special education and related services under the Individuals With Disabilities Education Act [Pub. L. 94-142, as amended] or section 504 of the Rehabilitation Act of 1973, as amended, and the responsibility of the school district to identify and appropriately serve such students.

3. The local school district's expectations of appropriate grade level for each student in the subjects required by statute to be taught. (See North Dakota Century Code sections 15-38-07, 15-41-06, and 15-41-24.) These subjects are as follows:

   a. At the elementary level: spelling, reading, writing, arithmetic, language, English grammar, geography, United States history, civil government, nature study, elements of agriculture, physiology, and hygiene.

   b. At the secondary level:

      (1) The following units of study must be made available to all students at least once during each four-year period:

         (a) Four units of English;

(b) Three units of mathematics;

(c) Four units of science;

(d) Three units of social studies;

(e) One unit of health and physical education;

(f) One unit of music; and

(g) Six units of any combination of the following course areas: business education, economics and the free enterprise system, foreign language, industrial arts, vocational education. Vocational education includes home economics, agriculture, office education, distributive education, trade industrial, technical, and health occupations.

(2) Four units of high school work is considered the minimum number of any year from the ninth grade through the twelfth grade.

4. Information regarding the nationally standardized achievement test ~~and nationally standardized academic aptitude test must include~~ including:

a. The name of the achievement test ~~and academic aptitude test used~~ administered by the district;

b. The dates of the empirical norming period.

c. The place of test administration must be the child's learning environment; and

d. A statement that the test must be administered by a ~~certificated~~ certified teacher ~~employed by the district or, if requested by the parent, a certificated teacher employed by a state-approved private or parochial school~~.

The financial responsibility of the parent for purchasing, administering, and scoring the tests must be as follows: There is no cost to the parent if the tests are administered by a ~~certificated~~ certified teacher employed by the district. The parent will be responsible for payment of the cost if the tests are administered by a ~~certificated~~ certified teacher employed by ~~a state-approved private or parochial school~~ the parent.

5. The school district requirements which must be met before high school credit for a course will be issued include:

a. Course content;

b. Textbook and materials used;

c. Periodic progress report (six-week or nine-week periods);

d. Tests used to measure progress; and

e. Other pertinent information to establish competency.

6. The requirements which must be met before a high school district can assure the superintendent of public instruction that a student has completed the requirements for high school graduation from that district through home-based instruction. The requirements must include:

a. That the school district will only accept high school credits issued by high schools approved by this or any other state.

b. Completion by the student of the credit requirements or student performance standards, or both, for high school graduation as established by the high school district.

7. A copy of state law concerning the requirements of home-based instruction.

8. A copy of the state definition of a dropout.

History: Effective September 1, 1990; amended effective April 1, 1992; March 1, 1994.
General Authority: ~~S.L. 1989, Ch. 198, § 5, S.L. 1991, ch. 181, § 1~~ NDCC 15-34.1-07
Law Implemented: ~~S.L. 1989, Ch. 198, § 5, S.L. 1991, ch. 181, § 1~~ NDCC 15-34.1-07

67-06-03-03. Responsibility for ~~supervision~~ monitoring by a ~~certificated~~ certified teacher. The school district shall assure that a ~~supervising~~ monitoring teacher in a ~~supervised~~ monitored program is ~~certificated and employed by the school district or, at the parent's request, by a state approved private or parochial school~~ certified.

History: Effective September 1, 1990; amended effective March 1, 1994.
General Authority: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07
Law Implemented: ~~S.L. 1989, Ch. 198, §§ 5, 7~~ NDCC 15-34.1-07

67-06-04-02. Basis for determination of reasonable academic progress. The determination of reasonable academic progress must be based upon each of the factors described in subsections 1 through ~~5~~ 4:

1. Nationally standardized achievement test results.

   a. Every student receiving home-based instruction must be tested annually using a nationally standardized achievement test as required by statute.

   b. The nationally standardized achievement test must be administered on a date to be set within the empirical norming period of the test used.

   c. The test must be administered by a ~~certificated~~ certified teacher ~~employed by the district or, if requested by the parent, a certificated teacher employed by a state-approved private or parochial school~~.

   d. The results of the nationally standardized achievement test must be submitted directly to the parent by the test administrator within five calendar days following receipt of the test results. A copy must be submitted to the local superintendent at the same time.

      (1) The parent shall file the nationally standardized achievement test results in the parent cumulative folder maintained for each student receiving home-based instruction.

      (2) The local superintendent shall file the nationally standardized achievement test results in the district cumulative folder which is maintained for each student receiving home-based instruction.

2. ~~Nationally standardized academic aptitude test results.~~

   ~~a. Every student receiving home-based instruction must be tested using a nationally standardized academic aptitude test in order to provide a basis to determine whether the student is making reasonable academic progress consistent with the student's age and stage of development.~~

   ~~b. The nationally standardized academic aptitude test:~~

      ~~(1) Must be administered twice during the span of grades one through six and once in grade seven or eight; and~~

~~(2) Must be administered at the designated grade levels along with the nationally standardized achievement test on a date to be set within the empirical norming period of the test used.~~

~~c. The results of the nationally standardized academic aptitude test must be submitted directly to the parent by the test administrator within five calendar days following the receipt of the test results. A copy must be submitted to the local superintendent at the same time.~~

~~(1) The parent shall file the nationally standardized academic aptitude test results in the parent cumulative folder maintained for each student receiving home-based instruction.~~

~~(2) The local superintendent shall file the nationally standardized academic aptitude test results in the district cumulative folder which is maintained for each student receiving home-based instruction.~~

~~3.~~ Teacher's progress reports in ~~supervised~~ monitored programs.

a. Every student in a ~~supervised~~ monitored program must be evaluated for academic progress by the ~~supervising~~ monitoring teacher based upon:

(1) The program of studies which includes the subjects required by statute to be taught;

(2) Observation of the student;

(3) Conference with the parent; and

(4) Data recorded by the parent.

b. The ~~supervising~~ monitoring teacher's evaluations must be compiled in a progress report which documents the continuing progress of the student in each subject area. The ~~supervising~~ monitoring teacher shall submit two progress reports in each school year to the local superintendent. The first progress report must be submitted in December and the second progress report must be submitted in May. A copy of each progress report must be provided to the parent at the time of filing.

~~4.~~ 3. Program adaptation documentation provided by the parent. The parent of every student who has scored below the thirtieth percentile nationally on the nationally standardized achievement test and has been found to be in need of program adaptation by the multidisciplinary assessment team shall submit documentation of the adapted plan and academic progress at the end of each school year pursuant to subdivision c of

subsection 3 of section 67-06-05-01, subsection 5 of section 67-06-05-01, and subsection 1 of section 67-06-05-02.

~~5.~~ 4. Individual education program reviews provided by the individual education program team.

a. An individual education program required in subdivision c of subsection 3 of section 67-06-05-01 must have periodic reviews completed by the individual education program team.

b. The individual education program team shall review progress on goals and objectives set for the student and such progress must be a determinant of academic progress.

History: Effective September 1, 1990; amended effective March 1, 1994.
General Authority: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07
Law Implemented: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07

CHAPTER 67-06-05

67-06-05-01. Student assessment procedures. An assessment must be conducted for students who score below the thirtieth percentile on the nationally standardized achievement test.

1. A student receiving home-based instruction whose annual nationally standardized achievement test results show a composite score below the thirtieth percentile must be evaluated by a multidisciplinary assessment team using the following procedure. Within fifteen calendar days of receipt by the local superintendent of a nationally standardized achievement test composite score which is below the thirtieth percentile, the local superintendent shall appoint, notify, and assemble the multidisciplinary assessment team. The multidisciplinary assessment team shall develop an assessment plan which:

   a. Identifies the members of the multidisciplinary assessment team;

   b. States the purpose of the assessment;

   c. Outlines the procedures to be followed; and

   d. Identifies the information which is to be gathered such as:

      (1) Levels of achievement and ability;

      (2) Discrepancy between achievement and ability;

      (3) Severity of discrepancy; and

      (4) Cause of the discrepancy; such as, specific learning disability; visual, hearing, or motor handicap; emotional disturbance; environmental, cultural, or economic disadvantage; or mental retardation.

2. The parent may seek an independent educational evaluation at the parent's expense. Such an evaluation must become part of the assessment plan.

3. The multidisciplinary assessment team shall submit the assessment plan to the local superintendent within thirty calendar days of the time the team is assembled. The assessment plan must include one of the following determinations:

   a. The student is developmentally disabled according to subsection 1 of North Dakota Century Code section

25-01.2-01 and, therefore, the parent is not entitled to an exemption under subsection 5 of North Dakota Century Code section 15-34.1-03~~, as amended by section 2 of chapter 198 of the 1989 Session Laws~~.

b. The student ~~is~~ does not ~~handicapped~~ have a disability according to the eligibility criteria of the department of public instruction and does not require specially designed instruction. The parent may continue to provide home-based instruction upon filing a statement from the school psychologist or clinical psychologist who is a member of the multidisciplinary assessment team. The statement must be filed with the superintendent of public instruction and must assure that:

~~(1)~~ ~~The~~ the student is making reasonable academic progress consistent with the student's learning abilities~~, and~~

~~(2) Whenever the nationally standardized achievement test score is five or more points lower than the nationally standardized academic aptitude test score, the parent shall adopt and implement a plan of program adaptation. The plan must be submitted to the local superintendent within thirty calendar days or before the start of the next school year, whichever comes first~~.

c. The student ~~is handicapped~~ has a disability, but is not developmentally disabled, according to the eligibility criteria of the department of public instruction~~. The student~~ and requires specially designed instruction which cannot be provided without special education and related services. To continue providing home-based instruction, the parent, on behalf of the team, shall file an individual education program with the superintendent of public instruction which:

(1) Has been developed within rules adopted by the department of public instruction; and

(2) Shows that the student's needs for special education are being addressed by persons qualified to provide special education.

4. The state-approved school psychologist or clinical psychologist, who is a member of the multidisciplinary assessment team, shall issue to the parent, the local superintendent, and the state superintendent of public instruction the team's written statement attesting to subdivision a, b, or c of subsection 3 of section 67-06-05-01 within ten calendar days following the completion of the assessment plan.

5. A copy of the assessment plan must be filed in the district cumulative folder by the local superintendent.

History: Effective September 1, 1990; amended effective March 1, 1994.
General Authority: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07
Law Implemented: ~~S.L. 1989, Ch. 198, §§ 2, 5~~ NDCC 15-34.1-07

67-06-05-02. Determining reasonable academic progress. For the student subject to section 67-06-05-01, the local superintendent shall annually determine if the student is making reasonable academic progress.

1. Determination of reasonable academic progress must be based upon a review of the following, when applicable:

   a. The results of the nationally standardized achievement test given annually; and

   b. ~~The results of the nationally standardized academic aptitude test given twice during the span of grades one through six and one in grade seven or eight.~~

   ~~c. The parent's plan of program adaptation developed in paragraph 2 of subdivision b of subsection 3 of section 67-06-05-01 and documentation of academic progress made in accordance with that plan; and~~

   ~~d.~~ The ~~supervising~~ monitoring teacher's documentation of academic progress in a ~~supervised~~ monitored program.

2. The local superintendent shall reconvene the multidisciplinary assessment team for the student who scored below the thirtieth percentile and is not making reasonable academic progress. The team shall reevaluate the student and make recommendations for improving the academic achievement of the student.

History: Effective September 1, 1990; amended effective March 1, 1994.
General Authority: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07
Law Implemented: ~~S.L. 1989, Ch. 198, § 5~~ NDCC 15-34.1-07

APRIL 1994

STAFF COMMENT: Article 67-09 contains all new material but is not underscored so as to improve readability.

ARTICLE 67-09

APPROVAL FOR SCHOOL CONSTRUCTION ESTIMATED TO COST MORE THAN TWENTY-FIVE THOUSAND DOLLARS

CHAPTER 67-09-01
APPROVAL FOR SCHOOL CONSTRUCTION ESTIMATED TO COST MORE THAN TWENTY-FIVE THOUSAND DOLLARS

67-09-01-01. Definitions. For purposes of this article:

1. "Application" means the appropriate construction approval application provided by the department or one sanctioned by the department, including all required supporting documentation.

2. "Board" means the North Dakota state board of public school education.

3. "Construction" means construction, purchase, repair, improvement, renovation, or modernization of any school building or facility.

4. "Consult" means to meet with, discuss data and plans, and seek advice and counsel.

5. "Department" means the North Dakota department of public instruction.

6. "District" means a North Dakota public school district.

7. "Emergency construction" means any new construction or remodeling construction that is requested as the result of destruction of buildings or facilities by fire, wind, or other act of God.

8. "Facility" includes a parking lot, athletic complex, or any other improvement to real property owned by the district.

9. "Facility plan" means the school district's facility plan required for new construction, or remodeling construction estimated to cost one hundred fifty thousand dollars or more, completed on forms provided or sanctioned by the department.

10. "New construction" means any construction that provides additional area to the current buildings or facilities and is estimated to cost more than twenty-five thousand dollars.

11. "Remodeling construction" means any construction that improves current buildings or facilities and is estimated to cost more than twenty-five thousand dollars.

12. "Superintendent" means the North Dakota superintendent of public instruction.

13. "Technical assistance" means counsel, advice, and involvement in the completion of the application and facility plan.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-02. Construction costing more than twenty-five thousand dollars must be approved. A district may not undertake construction of any school building or facility estimated to cost more than twenty-five thousand dollars unless the construction is approved by the superintendent.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-03. Consultation with the department required. The district shall consult with the department at least:

1. Sixty days prior to the submission of an application if the construction is new construction, or remodeling construction estimated to cost one hundred fifty thousand dollars or more; or

2. Thirty days prior to the submission of an application if the construction is remodeling construction estimated to cost less than one hundred fifty thousand dollars.

The department may waive the timelines in this section for applications submitted under section 67-09-01-06 before July 1, 1994, and for emergency construction.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-04. Preparing the application. The district shall obtain the appropriate application from the department. The district shall receive and consider technical assistance provided by the department in preparing the application.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-05. Facility plan required for certain construction. A district proposing to undertake new construction, or remodeling construction estimated to cost one hundred fifty thousand dollars or more must meet the requirements of this section and all other sections in this chapter.

1. The district must submit to the department a facility plan with the application for construction approval.

2. At the time of consultation with the department, the district shall complete and review its facility plan with the department. The district shall receive and consider technical assistance provided by the department in completing and reviewing the district's facility plan.

3. The district's facility plan must include:

   a. Alternatives considered by the district and reasons for rejecting alternatives;

   b. Evidence of attempted cooperation or collaboration with area schools, health and human service agencies, and other educational agencies and political subdivisions;

   c. Description of district programs and services and an assessment of improvements that will occur as a result of construction completion;

   d. The location of schoolsites in each surrounding school district, including surrounding districts' attendance numbers in elementary and high school, capacity of buildings, and distances from the applicant's district;

   e. Past, current, and projected enrollment data;

   f. Trend data on general fund revenues, expenditures, and fund balances;

   g. Trend data on tax levies;

   h. Trend data on taxable valuation per pupil;

   i. Current bonded indebtedness, debt retirement schedules, and total capital expenditures of the district;

   j. Current sources of district revenue;

   k. A description and preliminary diagrams of the proposed construction;

   l. Geographic information regarding area proposed to be served;

   m. A description of district schools and facilities;

   n. Violations of fire, health, safety, and any other required state or federal standards which will be corrected by the construction;

o. Trend data on school or facility maintenance;

p. Estimated differences in operating costs as a result of construction completion;

q. Description of programs to reduce energy costs and waste disposal costs; and

r. Other data as deemed advisable by the superintendent.

4. The district's facility plan must be approved by the department before it may be submitted to the superintendent with the application.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-06. Submission of application. The district shall submit the application to the department, along with its approved facility plan, if necessary. If the superintendent determines the application is not complete, the superintendent shall return the application to the district for proper completion.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-07. Demonstration of need and educational utility. The superintendent may not approve the application unless the district demonstrates to the superintendent's satisfaction the need and educational utility of the project based on criteria that include the following:

1. For remodeling construction estimated to cost less than one hundred fifty thousand dollars:

   a. The district demonstrates the requisite need for the remodeling construction;

   b. The building or facility will be in use for at least three years;

   c. Enrollment is likely to remain relatively stable for at least three years; and

   d. The remodeling construction will enhance or facilitate delivery of educational services in the district.

2. For new construction, or remodeling construction estimated to cost one hundred fifty thousand dollars or more:

a. The proposed building or facility is comparable in size and quality to buildings or facilities recently constructed in other districts that have similar enrollments;

b. The district has attempted cooperation or collaboration with area schools, health and human service agencies, and other educational agencies and political subdivisions;

c. The need for buildings or facilities could not be met within the district or adjacent districts at a comparable cost by leasing, repairing, remodeling, or sharing existing buildings or facilities or by using temporary buildings or facilities;

d. No form of cooperation with another district would provide the buildings or facilities to meet the needs of the students;

e. The building or facility will enhance or facilitate the delivery of educational services in the district;

f. The economic and population bases of the communities to be served are likely to grow or to remain at a level sufficient to ensure the cost effectiveness of the building or facility;

g. The building or facility meets or exceeds the size standards recommended by the department;

h. Appropriate efforts to determine how this building or facility fits into the learning needs of the area have been made;

i. The availability and manner of financing the construction has been thoroughly evaluated; and

j. The operating budget of the district can satisfactorily meet the projected operation cost of the proposed building or facility.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-08. Application acted on within sixty days. Within sixty days of receipt of the completed application, the superintendent shall either approve or disapprove the application and shall provide a written rationale for such approval or disapproval. However, if the application seeks approval of emergency construction, the superintendent shall approve or disapprove the application within seven days, or as soon thereafter as is reasonably possible.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-09. Appeal of disapproved application to board. If the superintendent disapproves the district's application, the district may appeal the superintendent's decision to the board by serving a written notice of appeal on the superintendent, with a statement of the reasons why the application should be approved, within thirty days of the mailing of the notification of disapproval. Within sixty days of receipt of the written appeal request, the board shall review the application, the superintendent's written rationale for disapproval, and the district's statement of reasons why the application should be approved, and determine whether the application should be approved. The board's decision on the district's application is final.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-10. Approval effective for two years. Construction approval received under this chapter is effective for two years from the date of approval. If the district has not commenced construction within the two-year period, the district must apply again for construction approval.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

67-09-01-11. Submission of architectural plans. Prior to commencement of approved construction, the district shall submit architectural plans required by law to the department.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1

STAFF COMMENT: Article 67-10 contains all new material but is not underscored so as to improve readability.

ARTICLE 67-10

SCHOOL CONSTRUCTION LOAN APPLICATION AND LOAN APPROVAL

CHAPTER 67-10-01
SCHOOL CONSTRUCTION LOAN APPLICATION AND LOAN APPROVAL

67-10-01-01. Definitions. For purposes of this article:

1. "Board" means the board of university and school lands.
2. "Department" means the North Dakota department of public instruction.
3. "District" means a North Dakota public school district.
4. "Fund" means the coal development trust fund controlled by the board of university and school lands.
5. "Loan application" means the construction loan application provided by the department of public instruction.
6. "Project" means a building or facility that a school district is authorized to construct, purchase, repair, improve, renovate, or modernize under North Dakota Century Code section 15-35-01.1.

7. "Superintendent" means the North Dakota superintendent of public instruction.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1, 15-60

67-10-01-02. Loan eligibility. A district may apply for a loan from the fund if the following are met:

1. The project has been approved by the superintendent or the state board of public school education pursuant to North Dakota Century Code section 15-35-01.1 and is estimated to cost in excess of fifty thousand dollars;

2. The district has an existing indebtedness equal to at least fifteen percent of the district's taxable valuation; and

3. The principal amount of the loan requested does not exceed the lesser of thirty percent of the taxable valuation of the district or five million dollars.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1, 15-60

67-10-01-03. Application form. The district shall acquire a loan application from the department and submit it to the superintendent. The district shall provide the following in the loan application:

1. Verification of existing indebtedness of at least fifteen percent of the district's taxable valuation;

2. A discussion of alternative sources or methods for financing the construction or improvement program;

3. Verification that the school board of the district intends to issue and sell evidences of indebtedness to finance the construction or improvement;

4. Past, current, and projected enrollment data;

5. Current bonded indebtedness, debt retirement schedules, and total capital expenditures of the district;

6. Current taxable valuation of the district;

7. Trend data of per-pupil taxable valuation of the district;

8. Current and projected operating expenses of the district;

9. Data on tax levies of the district; and

10. Other data as deemed advisable by the superintendent.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1, 15-60

67-10-01-04. Times loan applications considered. Loan applications received before July 1, 1994, will be considered for approval within forty-five days after the application is received. Thereafter, loan applications will be considered for approval two times each year, in the months of March and September. For consideration in March, the loan application must be received no later than February first. For consideration in September, the loan application must be received no later than August first.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1, 15-60

67-10-01-05. Loan approval - Demonstration of fiscal need and capacity to repay. Before the superintendent may approve a loan, the district must demonstrate to the superintendent's satisfaction fiscal need for the loan and capacity to repay the loan. To determine fiscal need and capacity to repay, the following factors will be considered:

1. The ratio between the district's total capital debt and taxable valuation (a 1:1 ratio indicates the highest level of need);

2. The ratio between the district's tax levies and the average district tax levies for the state of North Dakota (the higher the total tax levies in relationship to the average district tax levies, the greater the need);

3. The ratio between the district's total capital debt and the district's annual total expenditures (the higher the total capital debt in relationship to the total annual expenditures, the greater the need);

4. The ratio of the district's per-pupil taxable valuation to the average per-pupil taxable valuation for the state of North Dakota (the lower the per-pupil taxable valuation in relationship to the state average, the greater the need); and

5. A student population base that assures a reasonable level of cost effectiveness of the facility.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1

Law Implemented: NDCC 15-35-01.1, 15-60

67-10-01-06. Loan approval - Order - Determination of loan amount and percent of interest. Loan applications will be considered for approval in the order of approval of construction of the project by the superintendent or the state board of public school education. The superintendent may determine the loan amount and a percentage rate of interest to be paid on the loan.

1. The superintendent will not approve a loan amount that exceeds two million five hundred thousand dollars for any particular application. In determining the loan amount to be awarded, the superintendent shall consider the following:

   a. The total number of loan applications received and the total amount of loans requested in the six-month application period, or, if the application is received prior to July 1, 1994, the total number of loan applications received and the total amount of loans requested at the time the application is considered;

   b. The total amount of money the superintendent has determined will be approved for loans in the six-month period, or, if the application is received prior to July 1, 1994, the total amount of money the superintendent has determined will be approved for loans at the time the application is considered; and

   c. The cost of the project and the fiscal capacity of the district.

2. The interest on a loan may not exceed the rate of two percent below the net interest rate on comparable tax-exempt obligations as determined on the date the loan application is approved by the superintendent, provided the interest rate may not exceed six percent.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1, 15-60

67-10-01-07. Board approval. The superintendent shall submit any approved loan applications to the board for final approval with recommendations regarding the loan amounts, the rates of interest to be paid on the loans, and the terms of the loans. The board shall consider the loan applications in the order in which they were approved by the superintendent. The board shall consider the superintendent's recommendation in determining whether to approve the loan. A loan may not be approved if approval would increase the outstanding principal balance of loans made from the fund to more than twenty-five million

dollars. The superintendent shall notify each applicant of the action taken by the board.

History: Effective April 1, 1994.
General Authority: NDCC 15-35-01.1
Law Implemented: NDCC 15-35-01.1, 15-60

TITLE 69

Public Service Commission

DECEMBER 1993

CHAPTER 69-09-05-04

69-09-05-04. Rules for resale of telecommunications services.

1. Definitions.

   a. "End user" means a person who uses telecommunications service for his own use.

   b. "Premise cable" means telecommunications cable or channels on the reseller's side of the point of connection to the local exchange company (demarcation point).

   c. "Prepayment" means payments made by customers of a reseller in advance of receiving service.

   d. "Resale" means the subscription to local or long distance telecommunications services and facilities by one entity, and reoffered for profit or with markup to others with or without enhancements. Where reoffered service is part of a package, and the package is offered for profit or markup, it is resale.

   e. "Reseller" means a person reselling local or long distance telecommunications services. The definition does not include pay telephone providers, but does include cellular services.

   f. "Same continuous property" is contiguous real estate owned by the same individual, group of individuals, or other legal entity having title to the property. The property may be traversed by streets, ditches, or other similar

manmade or natural terrain features provided that, but for terrain features, the property would be contiguous and provided that such terrain features are of a nature and dimension that it is reasonable to treat the property as contiguous.

g. "Shared tenant service provider" means a person reselling telecommunications services to the tenants of a building complex on the same continuous property or to parties with a community of interest.

2. Resellers shall:

a. Obtain a certificate of registration from the commission authorizing the provision of local resale or long-distance resale services in the state of North Dakota.

b. If they require prepayment for service:

(1) Submit a performance bond in an amount specified by the commission; or

(2) Establish an escrow account in a North Dakota bank containing an amount equal to the prepayments collected at any given time, and file monthly reports showing escrow account activities and call completion data.

(3) The requirements of paragraphs 1 and 2 are waived for any company that has provided cellular service in North Dakota for one year without a formal complaint having been filed against it. The commission may revoke the waiver after notice and opportunity for hearing if necessary to protect the public interest.

c. File annual reports.

3. Resale of local exchange service, except cellular service, is restricted to provision of service to a building complex on the same continuous property, or to other parties having a community of interest with the reseller.

4. The commission will analyze each local exchange reseller's application to determine if the reseller serves parties having a community of interest.

5. Except for residents of dormitories or residence halls of schools, colleges, or universities, the end user has the unrestricted right to choose service from the local exchange.

6. Shared tenant service providers shall allow the tenant to use the shared tenant service providers premise cable and wire in

the event an end user wants to receive service from the local exchange company.

7. The reseller is responsible for the charges incurred for telecommunications services to which it subscribes for serving its end users.

History: Effective March 1, 1989; amended effective August 1, 1991; December 1, 1993.
General Authority: NDCC 28-32-02, 49-02-11
Law Implemented: NDCC 49-02-11, 49-21

JANUARY 1994

CHAPTER 69-03-01

69-03-01-02. Application for certificates or permits. Anyone wanting to obtain motor carrier operating authority must apply to the commission. The application ~~must be made on forms provided by the commission and~~ must be accompanied by:

1. The application fee.

2. A copy of the partnership agreement if the applicant is a partnership.

3. A copy of the articles of incorporation and a list of the directors, officers, and major stockholders if the applicant is a corporation.

History: Amended effective September 1, 1981; October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-12, 49-18-20

69-03-01-02.1. Application for temporary authority. Anyone wanting temporary motor carrier operating authority must file a request with the commission. The request must be accompanied by:

1. An application under section 69-03-01-02.

2. Supporting statements showing an immediate and urgent need for service ~~which cannot be met by existing carriers~~.

History: Effective September 1, 1981; amended effective September 1, 1985; October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-12, 49-18-20

69-03-01-06. Refunds. ~~If an application is withdrawn, the commission may retain the portion of the application fee necessary to cover the cost of processing the application prior to the withdrawal~~ If an application is withdrawn prior to the commission issuing a notice of opportunity for hearing, the application fee may be refunded.

History: Amended effective October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-32

69-03-01-07. Identification ~~card~~ certificate. A commission identification ~~card~~ certificate must be carried in ~~all~~ vehicles operated under authority issued by the commission.

History: Amended effective October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-41

69-03-01-08. Certificates and permits displayed. ~~A copy of the evidence~~ Evidence of authority issued by the commission must be carried in each vehicle operated under that authority and be available for inspection by authorized persons ~~at all times~~.

History: Amended effective October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-08, 49-18-19

69-03-01-09. Time for filing evidence of insurance, bonds, and tariffs. When the issuance or transfer of a certificate or permit is approved by the commission, the carrier has sixty days to file the necessary evidence of insurance, bonds, and tariffs, prior to the issuance of any certificate or permit. A failure to comply with this section is a waiver and abandonment of the certificate or permit.

History: Amended effective October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08
Law Implemented: NDCC 49-18-26

69-03-01-13. Sale or transfer of authority. No certificate or permit may be sold, transferred, assigned, or encumbered through acquisition of stock or otherwise without approval of the commission. Any party may apply to the commission for transfer or encumbrance of a

certificate or permit in good standing. ~~The original certificate or permit must accompany the application.~~

History: Amended effective September 1, 1981; October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-26

69-03-01-16. Commercial zones. Transportation ~~solely~~ within the commercial zone of a city is exempt from this chapter. A commercial zone is:

1. The city itself, ("base city");

2. Cities contiguous to the base city; and

3. Other cities and unincorporated areas adjacent to the base city as follows:

   a. When the base city has a population less than two thousand five hundred, all unincorporated areas within three miles [4.8 kilometers] of its corporate limits and all of any other city any part of which is within three miles [4.8 kilometers] of the corporate limits of the base city.

   b. When the base city has a population of two thousand five hundred but less than twenty-five thousand, all unincorporated areas within four miles [6.4 kilometers] of its corporate limits and all of any other city any part of which is within four miles [6.4 kilometers] of the corporate limits of the base city.

   c. When the base city has a population of twenty-five thousand or more, all unincorporated areas within six miles [9.6 kilometers] of its corporate limits and all of any other city any part of which is within six miles [9.6 kilometers] of the corporate limits of the base city.

History: Effective September 1, 1981; amended effective October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-02

CHAPTER 69-03-02

69-03-02-02. Compliance required. No certificate or permit will be forwarded to the applicant until ~~all~~ evidence of insurance ~~policies~~ and bonds are filed with and approved by the commission and the applicant complies with all other requirements of the law.

History: Amended effective October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-33

69-03-02-04. Minimum insurance - Carrier of property.

1. Each carrier authorized to transport hazardous materials (as defined by the United States secretary of transportation), oil or hazardous substances (as defined by the administrator of the environmental protection agency), or hazardous wastes (as defined by the administrator of the environmental protection agency) shall file and maintain evidence of insurance~~, guarantee,~~ and surety bond~~, or qualification as a self insurer~~ on each vehicle used for such transportation covering public liability, property damage, and environmental restoration in an amount not less than is required by the provisions of the Motor Carrier Act of 1980 as amended.

2. Each carrier of property (except property referred to in subsection 1) or passengers shall file and maintain evidence of insurance~~, guarantee,~~ and surety bond~~, or qualification as a self insurer~~ on each vehicle used for such transportation covering public liability, property damage, and environmental restoration in an amount not less than five hundred thousand dollars. The security must be conditioned to pay all final judgments arising out of one accident recovered against such motor carrier for bodily injuries to, or the death of, any person resulting from the negligent operation, maintenance, or use of motor vehicles under the certificate or permit, or for loss or damage to property (except property referred to in subsection 3), or both.

3. Each carrier of property shall file and maintain insurance or a surety bond on each vehicle used for such transportation covering direct physical loss of or physical damage to property of a shipper or consignee placed in the possession of the carrier as the result of transportation provided pursuant to the carrier's certificate or permit in an amount not less than ten thousand dollars. A carrier required by law to pay a shipper or consignee for loss, damage, or default for which a connecting motor carrier is responsible is subrogated, to the extent of the amount paid, to the rights of the shipper or consignee under any such security.

History: Amended effective January 1, 1982; October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-33

69-03-02-05. C.O.D. insurance or bond. ~~All motor~~ Motor carriers of property offering collect on delivery service shall furnish an insurance policy or bond in the amount of five thousand dollars to guarantee the payment by the carrier to the shipper or its agents, of all cash (or collect) on delivery charges collected by the carrier in connection with the operation or conduct of its business as such carrier.

History: Amended effective January 1, 1982; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-33

69-03-02-07. Period of effectiveness. ~~All motor~~ Motor carrier insurance policies or surety bonds required by the commission must be written to continue in force until canceled by fifteen days' written notice to the commission. The fifteen days' notice shall commence from the date written notice is actually received by the commission.

History: Amended effective October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-33

69-03-02-08. General endorsement. The insured under ~~every~~ public liability and property damage insurance ~~policy~~ policies or bond required by North Dakota Century Code section 49-18-33 shall obtain and have attached to the policy or bond, properly signed by an authorized resident agent or official of the insurance or bonding company, an endorsement whereby the insurance or bonding company agrees:

1. To waive the description of the motor vehicle to be insured thereunder, and agrees to pay, within the limits of the policy, any final judgment for personal injury, including death, resulting therefrom, and loss or damage to property, including property of passengers while carried on the motor vehicle for shipment or in transit, caused by any and all motor vehicles operated by the insured pursuant to a certificate of public convenience and necessity or permit issued to the insured by the public service commission in accordance with the laws of North Dakota.

2. That nothing contained in the policy shall relieve the insurer from liability for accidents caused by motor vehicles operated by the insured of which the description has been waived pursuant to the certificate of public convenience and necessity or permit.

3. That no cancellation of the policy shall take effect unless fifteen days' notice, in writing, shall have first been given to the public service commission ~~at its office in Bismarck, North Dakota; the~~. The fifteen days' written notice shall commence from the date the notice is actually received by the commission.

4. The insured may be required to reimburse the insurer for any payment the insurer would not have been obligated to make under the terms of the policy except for the provisions of the endorsement.

History: Amended effective September 1, 1981; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-33

69-03-02-11. Guarantee bond. ~~Guarantee bonds submitted by carriers offering collect on delivery service must be on forms furnished by the commission.~~ Repealed effective January 1, 1994.

History: ~~Amended effective September 1, 1985.~~
General Authority: ~~NDCC 49-18-08, 49-18-19~~
Law Implemented: ~~NDCC 49-18-33~~

69-03-03-04. Duplicate certificate or permit. ~~Requests for a duplicate certificate or permit must be accompanied by a written statement indicating the original has been lost or destroyed.~~ Repealed effective January 1, 1994.

History: ~~Amended effective September 1, 1981; October 1, 1987.~~
General Authority: ~~NDCC 49-18-08, 49-18-19~~
Law Implemented: ~~NDCC 49-18-32~~

69-03-04-02. Class A carriers - Changes in service. Changes in time schedule, stopping place, or a reduction in ~~the number of~~ service ~~vehicles operating over any line or route~~ must be filed with the commission at least fifteen days before the proposed effective date. Proposed changes must be similarily posted at regular stopping places.

1. ~~A new time schedule must bear the next consecutive number, and refer to the number of the time schedule canceled. Thus, if time schedule No. 1 is to be changed, time schedule No. 2 must be issued, showing that it is canceling time schedule No. 1, as follows:~~

~~Time Schedule No. 2~~
~~Cancels~~
~~Time Schedule No. 1~~

~~2.~~ The commission may, on its own motion, or on the filing of a ~~sufficient~~ valid protest by any person affected, order the time schedule withdrawn, modified, or suspended.

~~3.~~ 2. If good cause is shown, the commission may permit the time schedule to become effective on less than fifteen days' notice.

History: Amended effective October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08
Law Implemented: NDCC 49-18-08

CHAPTER 69-03-05

69-03-05-02. Uniform system prescribed. ~~Accounts and statistics shall be kept in accordance with the uniform system of accounts prescribed by the commission.~~ Repealed effective January 1, 1994.

History: ~~Amended effective October 1, 1987.~~
General Authority: ~~NDCC 49-18-08, 49-18-19~~
Law Implemented: ~~NDCC 49-18-08, 49-18-19~~

69-03-05-03. Filing. ~~On or before the fifteenth day of the fourth month following the close of its accounting year (calendar or fiscal) each carrier shall file an annual report with the commission. The report must be in a form required by the commission and must cover the operation of the company during the preceding year. Reports not filed by the due date are delinquent. The carrier may request an extension of time. If no extension is granted, the commission will suspend the certificate or permit of the delinquent carrier. The certificate or permit of a delinquent carrier may be revoked by the commission after five days' notice and opportunity to be heard.~~ Repealed effective January 1, 1994.

History: ~~Amended effective October 1, 1987.~~
General Authority: ~~NDCC 49-18-08, 49-18-19~~
Law Implemented: ~~NDCC 49-18-08, 49-18-19~~

69-03-05-06. Interstate operations. ~~Records of all interstate operations must be so kept that operating income and statistics for North Dakota can be ascertained.~~ Repealed effective January 1, 1994.

General Authority: ~~NDCC 49-18-08, 49-18-19~~
Law Implemented: ~~NDCC 49-18-08, 49-18-19~~

CHAPTER 69-03-06

69-03-06-01.1. General lease requirements. Unless otherwise provided by section 69-03-06-01.3 or 69-03-06-03, an authorized carrier may perform transportation with a vehicle it does not own only under the following conditions:

1. Lease. There is a written lease granting the use of the vehicle and meeting the requirements of section 69-03-06-01.2.

2. Commission approval. Three copies of the lease ~~are~~ must be filed with the commission. No lease will be valid unless approved by the transportation division of the commission.

3. Insurance. Every leased vehicle is covered by insurance in amounts not less than those set in chapter 69-03-02, and evidence of which is filed with the commission.

~~4. Identification. During the period of the lease there is displayed on both sides of each vehicle, identification signs showing the name of the motor carrier under whose authority the vehicle is being operated, and the carrier's address. The identification signs shall be legible, during daylight hours, from a distance of fifty feet [15.24 meters] while the vehicle is not in motion, and maintained as to remain legible.~~

~~5. Operation records. An authorized carrier leasing a vehicle under this chapter shall be prepared at any time it seeks to change its rates and charges, to submit evidence of the cost of operating the vehicle while leased to the carrier over the most recent twelve-month period.~~

History: Effective September 1, 1981; amended effective July 1, 1983; October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-08, 49-18-19, 49-18-39.1

69-03-06-01.2. Written lease requirements. The written lease required under sections 69-03-06-01.1 and 69-03-06-01.3 must provide for the following:

1. Parties. The lease must be made between the authorized carrier and the owner of the vehicle. The lease must be signed by these parties or by their authorized representatives.

2. Duration to be specific. The lease must specify the time and date ~~or the circumstances~~ on which the lease begins and ends.

3. **Exclusive possession and responsibilities.** The lease must provide that the authorized carrier lessee shall have exclusive possession, control, and use of the vehicle for the duration of the lease. The lease must further provide that the authorized carrier lessee shall assume complete responsibility for the operation of the vehicle for the duration of the lease.

4. **Compensation to be specific.** The amount to be paid by the authorized carrier for the vehicle and drivers' services must be stated in the lease or in an addendum which is attached to the lease. The amount to be paid may be expressed by any method of compensation mutually agreed upon by the parties to the lease. The compensation stated on the lease or in the attached addendum may apply to the vehicle and drivers' services either separately or as a combined amount.

5. **Items specific in lease.** The lease must specify the responsibility of each party with respect to the cost of fuel, fuel taxes, empty mileage, permits of all types, detention and accessorial services, base plates and licenses, and any unused portions of such items.

6. **Lessee responsible.** The lessee, under the terms of the lease, must be responsible for all claims for damages arising out of the use of the vehicle and for the lawful operation thereof.

7. **Insurance.** The lease must clearly specify the obligation of the authorized carrier to maintain insurance coverage for the protection of the public and shippers pursuant to chapter 69-03-02. The lease must further specify who is responsible for providing any other insurance coverage for the operation of the lease vehicle.

History: Effective September 1, 1981; amended effective July 1, 1983; October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-08, 49-18-19, 49-18-39.1

69-03-06-01.3. Short-term lease requirements. A carrier need not comply with the requirements of section 69-03-06-01.1 where transportation with a leased vehicle is performed pursuant to a lease of not more than thirty days' duration and where the following conditions are met:

1. **Lease.** There must be a written lease granting the use of the vehicle and meeting the requirements contained in section 69-03-06-01.2.

2. **Insurance.** Every vehicle subject to a lease must be covered by insurance in amounts not less than those prescribed in chapter 69-03-02.

3. ~~Identification. During the period of the lease there must be displayed on both sides of each vehicle, identification signs showing the name of the motor carrier under whose authority the vehicle is being operated, and the carrier's address. The identification signs must be legible, during daylight hours, from a distance of fifty feet [15.24 meters] while the vehicle is not in motion, and such signs maintained as to remain legible.~~

~~4.~~ Identification permit. The carrier shall complete and issue for the leased vehicle a temporary identification certificate secured from the commission which must be carried in the vehicle at all times while it is under lease. A copy of each temporary identification certificate must be returned to the commission within five days after issuance ~~along with a signed copy of the written lease~~.

History: Effective July 1, 1983; amended effective September 1, 1985; October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-08, 49-18-09, 49-18-39.1, 49-18-41

69-03-06-03. Lease requirements - Exemptions. The provisions of this chapter do not apply to:

1. Equipment leased by an authorized carrier from an individual or corporation whose business is the leasing of equipment with or without drivers for compensation.

2. Equipment used in transportation performed within a commercial zone in the state as determined by the commission.

3. Equipment leased for use in an emergency, with or without drivers, but only for the period of the emergency. A ~~full~~ description of the ~~circumstances considered as meeting the definition of an emergency, the reason equipment was leased or rented not in accordance with this chapter, and a complete description of the equipment and name or names of drivers~~ emergency and the equipment must be ~~filed with~~ reported to the commission.

4. Equipment used in transportation performed pursuant to any plan of operation specifically approved by the commission.

History: Amended effective September 1, 1981; October 1, 1987; January 1, 1994.
General Authority: NDCC 49-18-08, 49-18-19
Law Implemented: NDCC 49-18-08, 49-18-19

CHAPTER 69-03-11

REGISTRATION OF INTERSTATE COMMERCE COMMISSION OPERATING AUTHORITY

[Repealed effective January 1, 1994]

CHAPTER 69-04-03

69-04-03-01. Intrastate regulatory standards. Intrastate rail rates will be regulated in accordance with federal standards in effect as of ~~May 22, 1990~~ September 1, 1993, prescribed in the Interstate Commerce Act [Title 49, United States Code], corresponding Interstate Commerce Commission rules [Title 49, Code of Federal Regulations], the interstate commerce commission decision In the Matter of Ex Parte 388 A, State Intrastate Rail Rates Authority, Public Law 96-448, Recertification Process, 5 I.C.C. 2d 680 (1989). Copies of the laws and rules are available in the public service commission or the supreme court law library.

History: Effective September 1, 1982; amended effective February 1, 1991; January 1, 1994.
General Authority: NDCC 49-10.1-03
Law Implemented: NDCC 49-10.1-01

CHAPTER 69-08-01

69-08-01-01. Approved auction schools. ~~The state auctioneers association shall compile and file with the commission the names and addresses of approved auction schools. The association can add to or delete from the list as may be required to conform with this chapter.~~ Auction schools must apply to the commission to have their courses of study approved for use by North Dakota auctioneers. To be approved, a course of study must:

1. Require students to complete at least sixty hours of study in the presence of school instructors, at least forty hours of which is under the supervision of a licensed auctioneer with at least five years of experience.

2. Provide instruction in ethics, bid calling, sales management, advertising, contracts, accounting and bookkeeping, real estate, appraisals, closing statements, license law, uniform commercial codes, tax collection, bulk sales, and firearms.

3. Maintain a grading system that permits the issuance of diplomas or certificates only to students who successfully demonstrate competence in all required areas of study.

To have their course of study approved, an auction school must also provide the commission with a copy of the test instruments and grading standards used to determine student competence.

History: Amended effective January 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 51-05.1-02

FEBRUARY 1994

CHAPTER 69-07-01

69-07-01-04. Storage in other ~~than originating elevators~~ warehouses. ~~Values of grain on hand must equal outstanding storage liabilities at all times; provided, when fifty percent of rated capacity of the warehouse is occupied by grain held subject to warehouse receipts, the remainder may be placed in special binds or in general storage in any licensed and bonded warehouse within or without the state to remain in possession of the issuer of the original warehouse receipt.~~ All grain must be held in licensed and bonded warehouses, either within or outside the state. When grain is held in space that is not licensed by the warehouseman under North Dakota Century Code chapter 60-02, warehouse documents issued for that grain must identify the originating warehouse as the receiptholder. When grain held subject to warehouse receipts is stored in a warehouse that is not licensed under North Dakota Century Code chapter 60-02, the originating warehouse must increase its bond to provide protection for that grain as well as its own licensed warehouse space.

History: Amended effective May 1, 1984; February 1, 1994.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-03

69-07-01-06. Procedure for temporary closing. Whenever a warehouseman desires to temporarily close the warehouse for a period of more than fifteen days, the warehouseman shall first make application to the commission for permission to do so. ~~Blanks will be furnished for this purpose. Notice of the application to close shall be posted in a conspicuous place in the warehouse at the time application is made and given to holders of all outstanding receipts by registered mail at their last known address. Arrangements for redemption of receipts must be~~

~~made at a local point.~~ If closing of a warehouse is permitted, notice shall be posted in the office window and on the front driveway door stating ~~where and by whom receipts may be redeemed. When closing a warehouse for a period of less than fifteen days, the warehouseman must immediately post notices in the office window and on the front driveway door stating~~ the dates the warehouse will be closed, ~~and where and by whom~~ how receipts may be redeemed, and how the management may be contacted. ~~The above information, including the posting of notices, must be immediately mailed to the commission. Approved notices to be posted and approved notice to commission will be furnished by the commission on request.~~

History: Amended effective May 1, 1984; February 1, 1994.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-03, 60-02-39

69-07-03-09. Collateral warehouse receipts. A warehouseman may not issue a warehouse receipt to secure financing or for other security interests unless the grain represented by that receipt is owned by the warehouse.

History: Effective February 1, 1994.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-03

69-07-03-10. Warehouse receipts - Grain on hand. A warehouseman must maintain a grain inventory sufficient to cover outstanding warehouse receipts.

History: Effective February 1, 1994.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-03

CHAPTER 69-07-04

GRAIN ELEVATOR WEIGHMASTERS

[Repealed effective February 1, 1994]

MARCH 1994

STAFF COMMENT: Chapter 69-02-09 contains all new material but is not underscored so as to improve readability.

CHAPTER 69-02-09
TRADE SECRET PROCEDURES

69-02-09-01. Application to protect information. An applicant requesting trade secret protection in an administrative proceeding shall file an application with the commission. The application must include at least the following:

1. A general description of the nature of the information sought to be protected;

2. An explanation of why the information derives independent economic value, actual or potential, from not being generally known to other persons;

3. An explanation of why the information is not readily ascertainable by proper means by other persons;

4. A general description of the persons or entities that would obtain economic value from disclosure or use of the information;

5. A specific description of known competitors and competitors' goods and services that are pertinent to the tariff or rate filing; and

6. A description of the efforts used to maintain the secrecy of the information.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-02. Filing of application. The application must be addressed to and filed with the executive secretary of the commission. The trade secret material must be separately bound and placed in a sealed envelope, or other appropriate, sealed container, which must be labeled: TRADE SECRET - PRIVATE. An original and seven copies of the public portion of the application must be filed. Only one copy of the trade secret material must be filed.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-03. Processing the application. When an application for trade secret protection is filed, the commission staff shall examine the information and application and make a prima facie recommendation of whether the information is relevant and a trade secret under the definition of trade secret in North Dakota Century Code section 47-25.1-01. The commission will make a determination on the application from the application and the recommendation.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-04. Protective order. Upon a determination that information is relevant and trade secret, the commission shall issue a protective order limiting disclosure.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-05. Request for hearing - Who may request - Time - Burden of proof.

1. Upon a determination that the information is relevant but not trade secret, or upon a determination of irrelevance, the applicant will be notified and has seven days to request a hearing before the commission, or obtain appropriate injunctive relief from the courts. If no hearing is requested or the commission is not otherwise restrained, the information will become part of the public record without protection. The burden of proof in such a hearing is on the party seeking to prevent disclosure.

2. If any person disagrees with the designation of information as trade secret or with its nondisclosure, the person shall first attempt to informally dispose of the dispute with the party seeking to prevent disclosure. If the dispute cannot be resolved, any person may request a hearing before the commission to determine the trade secret status.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-06. Request for hearing - Contents. A request for hearing must be in writing. An original and seven copies of the request must be filed with the executive secretary of the commission. The request must identify the reason the information should be disclosed, or not considered trade secret. In any hearing the burden of proof is on the party seeking to prevent disclosure.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-07. Viewing trade secret information.

1. The commission and its staff may view protected information at any time. However, the commission and its staff are bound by the terms of these rules to keep the information confidential. The originator (applicant for trade secret status) may also view the information.

2. Others who wish to view protected information, including experts who are not regular full-time employees of the commission, and opposing counsel and experts, may do so only

after written authorization from the commission. The commission may grant authorization when the person wishing to view the information submits a written request that includes all of the following:

a. The name and address of the person who will view the information;

b. Identification, as specifically as possible, of the information requested;

c. A showing of good cause why the information is needed;

d. Identification of the purpose of the review;

e. Identification of the intended use of the information; and

f. An estimate of the time needed for review.

The requesting person shall file an original and seven copies of the written request with the commission and serve it upon the originator at least ten days prior to the time the person desires to view the information.

3. Any person requesting review of the information shall also execute a protective agreement form provided by the commission.

4. The commission shall disclose the information unless the originator shows good cause why disclosure should not be granted. When disclosed, trade secret information may not be removed from commission offices, and may be used only for purposes of the proceeding.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-08. References to trade secret material at hearings. To the extent that reference is made to any trade secret information by a person afforded access to such information during any aspect of the proceeding, the information should be referenced only by its title or its exhibit identification, or in a manner that does not unnecessarily disclose the confidential information. If specific disclosure of the confidential information is necessary during oral testimony or argument, it must be on such prior notice as is feasible and, in any event, on sufficient notice to clear the hearing room of persons not bound by this chapter.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-09. Protection of trade secret information. Any part of the record of a proceeding containing trade secret information, including exhibits and transcript pages, must be protected unless otherwise ordered by the commission. If a commission order requires a finding based on trade secret information, the order must reference the confidential nature of the finding and a separate, confidential document must be prepared to state fully the finding of fact and the trade secret information relied upon to support the finding.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-10. Copies of information used during hearing. Copies of the trade secret information may be made for use during a hearing for persons bound by these rules. If copies are made for hearing purposes, they must be numbered. Upon the completion of the hearing, all copies of the information must be returned to the disclosing party.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

69-02-09-11. Documents certified on appeal. When an order of the commission is appealed and the documents are certified to court, copies must be made of the trade secret information. The copies of trade secret information must be placed in a sealed envelope, or other appropriate, sealed container, and labeled: "TRADE SECRET - PRIVATE". The originals of the trade secret information must be retained in the commission's trade secret file. When the court issues its decision and returns the case record to the commission, the copies of trade secret information must be filed with the originals in the commission's trade secret file.

History: Effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-06, 47-25.1

TITLE 72

Secretary of State

MARCH 1994

CHAPTER 72-01-02

72-01-02-06. Rejections.

1. Any financing statement submitted for filing with any filing officer must be rejected if it does not have all of the following:

   a. Each debtor's social security number or tax identification number;

   b. Each debtor's signature, unless it meets one of the criteria specified in subsection 2 of North Dakota Century Code section 41-09-41;

   c. The secured party's signature if the filing is being submitted without the debtor's signature pursuant to subsection 2 of North Dakota Century Code section 41-09-41, or if the filing contains a notice of assignment by the secured party;

   d. The original file number of the financing statement which has lapsed if filed pursuant to subdivision c of subsection 2 of North Dakota Century Code section 41-09-41;

   e. An address for the secured party from which further information may be obtained; and

   f. Some collateral listed.

2. For the purposes of subsection 1, any debtor name preceded by d/b/a (doing business as) or a/k/a/ (also known as) or f/k/a (formerly known as) does not require a separate signature. It does, however, require the listing of the individual's social security number or the entity's tax identification number.

3. A request for refiling pursuant to section 72-01-02-02, continuation statement, termination statement, or other associated filing will be rejected if the financing statement or lien to which it relates is not on file as an active filing in that filing office.

4. Any amendment adding or changing collateral will be rejected if it does not contain the signature of each current debtor and the current secured party. Any amendment adding or changing the name of a debtor will be rejected if it does not contain the social security number or tax identification number and the signature of the affected debtor and the signature of the current secured party. Any other associated filing will be rejected if it does not contain the current secured party's signature.

5. A continuation statement submitted for filing with any filing officer must be rejected if it does not contain a social security number or tax identification number for each debtor unless that number was included on the original financing statement, submitted with the refiling, or included on a prior associated filing.

6. Any agricultural statutory lien submitted for filing with any filing officer must be rejected if it is not a verified statement containing all of the following:

   a. Name and address of lienholder;

   b. Debtor's name; and

   c. The debtor's social security number or tax identification number.

~~6.~~ 7. Any document tendered for filing which is rejected by the filing officer will be marked with the time and date it was tendered, whether the correct filing fee was tendered with the document, the reason for the rejection, and will indicate the filing officer. Any fees tendered with the rejected filing will be refunded.

~~7.~~ 8. Request for reinstatement of a filing.

   a. If a filing has been rejected pursuant to subsection 3, the secured party or lienholder may submit a request for reinstatement of filing. The request must be accompanied by two legible copies of the lien or original financing

statement and each associated filing which had been filed showing the file number, and an affidavit by the secured party or lienholder stating the debtor's current address and that the financing statement has not been terminated and has not lapsed or that the lien has not been released. If any debtor listed on the financing statement is currently involved in an insolvency proceeding, notice of that proceeding must be attached.

b. Upon receipt of a proper request for reinstatement, the filing officer shall reinstate the filing and send to each listed debtor a copy of the request for reinstatement, along with attachments, and notice that the financing statement or lien has been reinstated.

c. Any file which has been reinstated must be marked as a reinstated file both on the physical documents and in the index.

History: Effective February 1, 1992; amended effective March 1, 1994.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 41-09-41, 41-09-42, 41-09-44, 41-09-46

TITLE 75

Department of Human Services

MARCH 1994

CHAPTER 75-02-02

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code chapter 75-02-02, Medical Services.

A public hearing was conducted on August 5, 1993, concerning proposed amendments to North Dakota Administrative Code, chapter 75-02-02, Medical Services, specifically section 75-02-02-08, Amount, Duration, and Scope of Medical Assistance, and section 75-02-02-09, Nursing Facility Level of Care.

Funds appropriated for the purpose of providing payment for physician's services would, in the absence of emergency rulemaking, be completely expended before June 30, 1995, for amendments to section 75-02-02-08, concerning two new subdivisions which impose copayments on doctor office visits and which set limits for transportation costs.

The amendments to section 75-02-02-08 were adopted as interim final rules effective July 1, 1993. A failure to provide Medicaid benefits for persons who require services other than physician's services would cause the department to be unable to lawfully claim federal funds otherwise available and would result in a loss of federal revenues appropriated to support the administration of the Medicaid program, a duty imposed upon the Department of Human Services by North Dakota Century Code section 50-06-05.1 and North Dakota Century Code chapter 50-24.1.

The amendments to section 75-02-02-09, concerning the update of provisions which describe persons needing nursing facility services, are intended to conform state rules to the requirements for nursing facilities established by 42 U.S.C. section 1396r, which requirements are imposed with respect to the provision of medical assistance as that

term is defined in 42 U.S.C. section 1396d(a) and established as a condition of approval of the North Dakota State Plan for Medical Assistance pursuant to 42 U.S.C. section 1396a(a).

The amendments to section 75-02-02-09 were adopted as interim final rules effective July 1, 1993. A failure to conform the Medicaid program to federal requirements would cause the department to be unable to lawfully claim federal funds otherwise available to provide Medicaid benefits and would result in a loss of federal funds appropriated to support the administration of the Medicaid program, a duty imposed upon the Department of Human Services by North Dakota Century Code section 50-06-05.1 and North Dakota Century Code chapter 50-24.1.

Section 75-02-02-08(2)(f): Establishes limitations on the amount and circumstances in which the Medicaid program will pay for transportation services provided to a Medicaid recipient.

Section 75-02-02-08(2)(g): Requires a Medicaid recipient to make a two dollar copayment for each physician's office visit, and establishes several exceptions to that requirement.

Section 75-02-02-09: Revises the section which is used to determine whether a person is appropriate for nursing facility care. These amendments conform state rules to the requirements of 42 U.S.C. section 1396r.

Prepared by:
Blaine L. Nordwall
November 26, 1993

75-02-02-08. Amount, duration, and scope of medical assistance.

1. Within any limitations which may be established by rule, regulation, or statute and within the limits of legislative appropriations, eligible recipients may obtain the medical and remedial care and services which are described in the approved state plan for medical assistance in effect at the time the service is rendered and which may include:

   a. Inpatient hospital services (other than services in an institution for mental diseases). "Inpatient hospital services" are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases and which is licensed or formally approved as a hospital by an officially designated state standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation; and which has in effect a hospital utilization review plan applicable to

all patients who receive medical assistance under title XIX of the Act.

b. Outpatient hospital services. "Outpatient hospital services" are those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

c. Other laboratory and x-ray services. "Other laboratory and x-ray services" means professional and technical laboratory and radiological services ordered by a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law, and provided to a patient by, or under the direction of, a physician or licensed practitioner, in an office or similar facility other than a hospital outpatient department or a clinic, and provided to a patient by a laboratory that is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

d. Skilled nursing home services (other than services in an institution for mental diseases) for individuals twenty-one years of age or older. "Skilled nursing home services" means those items and services furnished by a licensed and otherwise eligible skilled nursing home or swing-bed hospital maintained primarily for the care and treatment of inpatients with disorders other than mental diseases which are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law.

e. Intermediate nursing care (other than services in an institution for mental diseases). "Intermediate nursing care" means those items and services furnished by a currently licensed intermediate care facility or swing-bed hospital maintained for the care and treatment of inpatients with disorders other than mental diseases which are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law.

f. Early and periodic screening and diagnosis of individuals under twenty-one years of age, and treatment of conditions

found. Early and periodic screening and diagnosis of individuals under the age of twenty-one who are eligible under the plan to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Federal financial participation is available for any item of medical or remedial care and services included under this subsection for individuals under the age of twenty-one. Such care and services may be provided under the plan to individuals under the age of twenty-one, even if such care and services are not provided, or are provided in lesser amount, duration, or scope to individuals twenty-one years of age or older.

g. Physician's services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere. "Physician's services" are those services provided, within the scope of practice of the physician's profession as defined by state law, by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.

h. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. This term means any medical or remedial care or services other than physicians' services, provided within the scope of practice as defined by state law, by an individual licensed as a practitioner under state law.

i. Home health care services. "Home health care services" in addition to the services of physicians, dentists, physical therapists, and other services and items available to patients in their homes and described elsewhere in these definitions, are any of the following items and services when they are provided on recommendation of a licensed physician to a patient in the patient's place of residence, but not including as a residence a hospital or a skilled nursing home:

   (1) Intermittent or part-time nursing services furnished by a home health agency.

   (2) Intermittent or part-time nursing services of a professional registered nurse or a licensed practical nurse when under the direction of the patient's physician, when no home health agency is available to provide nursing services.

   (3) Medical supplies, equipment, and appliances recommended by the physician as required in the care of the patient and suitable for use in the home.

(4) Services of a home health aide who is an individual assigned to give personal care services to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and the home health agency which assigns a professional registered nurse to provide continuing supervision of the aide on the aide's assignment. "Home health agency" means a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

j. Private duty nursing services. "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse, under the general direction of the patient's physician, to a patient in the patient's own home or extended care facility when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital, nursing home, or extended care facility.

k. Dental services. "Dental services" are any diagnostic, preventive, or corrective procedures administered by or under the supervision of a dentist in the practice of the dentist's profession and not excluded from coverage. Such services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual. "Dentist" means a person licensed to practice dentistry or dental surgery. Any procedure related to the preparation of "fixed bridgework" which involves the use of crowns and bridgework materials in concert with one another, but not including single crowns, is excluded from coverage unless a prior treatment authorization request, submitted by the attending dentist and approved by the department's dental consultant, describes a condition or combination of conditions which render the use of dentures impracticable or which may be more economically ameliorated by fixed bridgework than by dentures.

l. Physical therapy and related services. "Physical therapy and related services" means physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, and the use of such supplies and equipment as are necessary.

(1) "Physical therapy" means those services prescribed by a physician and provided to a patient by or under the supervision of a qualified physical therapist. A

qualified physical therapist is a graduate of a program of physical therapy approved by the council on medical education of the American medical association in collaboration with the American physical therapy association, or its equivalent, and where applicable, is licensed by the state.

(2) "Occupational therapy" means those services prescribed by a physician and provided to a patient and given by or under the supervision of a qualified occupational therapist. A qualified occupational therapist is registered by the American occupational therapy association or is a graduate of a program in occupational therapy approved by the council on medical education of the American medical association and is engaged in the required supplemental clinical experience prerequisite to registration by the American occupational therapy association.

(3) "Services for individuals with speech, hearing, and language disorders" are those diagnostic, screening, preventive, or corrective services provided by or under the supervision of a speech pathologist or audiologist in the practice of the pathologist's or audiologist's profession for which a patient is referred by a physician. A speech pathologist or audiologist is one who has been granted the certificate of clinical competence in the American speech and hearing association, or who has completed the equivalent educational requirements and work experience necessary for such a certificate, or who has completed the academic program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

m. Prescribed drugs, prosthetic devices, and dentures where a request is submitted by the attending dentist and granted prior approval by the department's dental consultant; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.

(1) "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed as such or in other acceptable dosage forms for the cure, mitigation, or prevention of disease, or for health maintenance, by a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's professional practice as defined and limited by federal and state law. With respect to "prescribed drugs" federal financial participation is available in expenditures

for drugs dispensed by licensed pharmacists and licensed authorized practitioners in accordance with North Dakota Century Code chapter 43-17. When dispensing, the practitioner must do so on the practitioner's written prescription and maintain records thereof.

(2) "Dentures" means artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by, or according to the directions of, a dentist. The term does not mean those artificial structures, commonly referred to as "fixed bridgework", which involve the use of crowns and bridgework materials in concert with one another.

(3) "Prosthetic devices" means replacement, corrective, or supportive devices prescribed for a patient by a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law for the purpose of artificially replacing a missing portion of the body, or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.

(4) "Eyeglasses" are lenses, including frames when necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the patient may select, to aid or improve vision.

n. Other diagnostic, screening, preventive, and rehabilitative services.

(1) "Diagnostic services" other than those for which provision is made elsewhere in these definitions, include any medical procedures or supplies recommended for a patient by the patient's physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law, as necessary to enable the physician or practitioner to identify the existence, nature, or extent of illness, injury, or other health deviation in the patient.

(2) "Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify suspects for more definitive studies.

(3) "Preventive services" are those provided by a physician or other licensed practitioner of the healing arts, within the scope of the physician's or practitioner's practice as defined by state law, to prevent illness, disease, disability, and other health deviations or their progression, prolong life, and promote physical and mental health and efficiency.

(4) "Rehabilitative services" in addition to those for which provision is made elsewhere in these definitions, include any medical remedial items or services prescribed for a patient by the patient's physician or other licensed practitioner of the healing arts, within the scope of the physician's or practitioner's practice as defined by state law, for the purpose of maximum reduction of physical or mental disability and restoration of the patient to the patient's best possible functional level.

o. Care and services in a certified mental institution for individuals under twenty-one years of age or sixty-five years of age or over.

p. Any other medical care and any other type of remedial care recognized under state law, specified by the secretary. This term includes, but is not limited to, the following items:

(1) Transportation, including expenses for transportation and other related travel expenses, necessary to securing medical examinations or treatment when determined by the agency to be necessary in the individual case. "Travel expenses" are defined to include the cost of transportation for the individual by ambulance, taxicab, common carrier, or other appropriate means; the cost of outside meals and lodging en route to, while receiving medical care, and returning from a medical resource; and the cost of an attendant may include transportation, meals, lodging, and salary of the attendant, except that no salary may be paid a member of the patient's family.

(2) Family planning services, including drugs, supplies, and devices, when such services are under the supervision of a physician. There will be freedom from coercion or pressure of mind and conscience and freedom of choice of method, so that individuals can choose in accordance with the dictates of their consciences.

(3) Whole blood, including items and services required in collection, storage, and administration, when it has

been recommended by a physician and when it is not available to the patient from other sources.

(4) Skilled nursing home services, as defined in subdivision d, provided to patients under twenty-one years of age.

(5) Emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services, even though the hospital does not currently meet the conditions for participation under title XVIII of the Social Security Act, or definitions of inpatient or outpatient hospital services set forth in subdivisions a and b.

2. The following limitations exist with respect to medical and remedial care and services covered or provided under the medical assistance program.

a. Coverage will not be extended and payment will not be made for diet remedies prescribed for eligible recipients.

b. Coverage will not be extended and payment will not be made for alcoholic beverages prescribed for eligible recipients.

c. Coverage will not be extended and payment will not be made for orthodontia prescribed for eligible recipients, except for orthodontia necessary to correct serious functional problems.

d. Coverage and payment for eye examinations and eyeglasses for eligible recipients shall be limited to examinations and eyeglass replacements necessitated because of visual impairment. Coverage and payment for eyeglass frames is available for a reasonable number of frames, and in a reasonable amount, not to exceed limits set by the department. The department shall make available to all practitioners dispensing eyeglass frames, and to anyone else who may make inquiry, information concerning established limits. No coverage exists, and no payment will be made, for eyeglass frames which exceed the limits.

e. Coverage and payment for home health care services and private duty nursing services must be limited to a monthly amount determined by taking the monthly charge, to the medical assistance program, for the most intensive level of nursing care in the most expensive nursing home in the state and subtracting therefrom the cost, in that month,

of all medical and remedial services furnished to the recipient (except physician services and prescribed drugs). For the purposes of determining this limit, remedial services include, but are not limited to, home and community-based services, service payments to the elderly and disabled, homemaker and home health aide services, and rehabilitative services, regardless of the source of payment for such services. This limit may be exceeded, in unusual and complex cases, if the provider has submitted a prior treatment authorization request describing each medical and remedial service to be received by the recipient, stating the cost of that service, describing the medical necessity for the provision of the home health care services or private duty nursing services, and explaining why less costly alternative treatment will not afford necessary medical care; and has had the request approved.

f. Coverage and payment for the following transportation services is limited to:

(1) Twenty cents per mile for travel in a private motor vehicle;

(2) Seventeen dollars per day for meals en route to, while receiving medical care, and while returning from a medical resource, for the person receiving medical care, and where medically necessary, an attendant; provided that days during which meals are provided by the medical resource are not counted; and

(3) Thirty-five dollars per night, in state, and fifty dollars per night, out of state, for lodging en route to, while receiving medical care, and while returning from a medical resource, for the person receiving medical care, and where medically necessary, an attendant; provided that nights during which lodging is provided by the medical resource are not counted.

g. Coverage and payment for physician's services furnished in the physician's office are subject to a copayment of two dollars for each office visit unless the medicaid recipient receiving the service:

(1) Lives in a nursing facility, intermediate care facility for the mentally retarded, the state hospital, or the Anne Carlsen school-hospital;

(2) Receives swing bed services in a hospital;

(3) Has not reached the age of twenty-one years;

(4) Is pregnant;

(5) Is entitled to have a portion of the cost of the visit paid for by medicare;

(6) Requires emergency services; or

(7) Receives family planning services during the visit.

3. Remedial services provided by residential facilities such as licensed homes for the aged and infirm, licensed foster care homes or facilities, and specialized facilities are not covered services but expenses incurred in securing such services must be deducted from countable income in determining financial eligibility. For the purposes of this chapter, "remedial services" means those services, provided in the above-identified facilities, which produce the maximum reduction of physical or mental disability and restoration of a recipient to the recipient's best possible functional level.

4. The department may refuse payment for any covered service or procedure for which a prior treatment authorization request is required but not secured, but shall consider making payment if the vendor demonstrates that the failure to secure the required prior treatment authorization request was the result of oversight and the vendor has not failed to secure a required prior treatment authorization request within the twelve months prior to the month in which the services or procedures were furnished.

5. A vendor of medical services which provides a covered service but fails to receive payment due to the operation of subsection 4, and which attempts to collect from the eligible recipient or the eligible recipient's responsible relatives any amounts which would have been paid by the department but for the operation of subsection 4, has by so doing breached the agreement referred to in subsection 4 of section 75-02-02-10.

History: Amended effective September 1, 1978; September 2, 1980; February 1, 1981; November 1, 1983; May 1, 1986; November 1, 1986; November 1, 1987; January 1, 1991; July 1, 1993.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR 431.53, 42 CFR 431.110, 42 CFR 435.1009, 42 CFR Part 440, 42 CFR Part 441, subparts A, B, & D, 45 CFR 435.732

75-02-02-09. Nursing ~~home~~ facility level of care.

1. ~~**Definition of a skilled nursing facility.** For~~ "Nursing facility level of care" means, for purposes of medical assistance, ~~a skilled nursing facility is one~~ services provided by a facility that meets the standards for nursing facility licensing established by the state department of

health and consolidated laboratories, and in addition, meets all requirements for ~~skilled~~ nursing facilities ~~as prescribed in~~ imposed under federal law and regulations governing the medical assistance ~~under title XIX of the Social Security Act~~ program.

2. ~~Definition of an intermediate care facility. An intermediate care facility is one that meets standards for licensing as established by the state department of health and consolidated laboratories and, in addition, meets all requirements for intermediate care facilities as prescribed in federal law and regulations governing medical assistance under title XIX of the Social Security Act.~~

~~3. Screening and utilization review. All recipients receiving skilled and intermediate care shall be subject to review by the medical assistance program to determine the appropriate level of care required. The medical assistance program shall take such steps as are necessary to assure that levels of care and quality of care as defined by federal law and regulation and the medical assistance state plan are followed.~~

~~4. Skilled nursing care. Skilled nursing care is care provided in a skilled nursing home that provides inpatient nursing care and related services for persons who require medically supervised nursing care on a continuous basis, but do not require the level of intensive care furnished in a general hospital. A skilled nursing home provides for:~~

~~a. Physician's services that include:~~

~~(1) Complete medical examination giving diagnosis and mental and physical functional capacity upon admission for each patient. This information is recorded on a physical examination form or transfer from a hospital or other medical institution and must be fully completed and signed.~~

~~(2) Recommendations for treatment.~~

~~(3) Periodic visits and progress reports including current medical findings at least as frequently as required by applicable federal regulation.~~

~~(4) Medication review every thirty days.~~

~~(5) Emergency care as needed. The phone number for the physician on call should be posted.~~

~~b. Ancillary services that include:~~

~~(1) Laboratory, x-ray, electrocardiogram, etc., are to be arranged for as recommended by the physician.~~

(2) Copies of all ancillary reports should be placed in the patient's medical file.

c. Social services that include:

(1) Social factors. Prior to admission or at the time of application, the medically related social needs of the patient are identified and become a part of the medical record in the facility.

(2) Supplemental notes to the social factors. Periodically, the social worker will complete a brief summary report describing the change in a patient's condition and the patient's need for a different level of care. This will become a part of the medical record in the facility.

(3) Refer to the explanation of social services at the end of the guidelines.

d. Dietary services that include:

(1) Dietary consultation by a dietitian who meets the American dietetic association standards for qualification as a dietitian, or a graduate holding a bachelor's degree with a major in food and nutrition.

(2) Supervised menus and meals planned to meet the dietary needs of all the patients.

e. Pharmaceutical services that include:

(1) Pharmacy consultant responsible for maintaining policies and procedures related to dispensing and administering drugs and biologicals.

(2) An approved emergency medication kit.

f. Restorative or maintenance services that include:

(1) Exercise therapy to meet the daily physical needs of the patient.

(2) Arrangement for physical therapy as recommended by the physician for rehabilitation to enable the patient to return home or to an alternate care facility.

g. Activity therapy that includes:

(1) Activity program under the supervision of an activity director.

(2) Program consistent with the needs and disability of the patients.

(3) Activities to be patient centered and meaningful.

h. Nursing services that include:

(1) Nursing supervision under the direction of a registered nurse who devotes full time to supervisory duties.

(2) In addition to the nursing supervisor, a licensed registered nurse or licensed practical nurse is on duty during each tour of duty, who is responsible for performing duties directly related to providing nursing services to patients.

(3) Auxiliary personnel, which includes nurse aides, orderlies, attendants, or ward clerks, who perform duties not constituting the practice of nursing, but provide personal care and delegated duties under the supervision of licensed nursing personnel.

(4) Written patient care policies and procedures governing nursing care that are available for all nursing staff members.

(5) Patient care plans that identify the total needs of each patient to assure that the patient's medical, emotional, and social needs are met.

(6) Maintain a clinical record for each patient in accordance with accepted professional principles. Each record should contain an identification sheet, medical history and diagnosis, social factors and supplemental reports, physician's orders and progress notes, nurse's observations, medication and treatment records, ancillary reports, transfer sheets, and special service reports.

(7) Inservice educational program for the training of auxiliary personnel, and continuing inservice programs for all levels of help.

5. Identification of those needing skilled nursing home care. The medical assistance program shall determine eligibility for skilled nursing care based upon the following criteria for skilled nursing functions that identify skilled nursing care:

a. Orally administered medications requiring changes of dosage.

b. Intravenous or intramuscular medications.

c. Narcotics for pain.

d. Uncontrolled diabetics.

e. Administration of medical gases.

f. Restoration measures directed by a physician to enable patient to return to the patient's own home.

g. Postoperative colostomy care for regulation.

h. Postoperative catheterizations following bladder surgery.

i. Dressings or treatment requiring aseptic technique.

j. Nasopharyngeal aspiration.

k. Levine tube and gastrostomy feedings.

l. Patients requiring extensive personal care due to permanent handicap, e.g., quadriplegia.

m. Agitated patient who may be dangerous to the patient or others.

n. Withdrawn patient whose needs must be anticipated.

6. Identification of those needing intermediate nursing care. The medical assistance program shall determine eligibility for intermediate nursing care based upon the following criteria for intermediate nursing functions that identify intermediate nursing care:

a. Oral medications after routine dosage has been established.

b. Routine intramuscular injections that are given during the hours a licensed nurse is on duty.

c. Change of routine dressings or aseptic dressing during the day tour of duty.

d. Routine catheter care and routine indwelling catheter irrigation.

e. Inhalation therapy that is given during the hours a licensed nurse is on duty and the therapy regimen is established.

f. Maintenance care of colostomy or ileostomy that has been regulated.

g. Care of the incontinent patient.

~~h. Supervision of personal care with bathing, dressing, and personal hygiene, including bed baths.~~

~~i. Observation of vital signs on an established routine.~~

~~j. Supervision of the senile and confused patient who may need restraints, needs constant watching for safety, and at times is uncooperative.~~

~~k. Assistance in training and feeding, ambulation, and toiletry.~~

~~l. Prevention and treatment of skin irritations and uncomplicated decubitus ulcers.~~

~~m. Supervision of therapeutic diets.~~

~~n. Maintenance nursing care.~~

~~o. Motivation or reality orientation, or both, therapy with a specific program outline, and documentation of participation and progress.~~

~~p. Supervision and protection of the mentally retarded and socially maladjusted.~~

~~q. Care of the chronically handicapped whose condition is stable, e.g., cerebral palsy, blind, deaf.~~

Except as provided in subsection 3 or 4, an individual who applies for care in a nursing facility, or who resides in a nursing facility, may demonstrate that a nursing facility level of care is medically necessary only if any one of the criteria in this subsection is met.

a. The individual's nursing facility stay is, or is anticipated to be, temporary for receipt of medicare part A benefits. A nursing facility stay may be based on this criterion for no more than fourteen days after termination of medicare part A benefits.

b. The individual is in a comatose state.

c. The individual requires the use of a ventilator at least six hours per day.

d. The individual has respiratory problems that require regular treatment, observation, or monitoring that may only be provided by or under the direction of a registered nurse (or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse), and is incapable of self-care.

e. The individual requires constant help sixty percent or more of the time with at least two of the activities of daily living of toileting, eating, transferring, and locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

f. The individual requires aspiration for maintenance of a clear airway.

g. The individual has dementia, physician diagnosed or supported with corroborative evidence, for at least six months, and as a direct result of that dementia, the individual's condition has deteriorated to the point where a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.

3. If no criteria of subsection 2 is met, an individual who applies for care in a nursing facility or who resides in a nursing facility may demonstrate that a nursing facility level of care is medically necessary if any two of the criteria in this subsection are met.

a. The individual requires administration of prescribed:

(1) Injectable medication;

(2) Intravenous medication or solutions (on a daily basis); or

(3) Routine oral medications, eye drops, or ointments (on a daily basis).

b. The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse).

c. The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments, such as gait training or bowel and bladder training, which are provided at least five days per week.

d. The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.

e. The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.

f. The individual requires constant help sixty percent or more of the time with any one of the activities of daily living of toileting, eating, transferring, or locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

g. The individual has resided in the nursing facility, from and after January 1, 1993, and is not transferring to another facility.

4. If no criteria of subsection 2 or 3 is met, an individual who applies for care in a nursing facility or who resides in a nursing facility may demonstrate that a nursing facility level of care is medically necessary if:

a. The individual is determined to have restorative potential; and

b. The nursing facility, to which the individual is applying or in which the individual is residing, exclusively provides residential services for nongeriatric, physically handicapped individuals.

5. a. Payment, by the department of human services, for care furnished in a nursing facility to individuals who were applicants for or recipients of medical assistance benefits prior to admission to the nursing facility may be made only for periods after a nursing facility level of care determination is made. If a nursing facility admits an individual who has applied for or is receiving medical assistance benefits before a nursing facility level of care determination is made, the nursing facility may not solicit or receive payment, from any source, for services furnished before the level of care determination is made.

b. Payment, by the department of human services, for care furnished in a nursing facility to individuals who become applicants for or recipients of medical assistance benefits after admission to the nursing facility may be made only after a nursing facility level of care determination is made.

c. Payment, by the department of human services, for care furnished in a nursing facility to individuals who are eligible for medicare benefits related to that care, and who are also eligible for medical assistance, may be made only after a nursing facility level of care determination is made.

~~7.~~ 6. ~~**Appropriateness of services. Skilled nursing facilities and intermediate care facilities**~~ A nursing facility shall ensure

that appropriate medical, social, and psychological services are provided to ~~all residents~~ each resident of the facility who ~~are~~ is dependent in whole or in part on the medical assistance program under title XIX of the Social Security Act~~, the~~. The appropriateness of such services ~~to~~ must be based on the ~~needs~~ need of each resident~~, such needs to include, but not be limited to,~~ to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and must consider, among other factors, age.

History: Amended effective September 1, 1979; July 1, 1993.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 442

CHAPTER 75-02-02.1

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code chapter 75-02-02.1, Eligibility for Medicaid.

A public hearing was conducted on August 5, 1993, concerning proposed amendments to North Dakota Administrative Code chapter 75-02-02.1, Eligibility for Medicaid.

Emergency rulemaking was necessary for sections 75-02-02.1-05, 75-02-02.1-06, 75-02-02.1-22, 75-02-02.1-26, 75-02-02.1-33, 75-02-02.1-39, and 75-02-02.1-40 because a delay in rulemaking was likely to cause a loss of federal revenues appropriated to support the administration of the Medicaid program, a duty imposed upon the Department of Human Services by North Dakota Century Code section 50-06-05.1 and North Dakota Century Code chapter 50-24.1, if the effective date of the amendments was February 1, 1994. During the period before the effective date, the unamended rules would not conform to 42 U.S.C. section 1396(a)(10)(E)(iii), which requires states administering Medicaid programs to provide, as a condition of receipt of federal funds, benefits to "special low-income Medicare beneficiaries." If the department did not conform the Medicaid program to the federal requirement, it may not lawfully claim federal funds otherwise available to provide Medicaid benefits.

Emergency rulemaking was necessary to amend section 75-02-02.1-40 because a delay in rulemaking was likely to cause a loss of federal revenues appropriated to support the administration of the Medicaid program, a duty imposed by North Dakota Century Code section 50-06-05.1 and North Dakota Century Code chapter 50-24.1, if the effective date of the amendments was February 1, 1994. Under current projections, the funds appropriated for the purpose of providing medical care to the "medically needy" would, in the absence of emergency rulemaking, be completely expended before June 30, 1995. The department would thereafter be unable to lawfully claim federal funds otherwise available to provide Medicaid benefits to persons eligible for Medicaid benefits where not in the category of "medically needy."

Emergency rulemaking was necessary to adopt section 75-02-02.1-12.1 because a delay was likely to cause a loss of federal revenues appropriated to support the administration of the Medicaid program, a duty imposed upon the Department of Human Services by North Dakota Century Code section 50-06-05.1 and North Dakota Century Code chapter 50-24.1, if the effective date of the amendments was February 1, 1994. During the period before the effective date, the unamended rule would not conform to 42 U.S.C. section 1396e, which requires states administering Medicaid programs to provide, as a condition of receipt of federal funds, for payment of certain costs associated with the enrollment of eligible individuals in certain group health plans. If the department does not conform the Medicaid program to federal

requirements, it is unable to lawfully claim federal funds otherwise available to provide Medicaid benefits.

The amendments were adopted as interim final rules effective July 1, 1993.

75-02-02.1-01, Definitions: Amends definition of "good faith effort to sell" and adds definitions of "contiguous" and "residing in the home."

75-02-02.1-05, Covered Groups: Adds coverage for special low-income Medicare beneficiaries.

75-02-02.1-06, Applicant's Choice of Aid Category: Adds coverage for special low-income Medicare beneficiaries.

75-02-02.1-12.1, Payment of Health Insurance Premiums, Coinsurance, and Deductibles: Adds new section to clarify coverage of insurance costs.

75-02-02.1-18, Coverage for Aliens: Limits coverage for certain aliens.

75-02-02.1-20, Extended Medicaid Benefits to Certain Families Who Cease Receipt of Aid to Families with Dependent Children Benefits: Provides for continuation of benefits for certain dependent children.

75-02-02.1-22, Eligibility of Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries: Adds coverage for special low-income Medicare beneficiaries, and clarifies exemption for burial funds and property which is essential to earning a livelihood.

75-02-02.1-23, Eligibility of Qualified Disabled and Working Individuals: Clarifies exemptions for burial funds and property which is essential to earning a livelihood.

75-02-02.1-24, Spousal Impoverishment Prevention: Removes obsolete language concerning calculation of spousal share of countable assets, and clarifies exemption for burial funds and property which is essential to earning a livelihood.

75-02-02.1-26, Asset Limits: Adds coverage for special low-income Medicare beneficiaries.

75-02-02.1-28, Excluded Assets: Excludes assets set aside for self-support in limited cases.

75-02-02.1-32, Valuation of Assets: Clarifies valuation of real property.

75-02-02.1-33, Disqualifying Transfers: Adds coverage for special low-income Medicare beneficiaries, and defines "person."

75-02-02.1-36, Disregarded Income: Adds coverage for special low-income Medicare beneficiaries, and increases the disregard of certain veterans' benefits.

75-02-02.1-38, Earned Income: Clarifies the calculation of earned income for self-employed persons.

75-02-02.1-39, Income Deductions: Adds coverage for special low-income Medicare beneficiaries, and clarifies coverage of insurance costs.

75-02-02.1-40, Income Levels: Adds coverage for special low-income Medicare beneficiaries, and reduces income levels.

75-02-02.1-41, Deeming of Income: Removes definition of "residing in the home."

Prepared by:
Blaine L. Nordwall
November 26, 1993

75-02-02.1-01. Definitions. For the purposes of this chapter:

1. "Agency" means the North Dakota department of human services.

2. "Aid to families with dependent children" means a program administered under North Dakota Century Code chapter 50-09 and title IV-A of the Social Security Act [42 U.S.C. 601 et seq.].

3. "Asset" means any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights.

4. "Blind" has the same meaning as the term has when used by the social security administration in the supplemental security income program.

5. "Child" means a person, under twenty-one, or, if blind or disabled, under age eighteen, who is not living independently.

6. "Contiguous" means real property which is not separated by other real property owned by others. Roads and other public rights of way which run through the property, even if owned by others, do not affect the property's contiguity.

7. "County agency" means the county social service board.

~~7.~~ 8. "Department" means the North Dakota department of human services.

~~8.~~ 9. "Disabled" has the same meaning as the term has when used by the social security administration in the supplemental security income program.

~~9.~~ 10. "Disabled adult child" means a disabled or blind person over the age of twenty-one who became blind or disabled before age twenty-two.

~~10.~~ 11. "Earned income" means income which is currently received as wages, salaries, commissions, or profits from activities in which an individual or family is engaged through either employment or self-employment. There must be an appreciable amount of personal involvement and effort, on the part of the individual or family, for income to be considered "earned".

~~11.~~ 12. "Full calendar month" means the period which begins at midnight on the last day of the previous month and ends at midnight on the last day of the month under consideration.

~~12.~~ 13. "Good faith effort to sell" means an honest effort to sell in a manner which is reasonably calculated to induce a willing buyer to believe that the property offered for sale is actually for sale at a fair price. A good faith effort to sell includes, at a minimum, making the offer at a stated minimum price equal to seventy-five percent of fair market value (sixty-six and two-thirds percent of fair market value with respect to determination of qualified disabled and working individual benefits under section 75-02-02.1-23), in the following manner:

a. To any coowner, joint owner, possessor, or occupier of the property, and, if no buyer is thereby secured;

b. To the regular market for such property, if any regular market exists, ~~and~~ or, if no ~~buyer is thereby secured~~ regular market exists;

c. By public advertisement for sale in a newspaper of general circulation, the circulation area of which includes the location of any property resource offered for sale, which advertisement was published successively for two weeks if the newspaper is a weekly publication and for one week if the newspaper is a daily publication, and which includes a plain and accurate description of the property and the name, address, and telephone number of a person who will answer inquiries and receive offers.

~~13.~~ 14. "Home" includes, when used in the phrase "the home occupied by the medicaid unit", the land on which the home is located, provided that the acreage [hectarage] does not exceed one hundred sixty contiguous acres [64.75 hectares] if rural or two acres [.81 hectares] if located within the established boundaries of a city.

~~14.~~ 15. "Institutionalized person" means a person who is an inpatient in a nursing facility, the state hospital, an accredited

residential treatment center for children, or the Anne Carlsen school-hospital, or who receives swing bed care in a hospital.

~~15.~~ 16. "Living independently" means, in reference to a child under the age of twenty-one or, if blind or disabled, under the age of eighteen, a status which arises in any of the following circumstances:

a. The applicant or recipient has served a tour of active duty with the armed services of the United States and lives separately and apart from the parent.

b. The applicant or recipient has married, even though that marriage may have been dissolved or annulled in a court of law.

c. The applicant or recipient has lived separately and apart from both parents for at least six consecutive months after the date the applicant or recipient left a parental home, continues to live separately and apart from both parents, and has received no support or assistance from either parent while living separately and apart. For purposes of this subdivision, periods when the applicant or recipient is attending an educational or training facility, receiving care in a specialized facility, or is an institutionalized person are deemed to be periods when the applicant or recipient was living with a parent.

d. Both parents from whom support could ordinarily be sought, and the property of such parents, is outside the jurisdiction of the courts of the United States or any of the United States.

~~16.~~ 17. "Medicaid" means a program implemented pursuant to North Dakota Century Code chapter 50-24.1 and 42 U.S.C. 1396 et seq. to furnish medical assistance, as defined in 42 U.S.C. 1396d(a), to persons determined eligible for medically necessary, covered medical, and remedial services.

~~17.~~ 18. "Medicaid unit" means an individual, a married couple, or a family with children under twenty-one years of age (or, with respect to a blind or disabled child, under eighteen years of age), whose income and assets are considered in determining eligibility for any member of that unit, without regard to whether the members of the unit all physically reside in the same location.

~~18.~~ 19. "Medicare cost sharing" means the following costs:

a. (1) Medicare part A premiums; and

(2) Medicare part B premiums;

b. Medicare coinsurance;

c. Medicare deductibles; and

d. Twenty percent of the allowed cost for medicare covered services where medicare covers only eighty percent of the allowed costs.

~~19.~~ 20. "Occupied" means, when used in the phrase "the home occupied by the medicaid unit", the home the medicaid unit is living in or, if temporarily absent from, possessed with an intention to return and the capability of returning within a reasonable length of time. Property is not occupied if the right to occupy has been given up through a rental or lease agreement, whether or not that rental or lease agreement is written. Property is not occupied by an individual in long-term care or the state hospital, with no spouse, disabled adult child, or child under age twenty-one at home, unless a physician has certified that the individual is likely to return home within six months.

~~20.~~ 21. "Persons deemed to be receiving aid to families with dependent children" means those persons who are not receiving an aid to families with dependent children money payment, but who must be treated as recipients of such benefits because federal law or regulations so provides.

~~21.~~ 22. "Pre-need funeral service contract" has the same meaning provided for in subsection 2 of North Dakota Century Code section 43-10.1-01.

~~22.~~ 23. "Property which is essential to earning a livelihood" means property which the applicant or recipient owns, and which the applicant or recipient is actively engaged in using to earn income, and where the total benefit of such income is derived for the applicant or recipient's needs. An applicant or recipient is actively engaged in using the property of that individual contributes significant current personal labor in using the property for income-producing purposes. The payment of social security taxes on the income from such current personal labor is an indicator of the active use of the property. Property from which an applicant or recipient is merely receiving rental or lease income is not essential to earning a livelihood. With respect to determination of qualified medicare beneficiary benefits under section 75-02-02.1-22, qualified disabled and working individual benefits under section 75-02-02.1-23, and benefits determined by applying section 75-02-02.1-24, concerning spousal impoverishment prevention, liquid assets may be included as property essential to earning a livelihood. The amount of a liquid asset used exclusively in a trade or business, which is essential to earning a livelihood, is limited to an amount reasonably necessary for the continuation of the business.

Liquid assets may not otherwise be treated as property essential to earning a livelihood.

~~23.~~ 24. "Property which is not saleable without working an undue hardship" means property which the owner has made a good faith effort to sell which has produced no buyer willing to pay an amount equaling or exceeding seventy-five percent of the property's fair market value (sixty-six and two-thirds percent of the property's fair market value with respect to determination of qualified disabled and working individual benefits under section 75-02-02.1-23), and which is continuously for sale. Property may not be included within this definition at any time earlier than the first day of the first month in which a good faith effort to sell is begun.

~~24.~~ 25. "Regulation", as used in 42 CFR 431.210, 431.244, and 435.912, includes any written statement of federal or state law or policy, including, but not limited to, federal and state constitutions, statutes, regulations, rules, policy manuals or directives, policy letters or instructions, and relevant controlling decisions of federal or state courts.

~~25.~~ 26. "Remedial services" means those services, provided in specialized facilities, which produce the maximum reduction of physical or mental disability and restoration of the facilities' residents to the residents' best possible level of functioning.

27. "Residing in the home" refers to individuals who are physically present, individuals who are temporarily absent, individuals attending educational facilities, individuals receiving acute medical care, and individuals receiving services in a specialized facility.

~~26.~~ 28. "Specialized facility" means a residential facility, including a basic care facility, a licensed family foster care home for children or adults, a licensed group foster care home for children or adults, a transitional living facility, a facility established to provide quarters to clients of a sheltered workshop, and any other facility determined by the department to be a provider of remedial services, but does not mean an acute care facility or a nursing facility.

~~27.~~ 29. "State agency" means the North Dakota department of human services.

~~28.~~ 30. "Supplemental security income" means a program administered under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

~~29.~~ 31. "The act" means the Social Security Act [42 U.S.C. 301 et seq.].

~~30.~~ 32. "Title II" means title II of the Social Security Act [42 U.S.C. 401 et seq.].

~~31.~~ 33. "Title IV-A" means title IV-A of the Social Security Act [42 U.S.C. 601 et seq.].

~~32.~~ 34. "Title IV-D" means title IV-D of the Social Security Act [42 U.S.C. 651 et seq.].

~~33.~~ 35. "Title IV-E" means title IV-E of the Social Security Act [42 U.S.C. 670 et seq.].

~~34.~~ 36. Title XVI" means title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

~~35.~~ 37. "Unearned income" means income which is not earned income.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-05. Covered groups. Within the limits of legislative appropriation, four broad coverage groups are included under the medicaid program. Within each coverage group, one or more aid categories is established. These coverage groups do not define eligibility for medicaid benefits. Any person who is within a coverage group must also demonstrate that all other eligibility criteria are met.

1. Categorically needy groups include:

   a. Persons who are receiving cash assistance payments through aid to families with dependent children.

   b. Persons who are deemed to be recipients of aid to families with dependent children including:

      (1) Individuals denied an aid to families with dependent children payment solely because the amount would be less than ten dollars;

      (2) Individuals whose aid to families with dependent children payments are reduced to zero by reason of recovery of overpayment of aid to families with dependent children funds;

      (3) Families who were receiving aid to families with dependent children cash assistance payments in at least three of the six months immediately preceding the month in which they became ineligible as a result (wholly or partly) of the collection or increased collection of child or spousal support and are deemed

to be recipients of aid to families with dependent children, and continue eligible for medicaid for four calendar months following the month for which the final cash payment was made;

(4) Children for whom adoption assistance maintenance payments are made under title IV-E;

(5) Children for whom foster care maintenance payments are made under title IV-E;

(6) Children who are living in North Dakota and are receiving title IV-E adoption assistance payments from another state; and

(7) Children in a foster care placement in North Dakota and receiving a title IV-E foster care payment from another state.

c. Families which received aid to families with dependent children payments in at least three of the six months immediately preceding the month in which the family became ineligible for aid to families with dependent children solely because of increased hours of, or income from, employment of the caretaker relative; or which became ineligible for aid to families with dependent children solely because a member of the family lost one of the time-limited aid to families with dependent children earned income disregards (the thirty dollar earned income disregard and the disregard of one-third of earned income).

d. Pregnant women whose pregnancy has been medically verified and who would be eligible for an aid to families with dependent children cash payment on the basis of the income and asset requirements of the state-approved aid to families with dependent children plan.

e. Eligible pregnant women who applied for medicaid during pregnancy continue to be eligible, as though they were pregnant, for sixty days after the day each pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.

f. Children born to eligible pregnant women who have applied for and been found eligible for medicaid on or before the day of the child's birth, for sixty days after the day of the child's birth and for the remaining days of the month in which the sixtieth day falls.

g. Aged, blind, or disabled individuals who are receiving supplemental security income payments or who appear on the state data exchange as zero payment as a result of

supplemental security income's recovery of an overpayment or who are suspended because the individuals do not have a protective payee, provided that the more restrictive medicaid criteria is met.

h. Individuals who meet the more restrictive requirements of the medicaid program and qualify for supplemental security income benefits under section 1619(a) or 1619(b) of the Act [42 U.S.C. 1382h(a) or 1382h(b)].

i. Essential spouses of, or persons essential to, individuals who received benefits, in December 1973 under the state's approved plan for title XVI of the Social Security Act (repealed), who were grandfathered into the supplemental security income program and who have continuously received benefits under the supplemental security income program and the medicaid program since the inception of the supplemental security income program, but only if the essential spouse of, or person essential to, the individual continues to reside with the individual.

2. Optional categorically needy groups include:

a. All individuals under age twenty-one who are not receiving aid to families with dependent children, but whose income and assets are at or below the aid to families with dependent children program limits.

b. All individuals under age twenty-one who are residing in adoptive homes and who have been determined under the state-subsidized adoption program to be eligible as provided in state law and in accordance with the requirements of the department.

c. All individuals under age twenty-one who qualify on the basis of financial eligibility for medicaid and who are residing in foster homes or private child care institutions licensed or approved by the department, irrespective of financial arrangements, including children in a "free" foster home placement.

3. Medically needy groups include:

a. Eligible caretaker relatives and individuals under age twenty-one in aid to families with dependent children families who do not meet financial or certain technical aid to families with dependent children requirements (i.e., work requirements) for a cash payment, but meet medically needy income and asset standards.

b. All individuals under the age of twenty-one who qualify for and require medical services on the basis of insufficient income and assets, but who do not qualify as

categorically needy, including children in stepparent families who are ineligible for aid to families with dependent children or children in non-IV-E foster care.

c. Pregnant women whose pregnancy has been medically verified and who, except for income and assets, would be eligible as categorically needy.

d. Pregnant women whose pregnancy has been medically verified and who qualify on the basis of financial eligibility.

e. Eligible pregnant women who applied for medicaid during pregnancy, and for whom recipient liability for the month was met no later than on the date each pregnancy ends, continue to be eligible, as though pregnant, for sixty days after the day each pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.

f. Aged, blind, or disabled individuals who would be eligible for supplemental security income benefits or certain state supplemental payments, but who have not applied for cash assistance or have sufficient income or assets to meet their maintenance needs.

g. Individuals under age twenty-one (who have been certified as needing the service) or age sixty-five and over in the state hospital who qualify on the basis of financial eligibility.

4. Poverty level groups include:

a. Pregnant women whose pregnancy has been medically verified and who meet the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred thirty-three percent of the poverty level.

b. Eligible pregnant women who applied for medicaid during their pregnancy who continue to be eligible for sixty days after the day each pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.

c. Children under the age of six who meet the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred thirty-three percent of the poverty level.

d. Children, age six or older, born after September 30, 1983, who meet the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred percent of the poverty level.

e. Qualified medicare beneficiaries are aged, blind, or disabled individuals who are entitled to medicare part A benefits, meet the medically needy nonfinancial criteria, have assets no greater than twice the supplemental security income resource standards, and have income at or below one hundred percent of the poverty level.

f. Qualified disabled and working individuals are individuals entitled to enroll in medicare part A under section 1818a of the Social Security Act [42 U.S.C. 1395i-2(a)], have income no greater than two hundred percent of the federal poverty level, have assets no greater than twice the supplemental security income resource standard, and are not eligible for medicaid under any other provision. The supplemental security income program income and asset methodologies must be used and none of the more restrictive 209b criteria may be applied.

g. Special low-income medicare beneficiaries are aged, blind, or disabled individuals who are entitled to medicare part A benefits, meet the medically needy nonfinancial criteria, have assets no greater than twice the supplemental security income resource standards, and have income above one hundred percent of the poverty level, but not in excess of one hundred ten percent of the poverty level until January 1, 1995, and thereafter, not in excess of one hundred twenty percent of the poverty level.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-06. **Applicant's choice of aid category.** A person who could establish eligibility under more than one aid category may have eligibility determined under the aid category the person selects. Except with respect to qualified medicare beneficiaries and special low-income medicare beneficiaries, who may also establish eligibility as aged, blind, or disabled, a person may establish eligibility under only one aid category.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-12.1. Payment of health insurance premiums, coinsurance, and deductibles.

1. For purposes of this section:

a. "Cost effective" means that medicaid payments for a set of medicaid-covered services are likely to exceed the cost of paying the health plan premium, coinsurance charges, and deductibles for those services.

b. "Employer group health plan" means any plan of an employer or contributed to by an employer (including a self-insurance plan) to pay for health care provided to the employer's employees, former employees, or families of employees or former employees.

c. "Health plan" means any plan under which a third party is obligated by contract to pay for health care provided to an applicant for or recipient of medicaid. "Health plan" includes "employer group health plan".

2. Except as provided in this subsection, a recipient of medicaid is eligible only if he or she enrolls in, remains enrolled in, and cooperates with the requirements of, any cost-effective employer group health plan, and any cost-effective optional coverage under the plan in which he or she is eligible to be enrolled.

a. A child may not be found ineligible as a result of a parent's failure to enroll the child or maintain the child's enrollment in a cost-effective employer group health plan.

b. A spouse may not be found ineligible as a result of his or her spouse's failure to enroll the spouse or maintain the spouse's enrollment in a cost-effective employer group health plan unless, under the terms of the plan, either spouse is allowed to execute the enrollment.

c. An individual may not be found ineligible, while waiting for an open enrollment period or for the conclusion of a waiting period, if the individual is not, under the terms of the plan, permitted to enroll until the open enrollment period or the conclusion of a waiting period unless the individual has, after applying for medicaid benefits, failed to enroll during an available open enrollment period or disenrolled.

3. An individual determined ineligible under subsection 2 remains ineligible until:

a. The individual becomes enrolled in the plan (even if the individual is not permitted to enroll until an open enrollment period or the conclusion of a waiting period); or

b. The plan is no longer considered to be cost effective.

4. If an applicant for or recipient of medicaid benefits is eligible for enrollment, but is not enrolled in medicare part B, enrollment in an employer group health plan will not be considered to be cost effective.

5. Any recipient of medicaid benefits who is enrolled in a cost-effective health plan may have the health plan premiums, coinsurance, and deductibles paid by medicaid.

6. Applicants for or recipients of medicaid benefits must provide information necessary to determine if an employer group health plan is cost effective and may provide information necessary to determine if any other health plan is cost effective.

7. Failure to enroll, continue enrollment, enroll in a cost-effective optional coverage, or cooperate with plan requirements will:

   a. In the case of an individual who may be determined ineligible under subsection 2, result in a loss of medicaid eligibility;

   b. Result in termination of payments for health plan premiums, coinsurance, and deductibles; and

   c. Result in nonpayment for services, by medicaid, which the health plan would pay, or would have paid, had the recipient conformed to the requirements of the health plan.

8. The department shall determine, using information provided by or at the direction of a medicaid applicant or recipient, guidelines established by the department, and other information at its disposal, whether a health plan is cost effective. The department may make determinations under this subsection on a case-by-case basis, on a plan-by-plan basis, or both.

History: Effective July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396b(a)(1), 42 USC 1396d(a), 42 USC 1396e

75-02-02.1-18. Coverage for aliens.

1. Aliens lawfully admitted for permanent residence. An alien who is lawfully admitted for permanent residence under color of law is eligible for medicaid if all other requirements for eligibility are met.

2. Aliens lawfully admitted for a temporary or specific period. An alien may be lawfully admitted for a temporary or specific

period of time. Such aliens are not eligible for medicaid because they do not meet the requirement that residence be permanent. Examples include aliens with student visas, visitors, tourists, some workers, and diplomats.

3. Aliens not lawfully admitted. Aliens not lawfully admitted for permanent residence are eligible for emergency services if, and only if:

   a. The alien has a medical condition (including ~~emergency~~ labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

      (1) Placing health in serious jeopardy;

      (2) Serious impairment to bodily functions; or

      (3) Serious dysfunction of any bodily organ or part; and

   b. The alien's need for emergency service continues.

4. The alien who meets the medical criteria in subdivision a of subsection 3 must also meet all other eligibility requirements for medicaid except the requirements concerning furnishing social security numbers and verification of alien status. Eligibility for medicaid ends when the emergency service has been provided.

5. Aliens who apply for legalization under the Immigration Reform and Control Act of 1986 [Pub. L. 99-603; title II, section 201(a)(1); 8 U.S.C. section 1255a] are not eligible for five years after the date of application for permanent residence, regardless of the date of entry into the county.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-20. Extended medicaid benefits to certain families who cease receipt of aid to families with dependent children benefits. Families who cease receipt of aid to families with dependent children benefits, and who continue to cooperate in obtaining payment and medical support, continue to be eligible for medicaid benefits without making further application for medicaid benefits in certain circumstances.

1. In the case of families who received aid to families with dependent children benefits in at least three of the six months immediately preceding the month in which the family became ineligible solely because of the hours of, or income

from, employment of the caretaker relative in the family unit; or because a member of the family unit loses the aid to families with dependent children disregard of thirty dollars of earned income; or the aid to families with dependent children disregard of one-third of earned income, medicaid benefits may continue for up to twelve months if:

a. In the first six-month period, the caretaker relative:

(1) Has a dependent child ~~living~~ residing in the home; and

(2) Remains a resident of the state; or

b. In the second six-month period, the caretaker relative:

(1) Has a dependent child ~~living~~ residing in the home;

(2) Remains a resident of the state;

(3) Remains employed (in cases where aid to families with dependent children ineligibility resulted from increases in hours of, or income from, employment of the caretaker relative); and

(4) Has gross earned income, less child care expenses the caretaker relative is responsible for, which, in either of the three month periods consisting of the fourth, fifth, and sixth months or the seventh, eighth, and ninth months, when totaled and divided by three, do not exceed one hundred ~~and~~ eighty-five percent of the poverty level.

2. A recipient who seeks eligibility under subsection 1 of this section must report and verify income and child care expenses for the fourth, fifth, and sixth months by the twenty-first day of the seventh month, and for the seventh, eighth, and ninth months by the twenty-first day of the tenth month. Failure to report income in the seventh month and the tenth month, or receipt of income in excess of one hundred ~~and~~ eighty-five percent of the poverty level, causes ineligibility effective on the last day, respectively, of the seventh month or the tenth month.

3. In the case of families who received aid to families with dependent children benefits in at least three of the six months immediately preceding the month in which the family becomes ineligible solely or partly as a result of the collection or increased collection of child or spousal support, medicaid benefits may continue for four calendar months following the month for which the final aid to families with dependent children benefit was paid if the caretaker relative:

a. Has a dependent child ~~living~~ residing in the home; and

b. Remains a resident of the state.

4. A family which seeks to demonstrate the receipt of aid to families with dependent children benefits in at least three of the six months immediately preceding the month in which the former aid to families with dependent children recipient became ineligible, must have been receiving aid to families with dependent children benefits in this state in the month immediately preceding the month in which the family became ineligible.

5. Benefits provided under this section may not be continued after the described period of eligibility even if the decision to close the case is appealed.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-22. Eligibility of qualified medicare beneficiaries and special low-income medicare beneficiaries.

1. Qualified medicare beneficiaries are entitled only to medicare cost-sharing benefits described in subsection ~~18~~ 19 of section 75-02-02.1-01.

2. Special low-income medicare beneficiaries are entitled only to medicare cost-sharing benefits described in paragraph 2 of subdivision a of subsection 19 of section 75-02-02.1-01.

3. Asset limits. The following asset limits apply to eligibility determinations for qualified medicare beneficiaries ~~eligibility determinations~~ and special low-income medicare beneficiaries. No person may be found to be a qualified medicare beneficiary or a special low-income medicare beneficiary unless the total value of all assets, not described in subsection ~~4~~ 5, does not exceed:

a. Four thousand dollars for a one-person unit; or

b. Six thousand dollars for a two-person unit.

~~3.~~ 4. Provision of this chapter governing asset considerations (75-02-02.1-25), valuation of assets (75-02-02.1-32), and forms of asset ownership (75-02-02.1-29) apply to eligibility determinations for qualified medicare ~~beneficiary eligibility determinations~~ beneficiaries and special low-income medicare beneficiaries except:

a. Half of a liquid asset held in common with another qualified medicare beneficiary or special low-income medicare beneficiary is presumed available;

b. Assets owned by a child, under age twenty-one, in the unit are not considered available in determining qualified medicare beneficiary eligibility or special low-income medicare beneficiary eligibility for the child's parent, except that all liquid assets held in common by the child and the parent are considered available to the parent; and

c. Assets owned by a spouse who is not residing with an applicant for or recipient of qualified medicare beneficiary benefits or special low-income medicare beneficiary benefits are not considered available in determining qualified medicare beneficiary eligibility or special low-income medicare beneficiary eligibility unless ~~they~~ the assets are liquid assets held in common.

~~4.~~ 5. Excluded assets for purposes of this section:

a. The assets described in subsections 2 through 5 of section 75-02-02.1-27 and a residence occupied by the person, the person's spouse, or the person's dependent relative are excluded. Terms used in this section have the following meanings:

(1) "Residence" includes all contiguous lands, including mineral interests, upon which it is located. The residence may include a mobile home suitable for use, and being used, as a principal place of residence. Rural property contiguous to the residence is excluded, even if rented or leased to a third party. The residence is excluded during the temporary institutionalization or other absence of the individual from the residence, so long as the individual intends to return. However, a six-month absence due to institutionalization ends the exclusion.

(2) "Relative" means a child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half brother, half sister, first cousin, or in-law.

(3) "Dependency" includes financial, medical, and other forms of dependency. Financial dependency exists with respect to someone whom a taxpayer is able to claim a deduction on a federal income tax return.

b. Property which is excluded under subsections 1, 2, ~~and~~ 4 through 10, and 12 of section 75-02-02.1-28 is excluded for purposes of this section.

c. Burial funds of up to one thousand five hundred dollars each, plus earnings on excluded burial funds ~~in and after the month of application~~ earned after July 1, 1987, held for the individual and for the individual's spouse are excluded. Burial funds may consist of revocable burial contracts; revocable burial trusts; other revocable burial arrangements, including the value of installment sales contracts for burial spaces; cash; financial accounts such as savings or checking accounts; or other financial instruments with a definite cash value, such as stocks, bonds, and certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or a signed statement. ~~Burial~~ Term burial insurance, irrevocable trusts, or any other irrevocable arrangement for burial must be considered at face value for meeting the burial fund exclusion. Combined face value of an individual's life insurance policies, which have any cash surrender value, with a total face value of one thousand five hundred dollars or less must be considered toward this exclusion. Cash surrender value of an individual's life insurance with a total face value in excess of one thousand five hundred dollars may be applied towards the burial fund exclusion.

d. A burial space or agreement which represents the purchase of a burial space held for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion set forth in subdivision c. Only one item intended to serve a particular burial purpose, per individual, may be excluded. For purposes of this subdivision:

(1) "Burial space" means a burial plot, ~~granite~~ gravesite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.

(2) "Held for" means the individual currently has title to or possesses a burial space intended for the individual's use or has a contract with a funeral service company for specified burial spaces for the individual's burial, such as an agreement which represents the individual's current right to use of the items at the amount shown~~; but does not mean any~~

~~arrangement where the individual does not currently own the space, or does not currently have the right to use the space, or where the seller is not currently obligated to provide the space.~~

(3) "Other member of the individual's immediate family" means the individual's parents, minor or adult children, siblings, and the spouses of those persons, whether the relationship is established by birth, adoption, or marriage, except that a relationship established by marriage ends if the marriage ends.

e. At the option of individual, and in lieu of (but not in addition to), the burial fund described in subdivision c and the burial space or agreement described in subdivision d, any prepayments or deposits which total three thousand dollars or less, and the interest accrued thereon after July 1, 1987, made under a pre-need funeral service contract. The individual must verify that the deposit is made in a manner such that the individual may obtain the deposit within five days after making a request directly to the financial institution, and without furnishing documents maintained by the funeral establishment or waiting for the financial establishment to secure permission from the funeral establishment.

f. Property essential to self-support is excluded.

(1) "Property essential to self-support" means:

(a) Property which the applicant or recipient owns, up to an equity value of six thousand dollars, which produces annual income at least equal to six percent of the excluded amount, and with respect to which the applicant or recipient is not actively engaged in using to produce income. Two or more properties may be excluded if each such property produces at least a six percent return and the combined equity value does not exceed six thousand dollars. Equity in such property is a countable asset to the extent that equity exceeds six thousand dollars and is a countable asset if it produces an annual return of less than six percent of equity. The property must be in current use, or, if not in current use, there must be a reasonable expectation that the use will resume, and the annual return test will be met within twelve months of the last use or, if the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use. If the property produces less than a six percent return, the property may nonetheless be

excluded, for a period of no more than twenty-four months, beginning with the first day of the tax year following the one in which the return dropped below six percent, only if the lower return is for reasons beyond the control of the applicant or recipient and there is a reasonable expectation that the property will again produce a six percent return.

(b) Nonbusiness property which the applicant or recipient owns, up to an equity value of six thousand dollars, when used to produce goods or services essential to daily activities, or, for instance, when used to grow produce or livestock solely for consumption in the individual's household. Equity in such property is a countable asset to the extent that equity exceeds six thousand dollars. The property must be in current use or, if not in current use, the asset must have been in such use and there must be a reasonable expectation that the use will resume within twelve months of the last use or, if the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use.

(c) Property which is essential to earning a livelihood. Such property may be excluded only during months when it is in current use or, if not in current use, when the asset has been in such use and there is a reasonable expectation that the use will resume within twelve months of the last use or, if the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use. Liquid assets used in the operation of a trade or business excluded under this subparagraph are also excluded provided that those liquid assets are exclusively so used and are not commingled with any liquid asset not so used.

(2) ~~Liquid~~ Except as provided in subparagraph c of paragraph 1, liquid assets are not property essential to self-support.

g. Lump sum payments of title II or supplemental security income benefits for six consecutive months following the month of receipt.

h. Real property, the sale of which would cause undue hardship to a coowner, is excluded for so long as the coowner uses the property as a principal residence, would

have to move if the property were sold, and has no other readily available housing.

i. Life insurance or burial insurance that generates a cash surrender value if the face value of all such life insurance or burial insurance policies on the life of that person total one thousand five hundred dollars or less.

j. ~~Assets set aside, by a blind or disabled (but not an aged) supplemental security income recipient, as a part of a plan to achieve self-support which has been approved by the secretary of the United States department of health and human services are excluded.~~

~~k.~~ The value of assistance, paid with respect to a dwelling unit occupied by the applicant or recipient, or by the applicant's or recipient's spouse, under the United States Housing Act of 1937 [42 U.S.C. 1437 et seq.], the National Housing Act [12 U.S.C. 1701 et seq.], section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949 [42 U.S.C. 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 U.S.C. 1701q(h)].

~~l.~~ k. For the nine-month period beginning with the month in which received, any amount received by the applicant or recipient, or the applicant's or recipient's spouse, from a fund established by a state to aid victims of crime, to the extent that the applicant or recipient, or the applicant's or recipient's spouse, demonstrates that such amount was paid in compensation for expenses incurred or losses suffered as a result of a crime.

~~m.~~ l. For the nine-month period beginning after the month in which received, relocation assistance provided by a state or local government to an applicant or recipient, or to the applicant's or recipient's spouse, comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 [42 U.S.C. 4621 et seq.] which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636].

~~n.~~ m. For the month of receipt and the following month, any refund of federal income taxes made to an applicant or recipient, or to the applicant's or recipient's spouse, by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit) and any payment made to an applicant or recipient, or to the applicant's or recipient's spouse, by an employer under section 3507 of the Internal Revenue Code of 1986 (relating to advance payment of earned income credit).

~~5.~~ 6. Assets excluded under subsection ~~4~~ 5 must be identifiable to be excluded:

~~6.~~ 7. a. Income calculations to determine qualified medicare beneficiary or special low-income medicare beneficiary eligibility must consider income in the manner provided for in section 75-02-02.1-34, income considerations; section 75-02-02.1-36, disregarded income; section 75-02-02.1-37, unearned income; section 75-02-02.1-38, earned income; and section 75-02-02.1-39, income deductions; except:

(1) Married individuals living separate and apart from a spouse are treated as single individuals.

(2) Income disregards under subsection 1 of section 75-02-02.1-36 are available even if the person resides in a nursing facility, the state hospital, ~~or~~ the Anne Carlsen school-hospital, or receives swing bed care in a hospital.

(3) The deductions described in subdivisions a, b, d, and h of subsection 1 of section 75-02-02.1-39, income deductions, are not allowed.

(4) The deductions described in subdivision i of subsection 1 and subdivision e of subsection 2 of section 75-02-02.1-39, income deductions, are allowed even if the person receives swing bed care in a hospital or resides in a nursing facility, the state hospital, or the Anne Carlsen school-hospital.

(5) The deduction described in subdivision f of subsection 2 of section 75-01-02.1-39, income deductions, is not allowed.

(6) Where a blind or disabled (but not an aged) supplemental security income recipient has a plan for achieving self-support which has been approved by the secretary of the United States department of health and human services, amounts of income necessary to and actually contributed to the plan are deducted.

b. A qualified medicare beneficiary applicant is eligible if countable income is equal to or less than one hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved, and if he or she meets all of the requirements described in this section.

c. A special low-income medicare beneficiary is eligible if countable income is more than one hundred percent but less than one hundred ten percent, or, after January 1, 1995, less than one hundred twenty percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved, and if he or she meets all of the requirements described in this section.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-23. Eligibility of qualified disabled and working individuals.

1. Qualified disabled and working individuals are entitled only to medicare cost-sharing benefits described in paragraph 1 of subdivision a of subsection ~~18~~ 19 of section 75-02-02.1-01.

2. Asset limits. The following asset limits apply to qualified disabled and working individual eligibility determinations. No person may be found to be a qualified disabled and working individual unless the total value of all assets not described in subsection 4 does not exceed:

   a. Four thousand dollars for a one-person unit; or

   b. Six thousand dollars for a two-person unit.

3. Provisions of this chapter governing asset considerations (75-02-02.1-25), valuation of assets (75-02-02.1-32), and forms of asset ownership (75-02-02.1-29) apply to qualified disabled and working individual eligibility determinations except:

   a. Half of a liquid asset held in common with another qualified disabled and working individual is presumed available;

   b. Assets owned by a child, under age twenty-one, in the unit are not considered available in determining qualified disabled and working individual eligibility for the child's parent except that all liquid assets held in common by the child and the parent are considered available to the parent; and

   c. Assets owned by a spouse who is not residing with an applicant for or recipient of qualified disabled and working individual benefits are not considered available

in determining qualified disabled and working individual eligibility unless they are liquid assets held in common.

4. Excluded assets for purposes of this section.

   a. The assets described in subsections 2 through 5 of section 75-02-02.1-27 and a residence occupied by the person, the person's spouse, or the person's dependent relative are excluded from consideration in determining qualified disabled and working individual eligibility. Terms used in this section have the following meaning:

      (1) "Residence" includes all contiguous lands, including mineral interests, upon which it is located. The residence may include a mobile home suitable for use, and being used, as a principal place of residence. Rural property contiguous to the residence is exempt, even if rented or leased to a third party. The residence remains exempt during the temporary institutionalization or other absence of the individual from the residence, so long as the individual intends to return. However, a six-month absence due to institutionalization ends the exemption.

      (2) "Relative" means a child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half brother, half sister, first cousin, or in-law.

      (3) "Dependency" includes financial, medical, and other forms of dependency. Financial dependency exists with respect to someone whom a taxpayer is able to claim a deduction on a federal income tax return.

   b. Property which is excluded under subsections 1, 2, ~~and~~ 4 through 10, and 12 of section 75-02-02.1-28 is excluded for purposes of this section.

   c. Burial funds of up to one thousand five hundred dollars each, plus earnings on excluded burial funds in and after the month of application, held for the individual and the individual's spouse are excluded. Burial funds may consist of revocable burial contracts; revocable burial trusts; other revocable burial arrangements, including the value of installment sales contracts for burial spaces; cash; financial accounts such as savings or checking accounts; or other financial instruments with a definite cash value, such as stocks, bonds, and certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or by a

signed statement. ~~Burial~~ Term burial insurance, irrevocable trusts, or any other irrevocable arrangement for burial must be considered at face value for meeting the burial fund exclusion. Combined face value of an individual's life insurance policies, which have any cash surrender value, with a total face value of one thousand five hundred dollars or less must be considered toward this exclusion. Cash values of an individual's life insurance with a total face value in excess of one thousand five hundred dollars may be applied towards the burial fund exclusion.

d. A burial space or agreement which represents the purchase of a burial space held for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion set forth in subdivision c. Only one item intended to serve a burial particular purpose, per individual, may be excluded. For purposes of this subdivision:

(1) "Burial space" means a burial plot, ~~granite~~ gravesite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.

(2) "Held for" means the individual currently has title to or possesses a burial space intended for the individual's use or has a contract with a funeral service company for specified burial spaces for the individual's burial, such as an agreement which represents the individual's current right to use of the items at the amount shown; but does not mean any arrangement where the individual does not currently own the space, or does not currently have the right to use the space, or where the seller is not currently obligated to provide the space.

(3) "Other members of the individual's immediate family" means the individual's parents, minor or adult children, siblings, and the spouses of those persons, whether the relationship is established by birth, adoption, or marriage, except that a relationship established by marriage ends if the marriage ends.

e. Property essential to self-support is excluded.

(1) "Property essential to self-support" means:

(a) Property which the applicant or recipient owns, up to an equity value of six thousand dollars, which produces annual income at least equal to six percent of the excluded amount, and with respect to which the applicant or recipient is not actively engaged in using to produce income. Two or more properties may be excluded if each such property produces at least a six percent return and the combined equity value does not exceed six thousand dollars. Equity in such property is a countable asset to the extent that equity exceeds six thousand dollars and is a countable asset if it produces an annual return of less than six percent of equity. The property must be in current use, or, if not in current use, there must be a reasonable expectation that the use will resume, and the annual return test will be met within twelve months of the last use or, if the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use. If the property produces less than a six percent return, the property may nonetheless be excluded, for a period of no more than twenty-four months, beginning with the first day of the tax year following the one in which the return dropped below six percent, only if the lower return is for reasons beyond the control of the applicant or recipient and there is a reasonable expectation that the property will again produce a six percent return.

(b) Nonbusiness property which the applicant or recipient owns, up to an equity value of six thousand dollars, when used to produce goods or services essential to daily activities, or, for instance, when used to grow produce or livestock solely for consumption in the individual's households. Equity in such property is a countable asset to the extent that equity exceeds six thousand dollars. The property must be in current use or, if not in current use, the asset must have been in such use and there must be a reasonable expectation that the use will resume within twelve months of the last use or, if the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use.

(c) Property which is essential to earning a livelihood. Such property may be excluded only during months when it is in current use or, if not in current use, when the asset has been in

such use and there is a reasonable expectation that the use will resume within twelve months of the last use or, if the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use. Liquid assets used in the operation of a trade or business excluded under this subparagraph are also excluded provided that those liquid assets are exclusively so used and not commingled with any liquid assets not so used.

(2) ~~Liquid~~ Except as provided in subparagraph c of paragraph 1, liquid assets are not property essential to self-support except when used as part of a trade or business.

f. Lump sum payments of title II or supplemental security income benefits are excluded for six consecutive months following the month of receipt.

g. Real property, the sale of which would cause undue hardship to a coowner, is excluded for so long as the coowner uses the property as a principal residence, would have to move if the property were sold, and has no other readily available housing.

h. Life insurance or burial insurance that generates a cash surrender value is excluded if the face value of all such life insurance or burial insurance policies of that person total one thousand five hundred dollars or less.

~~i. Assets set aside, by a blind or disabled (but not an aged) supplemental security income recipient, as a part of a plan to achieve self-support which has been approved by the secretary of the United States department of health and human services are excluded.~~

~~j.~~ The value of assistance, paid with respect to a dwelling unit occupied by the applicant or recipient, or by the applicant's or recipient's spouse, under the United States Housing Act of 1937 [42 U.S.C. 1437 et seq.], the National Housing Act [12 U.S.C. 1701 et seq.], section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949 [42 U.S.C. 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 U.S.C. 1701q(h)].

~~k.~~ j. For the nine-month period beginning with the month in which received, any amount received by the applicant or recipient, or the applicant's or recipient's spouse, from a fund established by a state to aid victims of crime, to the extent that the applicant or recipient, or the

applicant's or recipient's spouse, demonstrates that such amount was paid in compensation for expenses incurred or losses suffered as a result of a crime.

~~j.~~ k. For the nine-month period beginning after the month in which received, relocation assistance provided by a state or local government to an applicant or recipient, or to the applicant's or recipient's spouse, comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 [42 U.S.C. 4621 et seq.] which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636].

~~m.~~ l. For the month of receipt and the following month, any refund of federal income taxes made to an applicant or recipient, or to the applicant's or recipient's spouse, by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit) and any payment made to an applicant or recipient, or to the applicant's or recipient's spouse, by an employer under section 3507 of the Internal Revenue Code of 1986 (relating to advance payment of earned income credit).

5. Assets excluded under subsection 4 must be identifiable to be excluded.

6. a. Income calculations to determine qualified disabled and working individual eligibility must consider income in the manner provided for in section 75-02-02.1-34, income considerations; section 75-02-02.1-36, disregarded income; section 75-02-02.1-37, unearned income; section 75-02-02.1-38, earned income, and section 75-02-02.1-39, income deductions, except:

(1) Married individuals living separate and apart from a spouse are treated as single individuals; and

(2) The deductions described in subdivisions a, b, d, and h of subsection 1 of section 75-02-02.1-39, income deductions, are not allowed.

(3) Where a blind or disabled (but not an aged) supplemental security income recipient has a plan for achieving self-support which has been approved by the secretary of the United States department of health and human services, amounts of income necessary to, and actually contributed to, the plan are excluded.

b. A qualified disabled and working individual applicant is eligible if countable income is equal to or less than two hundred percent of the official poverty line, as defined by the United States office of management and budget, and

as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved, and if he or she meets all of the requirements described in this section; but is otherwise ineligible for medicaid.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-24. Spousal impoverishment prevention.

1. Definitions. For purposes of this section:

   a. "Community spouse" means the spouse of an institutionalized spouse.

   b. "Family member" means only minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse. For purposes of applying this definition, a family member is dependent only if he or she is, and may properly be, claimed as a dependent on the federal income tax return filed by the institutionalized spouse or the community spouse, or filed jointly by both.

   c. "Institutionalized spouse" means an individual who:

      (1) Is receiving swing bed care in a hospital or is in the state hospital or a nursing facility and, at the beginning of his or her institutionalization, is likely to be in the facility for at least thirty consecutive days (even though he or she does not actually remain in the facility for thirty consecutive days); and

      (2) Is married to a spouse who is not receiving swing bed care in a hospital or care in the state hospital or a nursing facility.

   d. "Monthly maintenance needs allowance" means for a community spouse, the maximum amount permitted under 42 U.S.C. 1396r-5(d)(3)(C), as adjusted pursuant to 42 U.S.C. 1396r-5(g).

2. Treatment of countable assets.

   a. Assessment. At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse ~~which begins on or after September 30, 1989~~, and upon receipt of relevant

documentation of resources, the total value described in subdivision b shall be assessed and documented.

b. Total joint countable assets. There shall be computed, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse ~~which begins on or after September 30, 1989~~:

(1) The total value of the countable assets to the extent either the institutionalized spouse or the community spouse has an ownership interest; and

(2) A spousal share:

~~(a) With respect to eligibility determinations made before July 1, 1992, is equal to one-half of such total value; and~~

~~(b) With respect to eligibility determinations made on or after July 1, 1992~~, which is equal to all countable assets up to the maximum amount permitted under 42 U.S.C. 1396r-5(f)(2)(A)(ii)(II), as adjusted pursuant to 42 U.S.C. 1396r-5(g).

c. In determining the assets of the institutionalized spouse at the time of application, all countable assets held by the institutionalized spouse, the community spouse, or both, must be considered available to the institutionalized spouse to the extent they exceed the community spouse countable asset allowance.

d. During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this chapter, no countable assets of the community spouse may be deemed available to the institutionalized spouse.

e. The institutionalized spouse is not ineligible by reason of assets determined under subdivision c to be available for the cost of care where:

(1) The institutionalized spouse has assigned to the state any rights to support from the community spouse; or

(2) It is determined that a denial of eligibility would work an undue hardship because the presumption described in subsection 4 of section 75-02-02.1-25 has been rebutted.

f. An institutionalized spouse is allowed the medically needy asset limit of three thousand dollars.

g. An institutionalized spouse is asset eligible if the total value of all countable assets of the community spouse and the institutionalized spouse is less than the total of the community spouse asset limit and the institutionalized spouse asset limit. The assets may be owned by either spouse provided that the institutionalized spouse complies with the requirements of subdivision h.

h. Permitting transfer of assets to community spouse. Transfers from spouse to spouse do not disqualify an applicant from receipt of medicaid benefits. In order to facilitate such transfers from an institutionalized spouse to a community spouse, where necessary to maximize the community spouse asset allowance, a brief period of time is permitted for such transfers after the institutionalized spouse is determined eligible for medicaid. During this period, such assets are not counted as available to the institutionalized spouse even though the assets are not yet transferred.

(1) An institutionalized spouse may transfer an amount equal to the community spouse countable asset allowance, but only to the extent the assets of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse.

(2) A transfer under paragraph 1 must be made by the end of the third calendar month after the month in which the eligibility decision is made.

(3) When an eligible institutionalized spouse exceeds the asset limits due to an increase in the value of assets or the receipt of assets not previously owned, an institutionalized spouse may transfer additional assets to the community spouse equal to no more than the current maximum community spouse countable asset allowance less the total value of assets transferred to, or for the sole benefit of, the community spouse, under paragraph 1 or previously transferred under this paragraph.

(4) A transfer under paragraph 3 must be made by the end of the third calendar month of a period which begins with the month in which the institutionalized spouse exceeded the asset limit.

(5) If a transfer made under paragraph 1 or 3 causes the total value of all assets owned by the community spouse immediately prior to the transfer under paragraph 1, plus the value of all assets transferred

under paragraph 1, plus the value of all assets transferred under paragraph 3, equals or exceeds the current maximum community spouse asset allowance, no further transfer may be made under paragraph 3.

(6) If a court has entered an order against an institutionalized spouse for the support of a community spouse, assets required by such order to be transferred, by the institutionalized spouse to the community spouse, may not be counted as available to the institutionalized spouse even though the assets are not yet transferred.

3. Community spouse countable asset allowance. A community spouse may retain or receive assets, which do not exceed the community spouse countable asset allowance, for purposes of determining the medicaid eligibility of the institutionalized spouse. The community spouse countable asset allowance means the spousal share determined under paragraph 2 of subdivision b of subsection 2, plus:

a. Any additional amount transferred under a court order in the manner and for the purpose described in paragraph 5 of subdivision h of subsection 2; or

b. Any additional amount established through a fair hearing conducted under subsection 7.

4. Countable and excluded assets. Countable assets include all assets which are not specifically excluded. Excluded assets are:

a. A residence occupied by the community spouse. For purposes of this subdivision, "residence" includes all contiguous lands, including mineral interests, upon which it is located. The residence may include a mobile home suitable for use, and being used, as a principal place of residence. Rural property contiguous to the residence is excluded, even if rented or leased to a third party. The residence is excluded during temporary absence of the community spouse from the residence, so long as the community spouse intends to return.

b. Household goods, personal effects, and an automobile or other vehicle primarily used for personal transportation.

c. A burial fund of up to one thousand five hundred dollars, plus earnings on excluded burial funds ~~in and after the month of application~~ earned after July 1, 1987. Burial funds may consist of revocable burial contracts; revocable burial trusts; other revocable burial arrangements, including the value of installment sales contracts for burial spaces; cash; financial accounts such as savings or

checking accounts; or other financial instruments with a definite cash value, such as stocks, bonds, and certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or signed statement. ~~Burial~~ Term burial insurance, irrevocable trusts, or any other irrevocable arrangement for burial must be considered at face value for meeting the burial fund exclusion. Combined face value of an individual's life insurance policies, which have any cash surrender value, with a total face value of one thousand five hundred dollars or less must be considered toward this exclusion. Cash surrender value of an individual's life insurance with a total face value in excess of one thousand five hundred dollars may be applied towards the burial fund exclusion.

d. A burial space or agreement which represents the purchase of a burial space held for the individual, the individual's spouse, or any other member of the individual's immediate family. The burial space exclusion is in addition to the burial fund exclusion set forth in subdivision c. Only one item intended to serve a particular burial purpose, per individual, may be excluded. For purposes of this subdivision:

(1) "Burial space" means a burial plot, ~~granite~~ gravesite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.

(2) "Held for" means the individual currently has title to or possesses a burial space intended for the individual's use or has a contract with a funeral service company for specified burial spaces for the individual's burial, such as an agreement which represents the individual's current right to use of the items at the amount shown~~, but does not mean any arrangement where the individual does not currently own the space, or does not currently have the right to use the space, or where the seller is not currently obligated to provide the space~~.

(3) "Other members of the individual's immediate family" means the individual's parents, minor or adult children, siblings, and the spouses of those persons, whether the relationship is established by birth,

adoption, or marriage, except that a relationship established by marriage ends if the marriage ends.

e. At the option of the institutionalized spouse, and in lieu of (but not in addition to) the burial fund described in subdivision c and the burial space or agreement described in subdivision d, any prepayments or deposits which total three thousand dollars or less, and the interest accrued thereon after July 1, 1987, made under a pre-need funeral service contract for the institutionalized spouse. The institutionalized spouse must verify that the deposit is made in a manner such that the institutionalized spouse may obtain the deposit within five days after making a request directly to the financial institution, and without furnishing documents maintained by the funeral establishment or writing for the financial institution to secure permission from the funeral establishment.

f. Property essential to self-support.

(1) "Property essential to self-support" means:

(a) Property which the community spouse or the institutionalized spouse owns, with an equity value not exceeding six thousand dollars, which produces annual income at least equal to six percent of equity value, and which neither spouse is actively engaged in using to produce income. Two or more properties may be excluded if each such property produces at least a six percent return and the combined equity value does not exceed six thousand dollars. Equity in such property is a countable asset to the extent that equity exceeds six thousand dollars and is a countable asset if it produces an annual return of less than six percent of equity. The property must be in current use, or, if not in current use, there must be a reasonable expectation that the use will resume, and the annual return test will be met within twelve months of the last use or, if the nonuse is due to the disabling condition of the community spouse or the institutionalized spouse, within twenty-four months of the last use. If the property produces less than a six percent return, the property may nonetheless be excluded, for a period of no more than twenty-four months, beginning with the first day of the tax year following the one in which the return dropped below six percent, only if the lower return is for reasons beyond the control of the community spouse or institutionalized spouse and there is a reasonable expectation

that the property will again produce a six percent return.

(b) Nonbusiness property which the community spouse or the institutionalized spouse owns, up to an equity value of six thousand dollars, when used to produce goods or services essential to daily activities, or, for instance, when used to grow produce or livestock solely for consumption in the community spouse's household. Equity in such property is a countable asset to the extent that equity exceeds six thousand dollars. The property must be in current use or, if not in current use, the asset must have been in such use and there must be a reasonable expectation that the use will resume within twelve months of the last use or, if the nonuse is due to the disabling condition of the community spouse or institutionalized spouse, within twenty-four months of the last use.

(c) Property which is essential to earning a livelihood. Such property may be excluded only during months when it is in current use or, if not in current use, when the asset has been in such use and there is a reasonable expectation that the use will resume within twelve months of the last use or, if the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use. Liquid assets used in the operation of a trade or business excluded under this subparagraph are also excluded provided that those liquid assets are exclusively so used and are not commingled with any liquid asset not so used.

(2) ~~Liquid~~ Except as provided in subparagraph c of paragraph 1, liquid assets are not property essential to self-support.

g. ~~Assets set aside, by a blind or disabled (but not an aged) individual, as a part of a plan, approved by the social security administration, for the individual to achieve self support.~~

~~h.~~ Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act [43 U.S.C. 1606(h) and 1606(c)].

~~i.~~ h. Assistance received under the Disaster Relief and Emergency Assistance Act [42 U.S.C. 5121 et seq.] or other

assistance provided pursuant to a federal statute on account of a catastrophe which is declared to be a major disaster by the president, and interest received on such assistance for a nine-month period beginning on the date such funds are received. When retained, this asset must be identifiable and not commingled with other assets.

~~j.~~ i. Any amounts received from the United States which are attributable to underpayments of benefits due for one or more prior months, under title II or title XVI of the Act [42 U.S.C. 401 et seq. and 1381 et seq.] for a six-month period beginning on the date such amounts are received.

~~k.~~ j. The value of assistance, paid with respect to a dwelling unit occupied by the community spouse, under the United States Housing Act of 1937 [42 U.S.C. 1437 et seq.], the National Housing Act [12 U.S.C. 1701 et seq.], section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949 [42 U.S.C. 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 U.S.C. 1701q(h)].

~~l.~~ k. For the nine-month period beginning with the month in which received, any amount received by the applicant or recipient, or the community spouse, from a fund established by a state to aid victims of crime, to the extent that the applicant or recipient, or the community spouse, demonstrates that such amount was paid in compensation for expenses incurred or losses suffered as a result of a crime.

~~m.~~ l. For the nine-month period beginning after the month in which received, relocation assistance provided by a state or local government to an applicant or recipient, or to a community spouse, comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 [42 U.S.C. 4621 et seq.] which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636].

~~n.~~ m. For the month of receipt and the following month, any refund of federal income taxes made to an applicant or recipient, or to the community spouse, by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit) and any payment made to an applicant or recipient, or to the community spouse, by an employer under section 3507 of the Internal Revenue Code of 1986 (relating to advance payment of earned income credit).

~~o.~~ n. Life insurance or burial insurance that generates a cash surrender value, if the face value of all such life

insurance or burial insurance policies on the life of that person total one thousand five hundred dollars or less.

~~p.~~ o. Property which is excluded under subsections 1, 2, 4, ~~and~~ 6 through 10, and 12 of section 75-02-02.1-28.

5. **Treatment of income.** Income calculations to determine medicaid eligibility for an institutionalized spouse must consider income in the manner provided for in section 75-02-02.1-34, income considerations; sections 75-02-02.1-36, disregarded income; section 75-02-02.1-37, unearned income; section 75-02-02.1-38, earned income; and section 75-02-02.1-39, income deductions, except:

   a. No income of the community spouse may be deemed available to the institutionalized spouse during any month in which an institutionalized spouse is in the institution.

   b. After an institutionalized spouse is determined or redetermined to be eligible for medicaid, in determining the amount of the institutionalized spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the institutionalized spouse's monthly income the following amounts in the following order:

      (1) A personal needs allowance.

      (2) A community spouse monthly income allowance, but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

      (3) A family allowance, for each family member, equal to one-third of an amount, determined in accordance with 42 U.S.C. 1396r-5(d)(3)(A)(i), less the monthly income of that family member.

      (4) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse.

6. **Medicaid eligibility application.** The provisions of this section describing the treatment of income and assets for the community spouse do not describe that treatment for the purposes of determining medicaid eligibility for the community spouse or for children of the community spouse.

7. **Notice and fair hearing.**

   a. Notice must be provided of the amount of the community spouse income allowance, of the amount of any family allowances, of the method of computing the amount of the community spouse countable asset allowance, and of the

right to a fair hearing respecting ownership or availability of income and assets, and the determination of the community spouse monthly income or countable asset allowance. The notice must be provided, upon a determination of medicaid eligibility of an institutionalized spouse, to both spouses, and upon a subsequent request by either spouse or a representative acting on behalf of either spouse, to the spouse making the request.

b. Fair hearing. A community spouse or an institutionalized spouse is entitled to a fair hearing under chapter 75-01-03 if application for medicaid has been made on behalf of the institutionalized spouse and either spouse is dissatisfied with a determination of:

(1) The community spouse monthly income allowance;

(2) The amount of monthly income otherwise available to the community spouse as determined in calculating the community spouse monthly income allowance;

(3) The computation of the spousal share of countable assets;

(4) The attribution of countable assets; or

(5) The determination of the community spouse countable asset allowance.

c. Any hearing respecting the determination of the community spouse countable asset allowance must be held within thirty days of the request for the hearing.

d. If either spouse establishes that the community spouse needs income, above the level provided by the monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs allowance for that spouse must be increased to an amount adequate to provide necessary additional income.

e. If either spouse establishes that the assets included within the community spouse countable asset allowance generate an amount of income inadequate to raise the community spouse's income to the monthly needs allowance, to the extent that total assets permit the community spouse countable asset allowance for that spouse must be increased to an amount adequate to provide such a monthly maintenance needs allowance.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.

General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396r-5

75-02-02.1-26. Asset limits. The following property provisions must be applied in determining medicaid eligibility. In all instances, including determinations of equity, property must be realistically evaluated in accord with current market value. Any reasonable costs which may be associated with liquidation of excess property must be taken into account. Except for those persons found eligible for medicare cost sharing as qualified medicare beneficiaries or special low-income medicare beneficiaries pursuant to section 75-02-02.1-22 or as qualified disabled and working individuals pursuant to section 75-02-02.1-23, no person may be found eligible for medicaid unless the total value of the medicaid unit's assets, in addition to assets exempted pursuant to section 75-02-02.1-27 or excluded pursuant to section 75-02-02.1-28, do not exceed:

1. Three thousand dollars for a one-person unit;

2. Six thousand dollars for a two-person unit; and

3. An additional amount of twenty-five dollars for each member of the unit in excess of two.

History: Effective December 1, 1991; amended effective July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-28. Excluded assets. Except as provided in sections 75-02-02.1-22 and 75-02-02.1-23, the following types of property interests will be excluded in determining if the available assets of an applicant or recipient exceed asset limits:

1. Property which is essential to earning a livelihood. Such property may be excluded only during months in which the applicant or recipient is actively engaged in using the asset to earn a livelihood. Assets which are used seasonably are excluded as long as continued seasonal use is reasonably anticipated.

2. Property which is not saleable without working an undue hardship. Such property may not be excluded earlier than the first day of the month in which good faith attempts to sell are begun, and continues to be excluded only for so long as the asset continues to be for sale.

   a. Persons seeking to establish retroactive eligibility must demonstrate that good faith attempts to sell were begun and continued in each of the months for which retroactive eligibility is sought. Information concerning attempts to sell, which demonstrate that an asset is not saleable

without working an undue hardship, are relevant to establishing eligibility in the month in which the good faith attempts to sell are begun, but are not relevant to months prior to that month and do not relate back to prior months.

b. Property may not be shown to be not saleable without working an undue hardship if the owner of the property fails to take action to collect amounts due and unpaid with respect to the property or otherwise fails to assure the receipt of regular and timely payments due with respect to the property.

3. Any prepayments or deposits which total three thousand dollars or less, and the interest accrued thereon after July 1, 1987, made under a pre-need funeral service contract for each applicant or recipient in the medicaid unit. The applicant or recipient must verify that the deposit is made in a manner such that the applicant or recipient may obtain the deposit within five days after making a request directly to the financial institution, and without furnishing documents maintained by the funeral establishment or waiting for the financial institution to secure permission from the funeral establishment.

4. Home replacement funds, derived from the sale of an excluded home, and if intended for the purchase of another excluded home, until the last day of the third month following the month in which the proceeds from the sale are received. When retained, this asset must be identifiable and not commingled with other assets.

5. Unspent assistance, and interest earned on unspent assistance, received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288] or some other federal statute, because of a presidentially declared major disaster, for nine months after receipt, and for up to an additional nine months, if circumstances beyond the person's control prevent the repair or replacement of the damaged, or destroyed property, and keep the person from contracting for such repair or replacement. When retained, this asset must be identifiable and not commingled with other assets.

6. Payments, interest earned on the payments, and in-kind items received for the repair or replacement of lost, damaged, or stolen excluded assets are excluded for nine months after receipt, and for up to an additional nine months, if circumstances beyond the person's control prevent the repair or replacement of the lost, damaged, or stolen assets, and keep the person from contracting for such repair or replacement. When retained, this asset must be identifiable and not commingled with other assets.

7. Agent orange payments. When retained, this asset must be identifiable and not commingled with other assets.

8. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act [Pub. L. 100-383]. When retained, this asset must be identifiable and not commingled with other assets.

9. German reparation payments to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act, which have been retained and not commingled with other assets.

10. Unspent financial assistance provided for attendance costs to undergraduate students under programs in title IV of the Higher Education Act or for attendance costs under bureau of Indian affairs student assistance programs. When retained, this asset must be identifiable and not commingled with other assets.

11. For the month of receipt and the following month, any refund of federal income taxes made to the applicant or recipient, by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit) and any payment made to an applicant or recipient by an employer under section 3507 of the Internal Revenue Code of 1986 (relating to the advance payment of earned income tax credit).

12. Assets set aside, by a blind or disabled (but not an aged) supplemental security income recipient, as a part of a plan to achieve self-support which has been approved by the secretary of the United States department of health and human services.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.3

75-02-02.1-32. Valuation of assets. It is not always possible to determine the value of assets with absolute certainty, but it is necessary to determine a value in order to determine eligibility. The valuation must be based on reasonably reliable information. It is the responsibility of the applicant or recipient, or the persons acting on behalf of the applicant or recipient, to furnish reasonably reliable information. However, because an applicant or recipient may not be knowledgeable of asset values, and particularly because that person may have a strong interest in the establishment of a particular value, whether or not that value is accurate, some verification of value must be obtained. If reasonably reliable information concerning the value of assets is not made available, eligibility may not be determined. Useful sources of verification include, but are not limited to:

1. With respect to liquid assets: account records maintained by banking facilities.

2. With respect to personal property other than liquid assets:

   a. Publicly traded stocks, bonds and securities: stock brokers.

   b. Autos, trucks, mobile homes, boats, or any other property listed in published valuation guides accepted in the trade: the valuation guide.

   c. With respect to harvested grains or produce: grain buyers, grain elevator operators, produce buyers; and, for crops grown on contract: the contract.

   d. With respect to stock in corporations not publicly traded: appraisers, accountants.

   e. With respect to other personal property: dealers and buyers of that property.

3. Real property.

   a. ~~With respect to surface interests: market value or "true and full" value from tax records, whichever represents an approximation of fair market value; real estate agents; appraisers; loan officers in local banking institutions. If a valuation from a source offered by the applicant or recipient is greatly different from fair market value established by tax records, an explanation for the difference must be made, particularly if the applicant or recipient may be able to influence the person furnishing the valuation.~~

   ~~b.~~ With respect to mineral interests: appraisers, specializing in minerals, mineral buyers, geologists.

   b. With respect to agricultural lands: appraisers, real estate agents dealing in the area, loan officers in local agricultural lending institutions, and other persons known to be knowledgeable of land sales in the area in which the lands are located, but not the "true and full" value from tax records.

   c. With respect to real property other than mineral interests and agricultural lands: market value or "true and full" value from tax records, whichever represents a reasonable approximation of fair market value; real estate agents dealing in the area; and loan officers in local lending institutions. If a valuation from a source offered by the applicant or recipient is greatly different from the true and full value established by tax records, an explanation

for the difference must be made, particularly if the applicant or recipient may be able to influence the person furnishing the valuation.

4. Divided or partial interests. Divided or partial interests include assets held by the applicant or recipients; jointly or in common with persons who are not in the medicaid unit; assets where the applicant or recipient or other persons within the medicaid unit own only a partial share of what is usually regarded as the entire asset; and interests where the applicant or recipient owns only a life estate or remainder interest in the asset.

   a. Liquid assets. The value of a partial or shared interest in a liquid asset is equal to the total value of that asset.

   b. Personal property other than liquid assets and real property other than life estates and remainder interests. The value of a partial or shared interest is a proportionate share of the total value of the asset equal to the proportionate share of the asset owned by the applicant or recipient.

   c. Life estates and remainder interests.

      (1) Real property interests may be divided in terms of the time when the owner of the interest is entitled to possession of the property. The owner of a life estate (life tenant) is entitled to possession of the real property for a period measured by the lifetime of a specific person or persons. A life tenant has the right to use the property and is entitled to any rents or profits from the property. A life tenant may sell the life estate, but such a sale does not change the identity of the person or persons whose lifetimes measure the duration of the life estate. A life estate may be referred to as a "life lease".

      (2) When a life estate is created, a right to possess the property, after the death of the life tenant, must also be created. That right is called a "remainder interest", and the owner of that right is called a "remainderman". Upon the death of the life tenant, the remainderman owns the property. The remainderman is not entitled to possess or use the property until the death of the life tenant. The remainderman does have the right to sell the remainder interest.

      (3) A life estate may be created where the right to possess the property returns, upon the death of the life tenant, to the person or entity which created the life estate. This rare form of ownership may

arise when a legal entity which does not die a natural death (i.e., a trust or corporation) creates a life estate. The right to have possession of property returned after the end of a life estate is properly called a "reversion", but is treated as a remainder interest for purposes of valuation.

(4) Life estate and remainder interest tables. These tables must be used to determine the value of a life estate or remainder interest. In order to use the table, it is necessary to first know the age of the life tenant or, if there are more than one life tenants, the age of the youngest life tenant; and the fair market value of the property which is subject to the life estate or remainder interest. The value of a life estate is found by selecting the appropriate age in the table and multiplying the corresponding life estate decimal fraction times the fair market value of the property. The value of a remainder interest is found by selecting the appropriate age of the life tenant in the table and multiplying the corresponding remainder interest decimal fraction times the fair market value of the property.

Life Estate and Remainder Interest Table

Age	Life Estate	Remainder Interest
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635

21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648

65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

(5) In some cases, the life tenant may suffer from a condition which is likely to cause death at an unusually early age. That circumstance decreases the value of the life estate and increases the value of the remainder interest. The existence of such a condition must be verified by a medical statement which estimates the remaining duration of life in years. The estimated remaining duration of life may be used, in conjunction with a mortality table, to determine the comparable age for application of the life estate and remainder interest table.

5. Contractual rights to receive money payments:

a. For various reasons, but usually because an applicant or recipient has sold property with a contract to receive a series of payments, rather than one payment, an applicant or recipient may own contractual rights to receive money payments. Such contractual rights are available assets subject to the asset limits. If the applicant or recipient has sold real property or a mobile home, and received in return a promise of payments of money at a later date, usually to be made periodically, and an attendant promise to return the property if the payments are not made, the arrangement is usually called a "contract for deed". The essential feature of the contract for deed is the right to receive future payments, usually coupled with a right to get the property back if the payments are not made. Contractual rights to receive money payments also arise out of other types of transactions. The valuable contract document may be called a note, accounts receivable, mortgage, or by some other name.

b. The value of contracts which provide interest at rates at or above the posted yields of the federal national mortgage association (Fannie Mae), as posted for standard conventional fixed rate mortgages, as published in the Wall Street Journal at its most recent publication of posted yields, is equal to the principal balance plus interest due to the time of valuation, provided that the contract is not in default. Some contracts may have been entered into when interest rates were lower, or a low interest rate or no interest may have been charged in a transaction between relatives. These contracts may not be saleable or negotiable at face value. That is not to say that such contractual rights have no value. A proper valuation may be made by a process called "discounting", which will take into account the changes in the interest rates. The discounted value may be determined by the applicant or recipient through the application of

paragraph 1 or by the legal services division of the state agency under paragraph 2.

(1) The discounting process requires estimating the present value of the money payments described in the contract. The formula for present value is:

$$PV = S \frac{1}{(1 + i)n} \text{ or } \frac{S}{(1 + i)n} \text{ or } S(1 + i)^{-n} \text{ where}$$

PV = present value of future sum of money
S = future sum of money
i = earnings rate for each compounding period
n = number of periods

The information to apply the formula is derived from the contract except for the factor "i". The earnings rate to be used for the factor "i" is the posted yields of the federal national mortgage association (Fannie Mae), as posted for standard conventional fixed rate mortgages, as published in the Wall Street Journal at its most recent publication of posted yields. The application of this formula will produce the highest reasonable determination of fair market value of the contractual rights to receive money payments. In the event the contract is in default, and there is no reasonable expectation that payments on the contract will be brought current within one year's time, the factor "S" is equal to the total of all outstanding principal and interest due on the contract and the factor "n" equals one.

(2) A request for a valuation, accompanied by the contract documents, may be sent to the legal services division. The request must indicate if the payments on the contract are current. If the payments are not current, the request must indicate the amount of each payment made and time each such payment was made.

c. In some cases, the price and terms of a contract for deed may, in combination, be extremely favorable to the buyer. If the sale is made with a minimal downpayment, low interest rates, a long payment period, or a combination of any of those factors, the effect may be a transfer for less than adequate consideration. In such cases, the valuation must also indicate the fair market value of the property sold as of the date of sale and the value of the contractual rights immediately after the sale.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04

Law Implemented: NDCC 50-24.1-02

75-02-02.1-33. Disqualifying transfers.

1. a. Except as provided in subsection 2, a person is ineligible for nursing facility services, swing bed services, and medicaid waivered services for a period of time, determined under this subsection, following the disposal of any asset by the person or the person's spouse for less than fair market value.

   b. The period of ineligibility begins with the month in which such assets were transferred, and the number of months in the period is equal to the lesser of:

      (1) Thirty months; or

      (2) The total uncompensated value of the assets so transferred, divided by the average monthly cost of nursing facility care in North Dakota in the year of application.

   c. A person is not ineligible because of subdivision a to the extent that the asset was the person's home and the home was transferred to:

      (1) The person's spouse;

      (2) The person's son or daughter who is under age twenty-one or blind or disabled;

      (3) The person's brother or sister who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the date the person became an institutionalized person;

      (4) The person's son or daughter (other than a child described in paragraph 2) who was residing in the person's home for a period of at least two years immediately before the date the person became an institutionalized person, and who provided care to the person which permitted the person to reside in the person's home, rather than in an institution or facility.

   d. A person is not ineligible because of subdivision a to the extent that the assets were transferred:

      (1) To the person's child described in paragraph 2 of subdivision c; or

(2) In trust for the sole benefit of the person's spouse, or the person's child described in paragraph 2 of subdivision c.

e. A person is not ineligible because of subdivision a to the extent that the person shows that:

(1) He or she intended to dispose of the assets either at fair market value or other valuable consideration, and makes a satisfactory showing that he or she had an objectively reasonable belief that adequate consideration was received;

(2) The assets were transferred exclusively for a purpose other than to qualify for medicaid; or

(3) A denial of eligibility would work an undue hardship, with respect to periods after the asset is returned, because the assigned or transferred asset has been returned to the assignor or transferor.

f. A person is not ineligible because of subdivision a to the extent that the asset transferred was:

(1) Household goods, personal effects, or an exempt motor vehicle.

(2) A burial fund of up to one thousand five hundred dollars, plus earnings on the burial fund.

(3) A burial space or agreement which represents the purchase of a burial space held for the transferor, the transferor's spouse, or any other member for the transferor's immediate family.

(4) Property essential to self-support, which means:

(a) Property which the transferor owns, to the extent the equity value does not exceed six thousand dollars, which produces annual income at least equal to six percent of equity value, and which the transferor is not actively engaged in using to produce income;

(b) Nonbusiness property which the transferor owns, to the extent the equity value does not exceed six thousand dollars when used to produce goods or services essential to daily activities or, for instance, when used to grow produce or livestock solely for consumption in the transferor's household; and

(c) Property which is essential to earning a livelihood.

(5) Assets set aside, by a blind or disabled (but not an aged) transferor, as a part of a plan approved by the social security administration, for the transferor to achieve self-support.

(6) Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288], or other assistance provided pursuant to a federal statute on account of a catastrophe which is declared to be a major disaster by the president, and interest earned on that assistance, but only for nine months following receipt of that assistance.

(7) Any amounts received from the United States which are attributable to underpayments of benefits due from one or more prior months, under title II or title XVI of the Act [42 U.S.C. 401 et seq. and 1381 et seq.], but only for six months following receipt of those amounts.

(8) The value of assistance, paid with respect to a dwelling unit occupied by the transferer, under the United States Housing Act of 1937 [42 U.S.C. 1437 et seq.], the National Housing Act [12 U.S.C. 1701 et seq.], section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949 [42 U.S.C. 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 U.S.C. 1701q(h)].

(9) Any amounts received by the transferor from a fund established by a state to aid victims of crime, to the extent that the transferor demonstrates that the amount was paid in compensation for expenses incurred or losses suffered as a result of a crime, but only for nine months following receipt of the amount.

(10) Relocation assistance amounts provided by a state or local government to the transferor, comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 [42 U.S.C. 4621 et seq.], which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636], but only for nine months following receipt of the amounts.

g. There is a presumption that a transfer for less than adequate consideration was made for purposes which include the purpose of qualifying for medicaid:

(1) In any case in which the person's assets remaining after the transfer produce income which, when added to other income available to the person, totals an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred in the month of transfer and in the twenty-nine months following the month of the transfer;

(2) In any case in which an application or inquiry about medicaid benefits was made by or on behalf of the person and the ~~person~~ individual making inquiry was informed of medicaid asset limits; or

(3) In any case in which the person was an applicant for or recipient of medicaid at the time the transfer was made.

h. An applicant or recipient who claims that an asset was transferred exclusively for a purpose other than to qualify for medicaid must show that a desire to receive medicaid benefits played no part in the decision to make the transfer and must rebut any presumption arising under subdivision g.

i. For purposes of this section:

(1) "Adequate consideration" means:

(a) In the case of an asset which is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and fungible commodities, one hundred percent of fair market value; and

(b) In the case of an asset which is subject to reasonable dispute concerning its value, seventy-five percent of fair market value.

(2) "Person" means an applicant for or recipient of medicaid.

(3) "Uncompensated value" means the difference between fair market value and the value of any consideration received.

2. The provisions of subsection 1 may not be applied to deny, to qualified medicare beneficiaries, special low-income medicare beneficiaries, and ~~to~~ qualified disabled and working individuals, benefits available solely due to their status as qualified medicare beneficiaries ~~and~~, special low-income medicare beneficiaries, or qualified disabled and working individuals.

3. Where the assignee or transferee is a relative of the assignor or transferor, services or assistance furnished by the assignee or transferee to the assignor or transferor may not be treated as consideration for the transferred property unless provided pursuant to a valid written contract entered into prior to the rendering of the service or assistance.

History: Effective December 1, 1991; amended effective December 1, 1991; June 1, 1992; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

75-02-02.1-36. Disregarded income.

1. The following types of income must be disregarded in determining medicaid eligibility for all persons except those residing in nursing facilities, the state hospital, the Anne Carlsen school-hospital, accredited residential treatment centers for children, and intermediate care facilities for the mentally retarded, and those persons receiving swing bed care in hospitals:

   a. Money payments made by the department in connection with foster care or the subsidized adoption program;

   b. Occasional small gifts;

   c. County general assistance that may be issued on an intermittent basis to cover emergency type situations;

   d. Income received as a housing allowance by programs sponsored by the United States department of housing and urban development and rent supplements or utility payments provided through the housing assistance program;

   e. Income of an individual living in the parental home if the individual is not included in the medicaid unit;

   f. Mandatory and optional supplementation payments;

   g. Educational loans, scholarships, grants, awards, and work study received by an undergraduate student;

   h. In-kind income except in-kind income received in lieu of wages;

   i. Per capita judgment funds paid to members of any Indian tribe under Pub. L. 92-254 or Pub. L. 93-134;

   j. Compensation received by volunteers participating in the action program as stipulated in the Domestic Volunteer Service Act of 1973 [Pub. L. 93-113], including foster

grandparents, older American community service program, retired senior volunteer program, service corps of retired executives, volunteers in service to America, and university year for action;

k. Benefits received through the low income home energy assistance program;

l. Training funds received from vocational rehabilitation;

m. Training allowances of up to thirty dollars per week provided through the tribal work experience program, ~~community work experience program, job assistance program~~ basic employment skills training, or job search. Funds in excess of thirty dollars per week are treated as unearned income;

n. Income tax refunds and earned income credits;

o. Needs-based payments, support services, and relocation expenses provided through programs established under the Job Training Partnership Act and through the job opportunities and basic skills program;

p. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by Pub. L. 94-114;

q. Income earned by a child, including income received through volunteers in service to America and Job Training Partnership Act; provided that the child is a full-time student or a part-time student who is not employed one hundred hours or more per month. A child retains status as a student during summer vacation if the child intends to return to school in the fall;

r. Payments from the family subsidy program;

s. The first fifty dollars per month of current child support received on behalf of children in the medicaid unit;

t. ~~Interest earned on and accrued to accounts;~~

~~u.~~ Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 [Pub. L. 91-646];

~~v.~~ u. Tax-exempt portions of payments made as a result of the Alaska Native Claims Settlement Act [Pub. L. 92-203];

~~w.~~ v. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts

made under the Wartime Relocation of Civilians Reparations Act [Pub. L. 100-383];

x. w. Agent orange payments;

~~y.~~ x. A loan from any source that is subject to a written agreement requiring repayment by the recipient;

~~z.~~ y. The medicare part B premium refunded by the social security administration;

~~aa.~~ z. Crime Victims Reparation Act payments;

~~bb.~~ aa. Lump-sum supplemental security income benefits in the month in which the benefit is received;

~~cc.~~ bb. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act; and

~~dd.~~ cc. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288] or some other federal statute, because of a presidentially declared major disaster, and interest earned on that assistance.

2. Only the following types of income may be disregarded in determining medicaid eligibility for persons residing in nursing facilities, the state hospital, the Anne Carlsen school-hospital, accredited residential treatment centers for children, and intermediate care facilities for the mentally retarded, and for persons receiving swing bed care in hospitals.

   a. Occasional small gifts; and

   b. For so long as 38 U.S.C. 32-03(f) remains effective, ~~forty five~~ fifty dollars of veterans administration improved pensions paid to a veteran, or a surviving spouse of a veteran, who has neither spouse nor child and who resides in a medicaid-approved nursing facility.

3. For purposes of this section:

   a. "Full-time student" means a person who attends school on a schedule equal to a full curriculum.

   b. "Student" means a child under the age of twenty-one years who regularly attends and makes satisfactory progress in a course of elementary or secondary school, college, university, or vocational training.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-38. Earned income.

1. Net earned income is determined by adding monthly net income from self-employment to other monthly earned income and subtracting the applicable deductions.

2. "Monthly net income from self-employment" means:

   a. In the case of self-employed persons whose business does not require the purchase of goods for sale or resale, seventy-five percent of gross monthly earnings from self-employment.

   b. In the case of self-employed persons whose business requires the purchase of goods for sale or resale, seventy-five percent of the result determined by subtracting cost of goods purchased from gross receipts, determined monthly.

   c. In the case of a business which furnishes room and board, monthly gross receipts less one hundred dollars per room and board client.

   d. In the case of self-employed persons in a service business which requires the purchase of goods or parts for repair or replacement, twenty-five percent of gross monthly earnings from self-employment.

   e. In the case of self-employed persons who receive income other than monthly, if the most recently available federal income tax return will accurately predict income, twenty-five percent of gross annual income, plus ~~the~~ any net gain ~~or minus the loss~~ resulting from the sale of capital items, plus ordinary gains or minus ordinary losses, divided by twelve. If the most recent available federal income tax return will not accurately predict income because the business has been recently established, because the business has been terminated or subject to severe reversal, because the applicant or recipient makes a convincing showing that actual net income is substantially less than twenty-five percent of gross profit, or because the county agency determines for any reason that actual net profits are substantially greater than twenty-five percent of gross profit, an amount determined by the county agency to represent the best estimate of monthly net income from self-employment will be used. A self-employed individual must provide, on a

monthly basis, the best information available on income and cost of goods. Income statements, when available, shall be used as a basis for computation. If the business is farming, or any other seasonal business, the annual net income, divided by twelve, is the monthly net income.

3. If earnings from more than one month are received in a lump sum payment, the payment must be divided by the number of months in which the income was earned, and the resulting monthly amounts are attributed to each of the months with respect to which the earnings were received.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-39. Income deductions.

1. The deductions described in this subsection must be allowed on either earned income or unearned income.

   a. The cost of premiums for health insurance carried by an individual or family. This cost may be deducted from income in the month the premium is paid or may be prorated over the months for which the premium affords coverage. ~~If the individual or family carries health insurance policies with duplicate coverage, the individual may choose the policy for which the premium is deducted. This deduction~~ Premium deductions may not be made in determining qualified medicare beneficiary, special low-income medicare beneficiary, and qualified disabled and working individual eligibility. For purposes of this deduction, premiums for health insurance include payments made for insurance, health care plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:

      (1) Limited to disability or income protection coverage;

      (2) Automobile medical payment coverage;

      (3) Supplemental to liability insurance;

      (4) Designed solely to provide payments on a per diem basis, daily indemnity, or nonexpense-incurred basis; or

      (5) Credit accident and health insurance.

b. (1) Medical expenses for necessary medical or remedial care may be deducted if the expense is:

(a) Incurred by a member of a medicaid unit in the month for which eligibility is being determined;

(b) Provided by a medical practitioner licensed to furnish the care;

(c) Not subject to payment by any third party, including medicaid and medicare;

(d) Not incurred for nursing facility services, swing bed services, or medicaid-waivered services during a period of ineligibility determined under section 75-02-02.1-33; and

(e) Claimed.

(2) Each medical or remedial care expense claimed for deduction must be documented by the applicant or recipient in a manner which describes the service, the date of the service, the amount of cost incurred, and the name of the service provider.

(3) This deduction may not be made in determining qualified medicare beneficiary, special low-income medicare beneficiary, and qualified disabled and working individual eligibility.

c. Court-ordered child and spousal support payments actually paid by a member of the medicaid unit on behalf of a person who is not a member of the medicaid unit.

d. The cost of premiums for ~~a~~ nursing insurance ~~policy~~ carried by an individual or the individual's spouse. ~~This~~ The cost of a premium may be deducted from income in the month the premium is paid or may be prorated over the months for which the premium affords coverage. ~~If the individual or family carries nursing insurance policies with duplicate coverage, the individual may choose the policy for which the premium is deducted. This deduction~~ Premium deductions may not be made in determining qualified medicare beneficiary, special low-income medicare beneficiary, and qualified disabled and working individual eligibility.

e. Reasonable child care expenses, not otherwise reimbursed, necessary to engage in employment or training.

f. With respect to each individual in the medicaid unit who is employed or in training, but who is not aged, blind,

disabled, or a child, thirty dollars as a work or training allowance.

g. Transportation expenses necessary to secure medical care provided for a member of the medicaid unit.

h. The cost of remedial care for an individual residing in a specialized facility. This deduction is limited to the difference between the facility rate and the regular medically needy income level. This deduction may not be made in determining qualified medicare beneficiary, special low-income medicare beneficiary, and qualified disabled and working individual eligibility.

i. Except with respect to income from aid to families with dependent children, supplemental security income, aid and attendance veterans' benefits, housebound veterans' benefits, veterans' clothing allowance, and need-based veterans' pensions, all aged, blind, and disabled applicants or recipients other than those residing in a nursing facility, the state hospital, an accredited residential treatment center for children, or the Anne Carlsen school-hospital, or receiving swing bed care in hospitals, twenty dollars, provided that:

(1) When more than one aged, blind, or disabled person lives together, no more than a total of twenty dollars may be deducted;

(2) When both earned and unearned income is available, this deduction must be made from unearned income; and

(3) When only earned income is available, this deduction must be made before deduction of sixty-five dollars plus one-half of the remaining monthly gross income made under subdivision e of subsection 2.

2. The deductions described in this subsection may be allowed only on earned income.

a. For all applicants or recipients except for aged, blind, or disabled applicants or recipients, mandatory payroll deductions and union dues withheld, or ninety dollars, whichever is greater;

b. Mandatory retirement plan deductions;

c. Union dues actually paid;

d. Expenses of a blind person, reasonably attributable to earning income;

e. For all aged, blind, or disabled applicants or recipients other than those residing in a nursing facility, the state hospital, or the Anne Carlsen school-hospital, or receiving swing bed care in a hospital, sixty-five dollars plus one-half of the remaining monthly gross earned income; provided that, when more than one aged, blind, or disabled person lives together, no more than sixty-five dollars, plus one-half of the remaining combined earned income, may be deducted; and

f. For all aged, blind, or disabled applicants or recipients residing in a nursing facility, the state hospital, an accredited residential treatment center for children, or the Anne Carlsen school-hospital, or receiving swing bed care in a hospital, mandatory payroll deductions actually withheld.

3. A deduction of payments made for services of a guardian or conservator may be made, up to a maximum deduction equal to ~~the greater of:~~

~~a.~~ ~~Five~~ five percent of countable gross monthly income excluding nonrecurring lump sum payments~~; or~~

~~b. An amount specifically approved as a reasonable fee in an order of a court with jurisdiction over the guardianship or conservatorship.~~

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-40. Income levels.

1. Levels of income for maintenance, in total dollar amounts, will be used as a basis for establishing financial eligibility for medicaid. The income levels applicable to individuals and units are:

a. Categorically needy income levels.

(1) Categorically needy aid to families with dependent children recipients - The income level which establishes aid to families with dependent children eligibility. Eligibility for medicaid exists as a result of aid to families with dependent children eligibility.

(2) Categorically needy aged, blind, and disabled recipients - ~~The~~ Except for individuals subject to

the nursing care income level, the income level which establishes supplemental security income eligibility.

b. Medically needy income levels.

(1) Regular income levels. Regular income levels are applied when a medicaid individual or unit resides in the individual's or the unit's own home or in a specialized facility, and when a medicaid individual has been screened as requiring nursing care, but elects to receive home and community-based services. The family size is increased for each unborn when determining the appropriate family size.

Number of Persons	Income Level Monthly	~~Yearly~~
1	~~$345~~ 369	~~$4140~~
2	~~400~~ 428	~~4800~~
3	~~435~~ 465	~~5220~~
4	~~530~~ 556	~~6360~~
5	~~600~~ 625	~~7200~~
6	~~665~~ 684	~~7980~~
7	~~705~~ 721	~~8460~~
8	~~740~~ 760	~~8880~~
9	~~770~~ 783	~~9240~~
10	~~795~~ 810	~~9540~~

For each person in the medicaid unit above ten, add twenty-one dollars to the monthly amount ~~and two hundred and fifty-two dollars to the yearly amount~~.

(2) Nursing care income level. The nursing care income level must be applied to residents receiving care in nursing facilities, intermediate care facilities for the developmentally disabled, the state hospital, the Riversedge facility, or the Anne Carlsen school-hospital, or receiving swing bed care in a hospital. This income level is ~~forty five~~ forty dollars monthly ~~and five hundred forty dollars yearly~~. This income level is effective for all full calendar months of nursing care for single individuals and for individuals with eligible family members at home. For institutionalized individuals with an ineligible community spouse, this income level is effective in the month of entry, during full calendar months, and in the month of discharge.

(3) Community spouse income level. The community spouse income level for a community spouse who is eligible for medicaid is subject to subdivision a, paragraph 1 of subdivision b, or subdivision c. The level for an ineligible community spouse is the maximum amount

permitted under 41 U.S.C. 1396r-5(d)(3)(C), as adjusted pursuant to 42 U.S.C. 1396r-5(g).

(4) Family member income level. Each additional family member living with the community spouse is allowed an income level equal to one-third of an amount determined in accordance with 42 U.S.C. 1396r-5(d)(3)(A)(i), less the monthly income of that family member. For purposes of this paragraph, "family member" has the meaning given in subdivision b of subsection 1 of section 75-02-02.1-24.

c. Poverty income level.

(1) Pregnant women and children under age six. The income level is equal to one hundred and thirty-three percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved. The family size is increased for each unborn when determining the appropriate family size.

(2) Qualified medicare beneficiaries. Income levels will be applied to individuals or family members living together whose family includes a member who is aged, blind, or disabled and who is entitled to part A ~~benefit~~ benefits under medicare. These income levels apply regardless of living arrangements. Individuals living apart from other family members are allowed separate income levels. The income level is equal to one hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to the family of the size involved.

(3) Children born after September 30, 1983. The income level is equal to one hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved, with respect to individuals and families including individuals born after September 30, 1983, who have attained at least the age of six years. The family size is increased for each unborn when determining the appropriate family size.

(4) Extended medicaid benefits. The income level is equal to one hundred and eighty-five percent of the official poverty line, as defined by the United

States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved. The family size is increased for each unborn when determining the appropriate family size.

(5) Qualified disabled and working individuals. Income levels will be applied to individuals or family members living together whose family includes a member who is disabled and who is entitled to part A benefits under medicare. The income levels apply regardless of living arrangements. Individuals living apart from other family members are allowed separate income levels. The income level is equal to two hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to the family of the size involved.

(6) Special low-income medicare beneficiaries. Income levels will be applied to individuals or family members living together whose family includes a member who is aged, blind, or disabled and who is entitled to part A benefits under medicare. These income levels apply regardless of living arrangements. Individuals living apart from other family members are allowed separate income levels. The income level is equal to one hundred ten percent, until January 1, 1995, and thereafter one hundred twenty percent, of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to the family of the size involved.

2. Determining the appropriate income level in special circumstances.

a. A child who is temporarily living out of the home of the child's parents, for the purpose of attending school, is not treated as living independently, but is allowed the regular income level for one in addition to the income level applicable for the family unit remaining at home.

b. During a month in which an individual with an eligible community spouse at home enters a nursing facility or leaves a nursing facility to return home, a month in which an individual enters a specialized facility or leaves a specialized facility to return home, or a month in which an individual elects to receive home and community-based services or terminates that election, the individual will be included in a family unit which also includes persons

remaining at home for the purpose of determining the family size and the application of the appropriate medically needy income level.

c. An individual without dependents who enters a nursing facility may continue at the regular income level for one if a physician certifies that the individual is likely to return to his or her home within six months.

d. A child who is living outside of the parental home, but who is not living independently; or a spouse who is temporarily living outside of the home to attend training or college, to secure medical treatment, because of temporary work relocation required by an employer, or for other reasons beyond the control of the spouse, is allowed a separate income level during all full calendar months during which the child or spouse lives outside the home.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-41. Deeming of income. Except as otherwise provided in this section, one hundred percent of the income of the ineligible medicaid unit in the home which exceeds the appropriate medicaid income level will be deemed to be available to all individuals residing in the home. ~~"Individuals residing in the home" include individuals who are physically present; individuals who are temporarily absent; individuals attending educational facilities; individuals receiving acute medical care; and individuals receiving service in a specialized facility.~~

1. Twenty-five percent of the income of that ineligible medicaid unit which exceeds the appropriate medicaid income level will be deemed available to an eligible individual receiving services in a specialized facility.

2. None of the income of the medicaid unit in the home will be deemed available to an eligible individual who resides, or is treated as residing, outside of the home of the medicaid unit on other than a temporary basis. Individuals who reside in a facility which provides nursing care services to them are residing outside the home on other than a temporary basis. Individuals receiving home and community-based services are treated as residing outside the home on other than a temporary basis.

3. None of the income of the medicaid unit in the home will be deemed available to an eligible child under the age of twenty-one or, if blind or disabled, under age eighteen, who is:

a. Living independently;

b. A child for whom adoption assistance maintenance payments are made under title IV-E;

c. A child for whom foster care maintenance payments are made under title IV-E;

d. A child, living in North Dakota, receiving title IV-E adoption assistance payments from another state; or

e. A child, in foster care placement in North Dakota, receiving a title IV-E foster care payment from another state.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

CHAPTER 75-03-14

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code chapter 75-03-14, Family Foster Care Homes.

Amends subsection 10 of section 75-03-14-03, relating to minimum physical standards for the home, to repeal the requirement that the home comply with all local fire ordinances and requirements and satisfactorily complete a fire inspection by the local fire inspector or the state fire marshal. The amendment would implement the intent of the Legislative Assembly in enacting Senate Bill No. 2048, which authorizes the department to require fire, heating, electrical, and other inspections of homes on a case-by-case basis.

The amendments are intended to conform the foster care program to requirements for federal reimbursement for foster care under the Adoption Assistance in Child Welfare Act of 1980, Public Law 96-272, Section 427, 94 Stat. 519, that foster care be provided in the least restrictive environment and in close proximity to the parental home.

The amendments were adopted as interim final rules effective July 1, 1993. A failure to conform the foster care program to federal requirements would cause the department to be unable to lawfully claim federal funds otherwise available to provide foster care and would cause a loss of revenues appropriated to support the administration of the foster care program, a duty imposed upon the Department of Human Services by North Dakota Century Code chapter 50-11.

Prepared by:
Blaine L. Nordwall
November 26, 1993

75-03-14-03. Minimum physical standards for the home.

1. The home must be a dwelling, mobile home, housing unit, or apartment occupied by an individual or a single family, which may include other relatives of at least second degree of kinship.

2. The home should have an operational telecommunications device, and must have available to it some means to make immediate contact with authorities in emergencies.

3. a. The home shall have sleeping rooms adequate for the foster care family and the foster children.

   b. All sleeping rooms shall be outside rooms and have ample window space for light and ventilation.

c. A room with a floor more than thirty inches [76.20 centimeters] below ground level on all sides should be considered a basement. Basements can be used for sleeping accommodations for children twelve years of age and older. Basement bedrooms must be equipped with the appropriate fire alarms and smoke detectors as recommended by the local fire department or state fire marshal. A basement which shall be used for the care of children must be equipped with more than one exit. The exit may be an accessible window.

4. Exterior doors must be maintained in such a manner which would permit easy exit. Interior doors should be designed to prevent children from being trapped.

5. Every closet door must be one that can be opened from the inside. Any bathroom doors must be designed so that the opening of the locked door can be accomplished from the outside in an emergency.

6. The house and premises must be clean, neat, and free from hazards that jeopardize health and safety.

7. The home must be equipped with adequate light, heat, ventilation, and plumbing for safe and comfortable occupancy. The house and grounds must be in compliance with any applicable state and local zoning requirements.

8. Any source other than an approved municipal water supply must be tested annually for compliance for approved drinking water standards. The sample should be tested and approved by the North Dakota state department of health and consolidated laboratories and the report submitted to the licensing agency.

9. The milk supply must be obtained from an approved source.

10. ~~The home must comply with all local fire ordinances and requirements. The~~ If required by the department, the home must satisfactorily complete a fire inspection by the local fire inspector or, in the absence of a local fire inspector, the state fire marshal ~~at the time of initial licensing and every two years thereafter. If substantial physical changes take place in the home between these inspection requirements, the home must also be inspected at that time~~. All deficiencies noted during the inspection must be remedied.

11. The home must be equipped with the approved Underwriters' Laboratories fire extinguishers, smoke detectors, and smoke alarms as recommended by the local fire inspector or state fire marshal. They must be in working condition at all times. In an apartment building, the fire extinguisher, smoke detectors, and smoke alarms must be inside the apartment.

History: Effective December 1, 1984; amended effective July 1, 1993.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

CHAPTER 75-03-15

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code chapter 75-03-15, Reimbursement for Providers of Services to Foster Children - Group Homes and Residential Child Care Facilities

Amends subdivision d of subsection 4 of section 75-03-15-04, concerning the limitation on allowable administrative cost reimbursement, to increase the limitation on allowable administrative cost reimbursement from ten percent to fifteen percent of total allowable costs exclusive of administrative costs.

The amendments are intended to conform the foster care program to requirements for federal reimbursement for foster care under the Adoption Assistance in Child Welfare Act of 1980, Public Law 96-272, Section 427, 94 Stat. 519, that foster care be provided in the least restrictive environment and in close proximity to the parental home.

The amendments were adopted as interim final rules effective July 1, 1993. A failure to conform the foster care program to federal requirements would cause the department to be unable to lawfully claim federal funds otherwise available to provide foster care and would cause a loss of revenues appropriated to support the administration of the foster care program, a duty imposed upon the Department of Human Services by North Dakota Century Code chapter 50-11.

Prepared by:
Blaine L. Nordwall
November 26, 1993

75-03-15-04. 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 following the facility's previous fiscal year and be effective from the date the rate is set until a subsequent rate is set based upon a subsequent 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 the reasonable resident-related costs from the previous year are determined, adjustments are then applied to the historical cost to determine the prospective rate. Reasonable resident-related costs will be determined with reference to instructions issued by the department.

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. Rate adjustments to provide appropriate compensation may be requested where major unforeseeable expenses are incurred. Such requests may be made to the director of the children and family services division who shall determine if the expense is resident related and beyond the control of those responsible for the management of the facilities. The following adjustment methods will be used:

a. Salary and fringe benefits will be adjusted using historical costs and budgeted salaries for permanent employees as approved by the board or a designee of the board if such designated authority is noted in the facility's board minutes. All approved raises will be included from the effective date of the raise, but will be limited to the unadjusted annual percentage increase, if any, in the consumer price index for urban wage earners and clerical workers, nonfood expenditure categories, United States city average, as of the ending day of the fiscal year of the facility reflected in the cost report under consideration. Signed copies of the board or board designee approval of salaries must be submitted with the cost report.

b. Property costs will be included in the rate at the historical amount unless adjusted in accordance with these rules.

c. The other costs of the facility will be projected based upon the historical cost plus the annual percent of increase, if any, in the "all items" index of the consumer price index, for the United States city average, as of the facility's fiscal yearend.

4. Limitations.

a. The department may accumulate and analyze statistics on costs incurred by the 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.

b. At such time as federal regulations establish a ceiling on foster care rates for these facilities, that ceiling shall also be considered the maximum for title IV-E payment.

c. A facility is expected to maintain an average annual occupancy rate of seventy-five percent. The computed resident 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 of the minimum bed occupancy allowance may be made for new facilities or existing facilities at the discretion of the department.

d. Administrative cost shall be limited to ~~ten~~ fifteen percent of total allowable costs exclusive of administrative costs.

5. Adjustments and appeal procedures.

a. Rate adjustments may be made to correct errors subsequently determined.

b. An adjustment must be made for those facilities which have terminated participation in the program and have disposed of its depreciable assets or which have changed ownership.

c. Any requests for reconsideration of the rate should be filed with the children and family services division 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, department of human services, state capitol. The appeal will be governed by chapter 75-01-03.

History: Effective November 1, 1985; amended effective July 1, 1993.
General Authority: NDCC 50-06-16, 50-11-03
Law Implemented: NDCC 50-06-05.1, 50-11-01.3

CHAPTER 75-04-06

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code chapter 75-04-06, Mental Retardation-Developmental Disabilities Case Management Services

Amends section 75-04-06-04, concerning criteria for service eligibility - children birth through age two, to clarify the meaning of "high risk" children and to replace obsolete language.

The amendments are intended to conform the services to mentally retarded-developmentally disabled persons program to the requirements of Part H of Public Law 99-457, as amended by Public Law 102-119.

The amendments were adopted as interim final rules effective July 1, 1993. A failure to conform the services to the mentally retarded-developmentally disabled persons program to the requirements under this public law would cause the department to be unable to lawfully claim federal funds otherwise available and would cause a loss of revenues appropriated to support the administration of programs for persons with developmental disabilities, a duty imposed upon the Department of Human Services by North Dakota Century Code section 50-06-01.4(2).

Prepared by:
Blaine L. Nordwall
November 26, 1993

75-04-06-04. Criteria for service eligibility - Children birth through age two.

1. Service eligibility for children from birth through age two is based on distinct and separate criteria designed to enable preventive services to be delivered. Young children may have conditions which could result in substantial functional limitations if early and appropriate intervention is not provided. The collective professional judgment of the team must be exercised to determine whether the child is high risk or developmentally delayed, and may need early intervention services. If a child, age birth through two, is either high risk or developmentally delayed, he or she may be included on the caseload of a mental retardation-developmental disabilities case manager and considered for those services designed to meet specific needs. Eligibility for continued service inclusion through mental retardation-developmental disabilities case management must be redetermined ~~at~~ by age three using criteria specified in sections 75-04-06-02 and 75-04-06-03.

2. For purposes of this section:

a. ~~"High risk" means a child, age birth through two, whose development is related to diagnosed disorders of known etiology and which have relatively well-known expectancies for developmental outcome within specified ranges of developmental delay.~~

~~b.~~ "Developmentally delayed ~~infant~~" means a child, age birth through two:

(1) ~~An infant who~~ Who is performing twenty-five percent below age norms in two or more of the following areas:

(a) Cognitive development;

(b) Gross motor development;

(c) Fine motor development;

(d) Sensory processing (hearing, vision, haptic);

(e) ~~Language~~ Communication development (expressive or receptive);

(f) ~~Psychosocial~~ Social or emotional development; or

(g) ~~Self-help skills~~ Adaptive development; or

(2) ~~An infant who~~ Who is performing at fifty percent below age norms in one or more of the following areas:

(a) Cognitive development;

(b) Physical development, including vision and hearing;

(c) ~~Language and speech~~ Communication development (expressive and receptive);

(d) ~~Psychosocial~~ Social or emotional development; or

(e) ~~Self-help skills~~ Adaptive development.

b. "High risk" means a child, age birth through two:

(1) Who, based on a diagnosed physical or mental condition, has a high probability of becoming developmentally delayed; or

(2) Who, based on informed clinical opinion which is documented by qualitative and quantitative evaluation

information, has a high probability of becoming developmentally delayed.

History: Effective July 1, 1991; amended effective July 1, 1993.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-01.2-02, 50-06-05.3

TITLE 81

Tax Commissioner

STAFF COMMENT: Sections 81-03-05.1-07 and 81-03-05.1-08 contain all new material but are not underscored so as to improve readability.

81-03-05.1-07. Net operating losses.

1. A North Dakota net operating loss must be computed after the allocation and apportionment of a taxpayer's income or loss to North Dakota.

2. A North Dakota net operating loss may be carried back or carried forward for the same number of years as a federal loss of like character, e.g., regular net operating loss, product liability loss, or foreign expropriation loss.

3. Irrespective of a corporation's treatment of a federal net operating loss, to carry forward a North Dakota net operating loss a corporation must make an election to do so on an original return that is timely filed for the year in which the loss was incurred. If an election is not made, the loss must be carried back.

4. If a corporation does not file a consolidated corporation income tax return pursuant to section 81-03-05.1-08, the corporation's North Dakota net operating loss may be carried back or carried forward even if:

   a. The ownership of the corporation in the loss year is not the same as the ownership in each of the years to which the loss is carried, e.g., the corporation is acquired by another corporation.

   b. The filing method used by the corporation in the loss year is not the same as the filing method used in each of the

years to which the loss is carried, e.g., separate entity filing versus combined reporting.

5. If a corporation files a consolidated corporation income tax return pursuant to section 81-03-05.1-08, a North Dakota net operating loss must be computed for each corporation included in the consolidated return for the year in which the loss was incurred. This net operating loss may be carried back or carried forward subject to the following conditions:

   a. If an election is made by the corporation filing the consolidated return to carry forward North Dakota net operating losses, each corporation included in the consolidated return must carry forward its North Dakota net operating loss.

   b. Each corporation included in the consolidated return may carry back or carry forward its net operating loss to the extent that the corporation had North Dakota taxable income in the year to which the loss is carried.

6. The commissioner may audit a North Dakota net operating loss and the taxable income of the year to which the loss is carried.

7. A corporation may not carry forward its North Dakota net operating loss if the corporation has been dissolved as a separate corporate entity.

8. This section is effective for all tax years beginning after December 31, 1992.

History: Effective December 1, 1993.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-01.3(2)(3)

81-03-05.1-08. Consolidated returns.

1. As used in this section:

   a. "Combined report" means a tax return on which the tax liability is computed using the method described in chapters 81-03-05.2 and 81-03-05.3.

   b. "Consolidated return" means a single corporation income tax return that reports the tax liability of more than one corporation engaged in business in or having sources of income from North Dakota.

   c. "Taxpayer" means a corporation liable to report income or loss to North Dakota.

2. Only taxpayers who compute their liability using the combined report method may file a consolidated return. They must obtain written permission to do so from the commissioner prior to filing the return. Permission to file a consolidated return will be granted by the commissioner if the taxpayer:

   a. Identifies the name and federal identification number of the corporation that will file the consolidated return.

   b. Reports the tax liabilities of all taxpayers in the combined report.

3. If permission to file a consolidated return has been obtained, all taxpayers in the combined group must continue to file a consolidated return until the commissioner is notified in writing of the combined group's intent to file individual returns.

4. This section is effective for all tax years beginning after December 31, 1992.

Example:	Corporation A	Corporation B	Corporation C	Combined Amounts
Facts:				
Federal taxable income	$ 500,000	$ (80,000)	$ 40,000	$ 460,000
Federal tax accrued	144,815	0	11,585	156,400
North Dakota property	150,000	0	10,000	
Total property	150,000	100,000	10,000	260,000
North Dakota payroll	60,000	0	40,000	
Total payroll	60,000	100,000	40,000	200,000
North Dakota sales	1,000,000	0	200,000	
Total sales	1,500,000	300,000	200,000	2,000,000

Computation of Apportionment Factor	Corporation A		Corporation C	
North Dakota property	$ 150,000		$ 10,000	
Combined property	260,000		260,000	
Property factor		.576923		.038462
North Dakota payroll	60,000		40,000	
Combined payroll	200,000		200,000	
Payroll factor		.300000		.200000
North Dakota sales	1,000,000		200,000	
Combined sales	2,000,000		2,000,000	
Sales factor		.500000		.100000
Sum of factors		1.376923		.338462
Apportionment factor		.458974		.112821

Computation of Tax Liability	Corporation A	Corporation C	Total Tax Due
Federal taxable income	$ 460,000	$ 460,000	
Federal tax deduction	156,400	156,400	
North Dakota apportionable income	303,600	303,600	
Apportionment factor	.458974	.112821	
North Dakota taxable income	139,345	34,252	
North Dakota tax due (1990 rates)	12,966	2,168	$ 15,134

History: Effective December 1, 1993.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-14

TITLE 82

Teachers' Fund for Retirement, Board of Trustees of the

APRIL 1994

CHAPTER 82-03-01

82-03-01-01. Vested teachers' withdrawal from fund - Refund. When a teacher who is vested terminates covered employment, the teacher may claim a refund of assessments paid to the fund during membership. A teacher wishing to claim a refund of assessments must request an application from the ~~fund~~ administrative office, complete the form, and return it for processing. Once the application has been processed, the refund will be paid after one hundred twenty calendar days have expired from the last date of covered employment.

The waiting period may be waived by the board if the teacher produces evidence that the teacher will not be returning to covered employment in North Dakota. The following evidence is required before the board will grant a waiver:

1. Copy of the teacher's resignation letter;

2. Proof that the teacher's employer has accepted the resignation, i.e., letter or copy of official school board minutes; and

3. Proof that the individual has either accepted noncovered employment or permanently relocated out of state.

No refund can be issued to a teacher who has terminated a teaching position only for the summer months or for a leave of absence.

History: Effective September 1, 1990; amended effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-20

82-03-01-04. Repurchase of forfeited service credit. An individual who has forfeited service credit under section 82-03-01-03 may repurchase such service upon returning to teach or becoming an active dual member in accordance with the following:

1. The teacher must have earned at least one year of benefit service credit following the return to teaching. If the repurchase payment is made within five years from the date of initial eligibility, the repurchase cost must be the amount withdrawn plus interest.

2. An active member of the public employees retirement system or the highway patrol retirement system may repurchase withdrawn service credit from the fund. If the repurchase is made within five years from the date of initial eligibility or July 1, 1987, the repurchase cost must be the amount withdrawn plus interest.

3. If the repurchase payment is not made within five years, the cost of the remaining service credit will be calculated on an actuarial equivalent basis.

4. The cost may be paid in a lump sum or in installments. Installments may be made monthly, quarterly, semiannually, or annually for up to five years. Interest is charged on the unpaid balance.

5. If a teacher retires prior to full payment of the repurchase amount, service credit will be granted in proportion to the actual payments made or the teacher may elect to make a lump sum payment to complete the purchase or elect to have the payments included in a refund of the account balance.

6. If a teacher passes away prior to full payment of the repurchase amount, service credit will be granted in proportion to the actual payments made or the designated beneficiary may elect to make a lump sum payment to complete the purchase or elect to have the payments included in a refund of the account balance.

History: Effective September 1, 1990; amended effective May 1, 1992; April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-24

82-03-01-05. Purchase of benefit service credit. A teacher may purchase additional eligible benefit service credit in accordance with the following:

1. Out-of-state teaching service must be verified by the out-of-state retirement system under which the service was earned.

2. Military service must be verified by submitting military service discharge documents.

3. Professional education time must be verified by submitting an official transcript from the educational institution attended.

4. ~~Nonpublic teaching service must be certified by the nonpublic employer.~~

~~5.~~ Legislative service must be certified by the teacher's participating employer and must indicate the number of uncompensated days and salary information as required by the fund.

~~6.~~ 5. Service as a federal administrator or teacher must be verified by the federal agency which employed the teacher.

In all cases, the purchase cost must be on an actuarial equivalent basis determined by applying the actuarial factors adopted by the board.

The cost may be paid in a lump sum or in installments. Installments may be made monthly, quarterly, semiannually, or annually for up to five years. Interest is charged on the unpaid balance at the actuarial assumption rate for investment earnings.

If a teacher retires prior to full payment of the purchase amount, service credit will be granted in proportion to the actual payments made, or the teacher may elect to make a lump sum payment to complete the purchase or elect to have the payments included in a refund of the account balance.

If a teacher passes away prior to full payment of the purchase amount, service credit will be granted in proportion to the actual payments made or the designated beneficiary may elect to make a lump sum payment to complete the purchase or elect to have the payments included in a refund of the account balance.

History: Effective September 1, 1990; amended effective May 1, 1992; April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-24

CHAPTER 82-05-01

82-05-01-01. Application for benefits. A teacher or beneficiary must make written application for benefits on enrollment forms provided by the fund before benefits can be paid. The enrollment form must be signed and notarized. The form of payment option selected may not be changed after the first benefit payment has been accepted by the teacher or beneficiary.

Retirement benefits may not be issued to a teacher who has terminated a teaching position only for the summer months or for a leave of absence.

History: Effective September 1, 1990; amended effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-10

82-05-01-03. Designation of beneficiary. The teacher shall designate a survivor or a beneficiary on written forms provided by the fund prior to the beginning of benefit payments under a joint and survivor annuity. After benefit payments have begun, the teacher may not change the designated survivor or beneficiary~~.~~, except under the following circumstances:

1. If the designated beneficiary precedes the teacher in death, the teacher, upon remarriage, may name the new spouse as the designated beneficiary under the same retirement option selected at retirement.

2. If the marriage of a teacher and the designated beneficiary is dissolved and if the divorce decree provides for sole retention of the retirement benefit by the teacher, the teacher upon remarriage may name the new spouse as the designated beneficiary under the same retirement option selected at retirement.

The teacher must provide proof of good health before the board can permit a change in the designated beneficiary. A medical examination conducted by a licensed medical doctor is required.

The teacher is required to provide proof of age for the new beneficiary.

The board must adjust the monthly retirement benefit to the actuarially equivalent amount based on the new designated beneficiary's age.

History: Effective September 1, 1990; amended effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-16

82-05-01-04. Proof of marriage. A teacher applying for a retirement benefit with a continuing annuity under the joint and survivor option must provide proof of marriage, if the designated beneficiary is more than ten years younger than the teacher.

History: Effective May 1, 1992; amended effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-10

82-05-02-02. Optional forms of benefit payments. A teacher may elect to receive benefits under article 82-05 in any one of the following forms:

1. Option I. A one hundred percent joint and survivor annuity.

2. Option II. A fifty percent joint and survivor annuity.

3. Option III. An annuity payable to the teacher or the teacher's designated beneficiary for the life of the teacher or sixty months, whichever is longer.

4. Option IV. An annuity payable to the teacher or the teacher's designated beneficiary for the life of the teacher or one hundred twenty months, whichever is longer.

Benefits under the optional forms of payment must be determined on an actuarial equivalent basis. The teacher's choice of benefit under this section is irrevocable; provided, however, that if a teacher's beneficiary predeceases the teacher under options I or II, or if the marriage of a teacher and the designated beneficiary is dissolved and if the divorce decree provides for sole retention of the retirement benefit by the teacher, the form of benefits automatically reverts to the standard form of benefit under section 82-05-02-01.

History: Effective September 1, 1990; amended effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-16

82-05-02-04. Retroactive retirement eligibility. Upon application, a teacher is entitled to receive benefits retroactive to the date of initial eligibility in accordance with the benefit option selected. Teachers may not collect interest on retroactive back benefits.

History: Effective September 1, 1990; amended effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-10, 15-39.1-16

82-05-03-02. **Death benefits - Proof of death.** Death benefits will not be paid until the teacher's beneficiary or legal heir submits to the fund proof of the teacher's death. A death certificate will normally be required as proof of death, but in certain cases, the ~~executive director~~ retirement officer may accept proof other than a death certificate.

History: Effective September 1, 1990; amended effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-17

82-07-01-03. Determination of disability - Procedures. The following procedures govern the determination of disability benefits under the fund:

1. Application.

   a. Application for disability benefits must be made within six months from the last date of covered employment on the form provided by the fund.

   b. If the fund member is unable or unwilling to file an application, the teacher's employer or legal representative may file the teacher's disability application.

   c. The application must explain the cause of the disability, the limitations caused by the disability, the treatment being followed, and the effect of the disability on the individual's ability to perform as a teacher.

2. Medical examination.

   a. The applicant for disability retirement must provide the fund with medical examination reports.

   b. An initial medical examination should be completed by the teacher's attending or family physician on the medical examination form provided by the fund. If deemed necessary by the fund's medical consultant, an additional examination must be completed by a specialist in the disability involved. Available medical or hospital reports may be accepted in lieu of a medical examination report if deemed acceptable by the fund's medical consultant.

   c. The fund is not liable for any costs incurred by the applicant in undergoing medical examinations and completing and submitting the necessary medical examination reports, medical reports, and hospital reports.

3. Medical consultant.

   a. The fund shall retain a medical doctor to act as its consultant on disability retirement applications.

   b. The medical consultant shall review all medical information provided by the applicant.

c. The medical consultant shall advise the board regarding the medical diagnosis and whether the condition is a "total disability".

4. Decision.

a. The board shall consider applications for disability retirement at regularly scheduled board meetings. The discussion concerning disability applications must be confidential and closed to the general public.

b. The applicant must be notified of the time and date of the meeting and may attend or be represented.

c. The ~~executive director~~ retirement officer shall provide to the board for its consideration a case history brief that includes membership history, medical examination summary, and the medical consultant's conclusions and recommendations.

d. The board shall make the determination for eligibility at the meeting unless additional evidence or information is needed.

e. If awarded, the disability annuity is payable on, or retroactive to, the first day of the month following the teacher's termination from covered employment.

5. Redetermination and recertification.

a. A disabled annuitant is subject to redetermination and recertification to maintain eligibility. The schedule for redetermination and recertification must be as follows:

(1) Temporary disability. On July first, following the first anniversary date of disability retirement, and every two years thereafter (unless normal retirement is reached). No further recertification is required after the fourth recertification of temporary disability has been filed and accepted.

(2) Permanent disability. On July first, following the second anniversary date or disability retirement, and five years thereafter. No further recertification is required after the second recertification of permanent disability has been filed and accepted.

b. The fund may require additional recertifications, or waive the necessity for a recertification, if the facts warrant this action.

c. The fund will send a recertification form to the disabled annuitant to be completed and sent back to the fund.

d. The fund may require the disabled annuitant to be reexamined by a doctor at the annuitant's own expense. The submission of medical reports by the teacher, and the review of those reports by the fund's medical consultant, may satisfy the reexamination requirement.

e. The ~~executive director~~ retirement officer will make the redetermination and recertification decision and bring the matter to the board only if warranted. The disability annuitant may appeal an adverse recertification decision to the board in the same manner as the initial determination.

f. If it is determined that the disability annuitant was not eligible for benefits during any time period when benefits were provided, the executive director may do all things necessary to recover the erroneously paid benefits.

History: Effective September 1, 1990; amended effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-18

82-08-01-02. Qualified domestic relations order procedures. Upon receipt of a domestic relations order, the retirement officer shall:

1. Send an initial notice to each person named therein, together with an explanation of the procedures followed by the fund.

2. If the ~~account is in pay status or begins pay status during the review, segregate in a separate account of the fund or in an escrow account amounts which the alternative payee would be entitled to by direction of the order, if any~~ teacher or alternate payee receives any distribution that should not have been paid per the order, the teacher or alternate payee is designated a constructive trustee for the amount received and shall immediately notify the retirement and investment office and comply with written instructions as to the distribution of the amount received.

3. Review the domestic relations order to determine if it is a qualified order.

4. If the order is determined to be qualified within eighteen months of receipt:

   a. Send notice to all persons named in the order and any representatives designated in writing by such person that a determination has been made that the order is a qualified domestic relations order.

   b. Comply with the terms of the order.

   c. Distribute the amounts~~, plus interest, to the alternate payee if a segregated account or an escrow account has been established for an alternate payee~~ as outlined in the order.

5. In the event that the order is determined not to be a qualified domestic relations order or a determination cannot be made as to whether the order is qualified or not qualified within eighteen months of receipt of such order:

   a. Send written notification of such to all parties.

   b. ~~Distribute the amounts in the segregated account or escrow account, plus interest, to the person or persons who would be entitled to receive such amount in the absence of an order if a segregated account or an escrow account has been established for an alternate payee.~~

~~c.~~ Apply the qualified domestic relations order prospectively only if determined after the expiration of the eighteen-month period the order as modified, if applicable, is a qualified domestic relations order.

History: Effective September 1, 1990; amended effective May 1, 1992; April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-12.2

STAFF COMMENT: Section 82-08-01-03 contains all new material but is not underscored so as to improve readability.

82-08-01-03. Format for a qualified domestic relations order. A qualified domestic relations order must be substantially in the following form:

ACTIVE MEMBERS

STATE OF NORTH DAKOTA IN DISTRICT COURT

COUNTY OF _____ _____ JUDICIAL DISTRICT

_____,)
)
Plaintiff,) QUALIFIED DOMESTIC
) RELATIONS ORDER
)
-vs-) Case No. _____
)
_____,)
)
Defendant.)

. . . . . .

This Order is intended to meet the requirements of a "Qualified Domestic Relations Order" relating to the North Dakota Teachers' Fund for Retirement, hereafter referred to as the "Plan". The Order is made pursuant to North Dakota Century Code section 15-39.1-12.2. The Order is an integral part of the judgment entered on [DATE OF DIVORCE] granting a divorce to the above-entitled parties. [This Order is also drawn pursuant to the laws of the state of North Dakota relating to the equitable distribution of marital property between spouses and former spouses in actions for dissolution of a marriage.] or [This Order is drawn pursuant to the laws of the state of North Dakota relating to the provision of child support to a minor child in actions for dissolution of a marriage.]

BACKGROUND INFORMATION

[MEMBER'S NAME AND SOCIAL SECURITY NUMBER] is the participating member whose last known address is [MEMBER'S ADDRESS]. The member's date of birth is [MEMBER'S D.O.B.].

[ALTERNATE PAYEE'S NAME AND SOCIAL SECURITY NUMBER] is the alternate payee whose last known address is [ALTERNATE PAYEE'S ADDRESS]. The alternate payee's date of birth is [ALTERNATE PAYEE'S D.O.B.].

The participating member and the alternate payee were married on [DATE OF MARRIAGE].

IT IS HEREBY ORDERED THAT:

I. BENEFITS

Benefits under the plan are distributed as follows: (Choose one)

1. The alternate payee is awarded [%] of the member's accrued annuity benefit as of [DATE OF DIVORCE]; (OR)

2. The alternate payee is awarded [$] of the member's accrued annuity benefit as of [DATE OF DIVORCE].

II. TIME OF BENEFIT RECEIPT

Benefit payments to the alternate payee will begin: (Choose one)

1. When the participating member reaches normal retirement age under the plan. (OR)

2. When the participating member qualifies for early retirement. (Note: Benefits in this event are payable even if the member has not separated from covered employment.) (OR)

3. When the alternate payee reaches [DATE OR EVENT]. (Note: The date or event must be after the date participating member would qualify for early retirement.) (OR)

4. When the participating member retires.

III. DURATION OF PAYMENTS TO ALTERNATE PAYEE

NOTE: Choose the appropriate optional language as applicable under the following rules:

- Choose option A if the benefits to the alternate payee are to be paid over the alternate payee's life. Option A must be chosen if the benefits to the alternate payee are to begin before the member's benefits are in pay status.

- Choose option B if the benefits to the alternate payee are to be paid over the member's life under the single life annuity option with no surviving spouse annuity benefits upon the member's death.

- Choose option C if the benefits to the alternate payee are to be paid over the member's life under one of the plan's joint and survivor or term certain and life options with the alternate payee as the survivor beneficiary for continuing annuity payments upon the member's death.

A. OVER LIFE OF THE ALTERNATE PAYEE (Choose one)

1. The payments shall be made to the alternate payee on a monthly basis over the life of the alternate payee and shall cease upon the alternate payee's death. The payment shall be calculated on the basis of a single life annuity and will be actuarially adjusted based upon the plan's assumptions to reflect the life expectancy of the alternate payee.

(OR)

2. The payments shall be made to the alternate payee on a monthly basis over the life of the alternate payee and calculated on the basis of:

(Choose one)

(a) a 5-year term certain and life option; (OR)

(b) a 10-year term certain and life option.

Upon the alternate payee's death, payments will continue to the alternate payee's designated beneficiary under the term certain and life option identified above.

B. OVER THE LIFE OF THE PARTICIPATING MEMBER (SINGLE LIFE ANNUITY)

The payments shall be made to the alternate payee on a monthly basis over the life of the participating member and shall cease upon the member's death.

C. OVER THE LIFE OF THE PARTICIPATING MEMBER (SURVIVOR OR TERM CERTAIN AND LIFE ANNUITY)

The payments shall be made to the alternate payee on a monthly basis over the life of the participating member with a continuing monthly annuity payable to the surviving alternate payee after the member's death. The amount of the payments to the alternate payee will be calculated on the basis of: (Choose one)

(a) a 100% joint and survivor annuity option (OR)

(b) a 50% joint and survivor annuity option (OR)

(c) a 5-year term certain and life option (OR)

(d) a 10-year term certain and life option.

IV. MEMBER WITHDRAWS FROM RETIREMENT SYSTEM (Choose one)

A. If the participating member discontinues employment and withdraws the member account in a lump sum the alternate payee shall receive [___%] of the member's account balance as of [DATE OF DIVORCE] accumulated with interest as required by the Plan from the divorce date until the refund is paid; (OR)

B. If the participating member discontinues employment and withdraws the member account in a lump sum, the alternate payee shall receive [$_____] from the member's account balance accumulated with interest as required by the Plan from [DATE OF DIVORCE] until the refund is paid. [Note: The dollar amount in this option cannot exceed the member's account balance.]

V. LIMITATIONS OF THIS ORDER (Order must reflect all provisions of this section.)

A. This order recognizes the existence of the right of the alternate payee to receive all OR a portion of the benefits payable to the participating members as indicated above.

B. Nothing contained in this Order shall be construed to require any Plan or Plan administrator:

1. To provide to the alternate employee any type or form of benefit or any option not otherwise available to the participating member under the Plan.

2. To provide the alternate payee benefits, as determined on the basis of actuarial value, not available to the participating member.

3. To pay any benefits to the alternate payee which are required to be paid to another alternate payee under another order previously determined by the Plan administrator to be a qualified domestic relations order.

4. To apply the provisions of this Order to disability benefits that the participating member may be entitled to receive.

C. If the alternate payee dies prior to receipt of benefits under this order, the entire amount that may be due to the alternate payee reverts to the participating member.

D. If the participating member dies prior to retirement, the alternate payee will receive _____% share of the member's survivor benefits as of [DATE OF DIVORCE].

E. The benefit enhancements provided by the North Dakota legislature for service during the marital relationship which are adopted after the end of the marital relationship apply to the alternate payee's portion of benefits under this order.

F. If participant or alternate payee receives any distribution that should not have been paid per this Order, the participant or alternate payee is designated a constructive trustee for the amount received and shall immediately notify TFFR and comply with written instructions as to the distribution of the amount received.

G. Alternate payee is ORDERED to report any payments received on any applicable income tax return in accordance with Internal Revenue Code provisions or regulations in effect at the time any payments are issued by TFFR. The plan is authorized to issue Form 1099R, or other applicable form on any direct payment made to alternate payee. Plan participant and alternate payee must comply with Internal Revenue Code and any applicable regulations.

H. Alternate payee is ORDERED to provide the plan prompt written notification of any changes in alternate payee's mailing address. TFFR shall not be liable for failing to make payments to alternate payee if TFFR does not have current mailing address for alternate payee at time of payment.

I. Alternate payee shall furnish a certified copy of this Order to TFFR.

J. The Court retains jurisdiction to amend this Order so that it will constitute a qualified domestic relations order under the plan even though all other matters incident to this action or proceeding have been fully and finally adjudicated. If TFFR determines at any time that changes in the law, the administration of the plan, or any other circumstances make it impossible to calculate the portion of a distribution awarded to alternate payee by this Order and so notifies the parties, either or both parties shall immediately petition the Court for reformation of the Order.

Signed this _____ day of _____, 19___.

_____
(Judge Presiding)

OR

RETIRED MEMBERS

This Order is intended to meet the requirements of a "Qualified Domestic Relations Order" relating to the North Dakota Teachers' Fund for Retirement, hereafter referred to as the "Plan". The Order is made pursuant to North Dakota Century Code section 15-39.1-12.2. The Order is an integral part of the judgment entered on [DATE OF DIVORCE] granting a divorce to the above-entitled parties. [This Order is also drawn pursuant to the laws of the state of North Dakota relating to the equitable distribution of marital property between spouses and former spouses in actions for dissolution of a marriage.] or [This Order is drawn pursuant to the laws of the state of North Dakota relating to the provision of child support to a minor child in actions for dissolution of a marriage.]

BACKGROUND INFORMATION

[MEMBER'S NAME AND SOCIAL SECURITY NUMBER] is the participating member whose last known address is [MEMBER'S ADDRESS]. The member's date of birth is [MEMBER'S D.O.B.].

[ALTERNATE PAYEE'S NAME AND SOCIAL SECURITY NUMBER] is the alternate payee whose last known address is [ALTERNATE PAYEE'S ADDRESS]. The alternate payee's date of birth is [ALTERNATE PAYEE'S D.O.B.].

The participating member and the alternate payee were married on [DATE OF MARRIAGE].

IT IS HEREBY ORDERED THAT:

I. BENEFITS

Benefits to the participating member under the plan are distributed as follows: (Choose one)

1. The alternate payee is awarded [%] of the monthly retirement benefit as of [DATE OF DIVORCE]; (OR)

2. The alternate payee is awarded [$] of the monthly retirement benefit as of [DATE OF DIVORCE].

II. TIME OF BENEFIT RECEIPT.

The benefits are payable to the alternate payee in the month following receipt of this order by the plan or plan administrator as the participating member is currently retired and receiving benefits under the Plan.

III. DURATION OF BENEFITS TO ALTERNATE PAYEE

NOTE: Choose the appropriate optional language as applicable under the following rules:

- Choose option A if the benefits to the alternate payee are to be paid over the alternate payee's life.

- Choose option B if the benefits to the alternate payee are to be paid over the member's life under the single life annuity option with no surviving spouse annuity benefits upon the member's death.

- Choose option C if the benefits to the alternate payee are to be paid over the member's life under one of the plan's joint and survivor or term certain and life options with the alternate payee as the survivor beneficiary for continuing annuity payments upon the member's death.

A. OVER LIFE OF THE ALTERNATE PAYEE (Choose one)

1. The payments shall be made to the alternate payee on a monthly basis over the life of the alternate payee and shall cease upon the alternate payee's death. The payments shall be calculated on the basis of a single life annuity and will be actuarially adjusted based upon the Plan's assumptions to reflect the life expectancy of the alternate payee.

   Upon the member's death, the alternate payee, if living, will receive the survivor benefits, if any, payable to the alternate payee under the annuity option existing at the time of the member's death.

(OR)

2. The payments shall be made to the alternate payee on a monthly basis over the life of the alternate payee and calculated on the basis of: (Choose one)

   (a) a 5-year term certain and life option; (OR)

   (b) a 10-year term certain and life option.

   Upon the alternate payee's death, payments will continue to the alternate payee's designated beneficiary under the term certain and life option identified above.

   Upon the member's death, the alternate payee, if living, will receive the survivor benefits, if any, payable to the alternate payee under the annuity option existing at the time of the member's death.

B. OVER THE LIFE OF THE PARTICIPATING MEMBER (SINGLE LIFE ANNUITY)

The payments shall be made to the alternate payee on a monthly basis over the life of the participating member and shall cease upon the member's death.

C. OVER THE LIFE OF THE PARTICIPATING MEMBER (SURVIVOR OR TERM CERTAIN AND LIFE ANNUITY)

The payments shall be made to the alternate payee on a monthly basis over the life of the participating member with a continuing monthly annuity payable to the surviving alternate payee after the member's death. The amount of the payments to the alternate payee will be calculated on the basis of: (Choose the survivor annuity option in existence at the time of the divorce or legal separation. NOTE: The option indicated may not result in a change from the existing original option elected by the member.)

(1) 100% joint and survivor option (OR)

(2) 50% joint and survivor option (OR)

(3) 5-year term certain and life option (OR)

(4) 10-year term certain and life option.

IV. LIMITATIONS OF THIS ORDER (Order must reflect all provisions of this section.)

A. This order recognizes the existence of the right of the alternate payee to receive all OR a portion of the benefits payable to the participating members as indicated above.

B. Nothing contained in this Order shall be construed to require any Plan or Plan administrator:

1. To provide to the alternate employee any type or form of benefit or any option not otherwise available to the participating member under the Plan.

2. To provide the alternate payee benefits, as determined on the basis of actuarial value, not available to the participating member.

3. To pay any benefits to the alternate payee which are required to be paid to another alternate payee under another order previously determined by the Plan administrator to be a qualified domestic relations order.

4. To apply the provisions of this Order to disability benefits that the participating member may be entitled to receive.

C. If the alternate payee dies prior to receipt of benefits under this order, the entire amount that may be due to the alternate payee reverts to the participating member.

D. The benefit enhancements provided by the North Dakota legislature for service during the marital relationship which are adopted after the end of the marital relationship apply to the alternate payee's portion of benefits under this order.

E. If the participant or alternate payee receives any distribution that should not have been paid per this Order, the participant or alternate payee is designated a constructive trustee for the amount received and shall immediately notify TFFR and comply with written instructions as to the distribution of the amount received.

F. Alternate payee is ORDERED to report any payments received on any applicable income tax return in accordance with Internal Revenue Code provisions or regulations in effect at the time any payments are issued by TFFR. The plan is authorized to issue form 1099R, or other applicable form on any direct payment made to alternate payee. Plan participant and alternate payee must comply with the Internal Revenue Code and any applicable regulations.

G. Alternate payee is ORDERED to provide the plan prompt written notification of any changes in alternate payee's mailing address. TFFR shall not be liable for failing to make payments to alternate payee if TFFR does not have current mailing address for alternate payee at time of payment.

H. Alternate payee shall furnish a certified copy of this Order to TFFR.

I. The Court retains jurisdiction to amend this Order so that it will constitute a qualified domestic relations order under the plan even though all other matters incident to this action or proceeding have been fully and finally adjudicated. If TFFR determines at any time that changes in the law, the administration of the plan, or any other circumstances make it impossible to calculate the portion of a distribution awarded to alternate payee by this Order and so notifies the parties, either or both parties shall immediately petition the Court for reformation of the Order.

Signed this _____ day of _____, 19____.

_____
(Judge Presiding)

History: Effective April 1, 1994.
General Authority: NDCC 15-39.1-07
Law Implemented: NDCC 15-39.1-12.2

TITLE 89

Water Commission

FEBRUARY 1994

CHAPTER 89-03-01

89-03-01-01. Submission of application for conditional water permit. Application for a conditional water permit must be submitted to the state engineer on the form provided by the state engineer. A map containing the information prescribed by the state engineer must accompany the application. The map must be prepared from a survey, aerial photograph, or topographic map, and must be certified by a licensed surveyor unless another type of map is first approved by the state engineer. Application forms are available at the office of the state engineer in Bismarck. A fee schedule and instructions for completion of the form are ~~attached to~~ enclosed with it. Information not requested in the application may nonetheless be required by the state engineer.

History: Amended effective April 1, 1989; February 1, 1994.
General Authority: NDCC 28-32-02, 61-03-13
Law Implemented: NDCC 61-04-03, 61-04-06(4)(f)

89-03-01-04. Notice of application.

1. When a proper application is filed, the state engineer will forward the appropriate number of completed notice of application forms to the applicant. The notice will include, but is not limited to, the following essential facts: the places and use of appropriation, the amount of and purpose for which the water is to be used, the applicant's name and address, and the newspaper in which the time and place of hearing will be published.

2. Upon receipt of the completed notice forms, the applicant shall send a notice of application by certified mail to the following:

   a. To the governing body of each city located wholly or in part within a one-mile [1.6-kilometer] radius of the proposed point of diversion.

   b. To the governing body of the township or other governing authority of each rural subdivision located wholly or in part within a one-mile [1.6-kilometer] radius of the proposed point of diversion. A rural subdivision is a subdivision which has lots of ten acres [4.05 hectares] or less and is geographically located outside of a city.

   c. To the governing body of the township or other governing authority for each rural tract of land which is owned by more than ten individuals and is located wholly or in part within a one-mile [1.6-kilometer] radius of the proposed point of diversion.

   d. Except for record title owners whose land falls within subdivision a, b, or c, each record title owner of real estate within a one-mile [1.6-kilometer] radius of the proposed point of diversion. The determination of title owners must be based on title records on file with the register of deeds of the appropriate county. For land subject to a contract for deed, the contract's grantor and grantee must both be notified.

   e. To each person holding a water permit for the appropriation of water from an appropriation site located within a radius of one mile [1.61 kilometers] of the location of the proposed water appropriation site. The state engineer shall provide the applicant a list of all persons who must be notified under this subdivision.

   f. To each municipal or public use water facility in the county in which the proposed water appropriation site is located. The state engineer shall provide the applicant a list of all municipal or public use water facilities that must be notified under this subdivision.

3. After notice of application has been mailed to those required by this section, the applicant shall properly complete an affidavit of notice and return it to the state engineer by certified mail. The affidavit of notice must state how the applicant determined the record title owners and must list the names and addresses of those who were sent notices by certified mail. This affidavit must be mailed to the state engineer within sixty days from the date the state engineer sent the notices of application to the applicant. If a properly completed affidavit of notice is not submitted within

sixty days, the priority date of the conditional water permit application will be amended to the date on which the state engineer receives the affidavit of notice. If a properly completed affidavit of notice is not submitted within one hundred twenty days, the application must be considered to have been withdrawn by the applicant.

History: Amended effective April 1, 1989; November 1, 1989; February 1, 1994.
General Authority: NDCC 28-32-02, 61-03-13
Law Implemented: NDCC 61-04-05

89-03-01-05. Publication of notice of hearing.

1. Upon receipt of an applicant's properly completed affidavit of notice by certified mail, the state engineer shall set a date for a hearing on the application.

2. The state engineer ~~will~~ shall provide a notice of hearing to ~~a newspaper of general circulation in the area of~~ the official newspaper of the county in which the proposed point of diversion is located and instruct the newspaper to publish the notice once a week for two consecutive weeks.

3. A copy of the notice of hearing shall be forwarded to the applicant so that the notice may be reviewed for accuracy.

4. The applicant must pay costs of publication.

History: Amended effective April 1, 1989; November 1, 1989; February 1, 1994.
General Authority: NDCC 28-32-02, 61-03-13
Law Implemented: NDCC 61-04-05

89-03-01-06.1. Consideration of evidence not contained in the state engineer's record. ~~The~~ Unless specifically left open by the hearing officer for the purpose of receiving additional evidence or testimony, the record of the state engineer's hearing must be closed at the conclusion of the state engineer's formal hearing. It is in the state engineer's discretion to receive testimony and evidence that is not contained in the record. However, the state engineer, before considering any evidence not contained in the record, will transmit the evidence to the parties of record for their examination and comment. The costs of reproducing and transmitting the evidence must be paid in advance by the party offering the evidence. Written comment or a request for a supplemental hearing must be submitted to the state engineer within ten days after transmittal of the additional evidence. Any request for a supplemental hearing must provide sufficient information to allow the state engineer to determine if a supplemental hearing is warranted. If a supplemental hearing is warranted, ten days' notice by certified mail must be afforded the parties of record to

inform them of the date, time, place, and nature of the hearing. All supplemental hearings must be held in Bismarck.

History: Effective April 1, 1989; amended effective February 1, 1994.
General Authority: NDCC 28-32-02, 61-03-13, 61-32-04
Law Implemented: NDCC 28-32-07

89-03-01-06.3. Record - Official notice. Unless specifically excluded by the hearing officer, the record in each water permit hearing heard by the state engineer includes, when available, the following reports or records, or portions thereof, relevant to the proposed appropriation:

1. United States soil conservation service reports including the North Dakota hydrology manual, North Dakota irrigation guide, and county soil survey reports.
2. United States geological survey and state water commission streamflow records.
3. United States geological survey and state water commission water quality data.
4. National oceanic and atmospheric administration climatological data.
5. United States geological survey topographic maps.
6. State water commission water permit files.
7. State water commission annual water use reports.
8. State water commission and United States geological survey ground water level data.
9. North Dakota board of water well contractors well completion reports.
10. State water commission test hole records.
11. State water commission water resource investigations reports and ground water study reports.
12. State water commission and United States geological survey county ground water study reports.
13. Information in state water commission files and records and other published reports.

History: Effective February 1, 1994.
General Authority: NDCC 28-32-06
Law Implemented: NDCC 28-32-06

TITLE 92

Workers Compensation Bureau

JANUARY 1994

CHAPTER 92-01-01

92-01-01-01. Organization and functions of the workers compensation bureau.

1. Organization of bureau.

   a. History. The Workmen's Compensation Act was passed in 1919 and is codified as North Dakota Century Code title 65. Effective July 1, 1987, the workmen's compensation bureau was changed to the workers compensation bureau. The Act requires the governor to appoint an executive director to administer the Act. The workers' compensation fund is an exclusive state fund which contracts with employers in this state to provide "no fault" insurance for workers injured in the course of employment.

   b. ~~Departments~~ Structure. The bureau is administered by the executive director and consists of ~~the following~~ six departments:

      (1) ~~Administration.~~

      ~~(2)~~ Claims and rehabilitation.

      ~~(3)~~ (2) Legal.

      ~~(4)~~ (3) Loss prevention.

      ~~(5)~~ (4) ~~Management~~ Administrative services.

~~(6)~~ (5) ~~Underwriting~~ Policyholder services.

(6) Medical and technical services.

c. Executive director. The governor shall appoint the director of the bureau who is subject to the supervision and direction of the governor and who shall serve at the pleasure of the governor. The appointment must be on a nonpartisan, merit basis, in accordance with chapter 54-42. The governor shall set the compensation and prescribe the duties of the director. The director may appoint the director of any division of the bureau which is established by the director. The appointment of a division director must be on a nonpartisan, merit basis.

The present executive director is:

~~Helen Tracy~~ Diane Alm
Executive Director

2. ~~Functions of bureau departments~~ Bureau functions. The executive director and the executive director's staff in the executive office are responsible for the traditional management functions of planning, programming, budgeting, staffing, evaluating, and reviewing. Some aspects of each of these functions are delegated to department directors and other managers.

Department functions are as follows:

a. ~~Administration. This department provides overall bureau supervision, procurement of supplies and equipment, and maintenance of executive offices and services.~~

~~b.~~ Claims and rehabilitation. This department investigates and manages individual workers' compensation claims for medical, disability, and rehabilitation benefits payments. Vocational rehabilitation ~~and managed medical care~~ services are provided through private vendors under contract to the bureau and managed by this department.

~~c.~~ b. Legal. This department provides support services to legal counsel provided to the bureau by the attorney general. The department provides administrative hearings and binding arbitration as options for dispute resolution. ~~The department administers provisions of the North Dakota Crime Victims Reparations Act.~~

~~d.~~ c. Loss prevention. This department assists employers with loss prevention program design, implementation and training, conducts workplace safety inspections and investigates industrial accidents. The department

~~inspects boilers operated throughout the state and maintains records of all inspections conducted by department and private insurance inspections~~ certifies safety programs for employers' qualification for premium discounts.

~~e.~~ d. ~~Management~~ Administrative services. This department ~~consists of four units: accounting and budgeting, data processing, research and statistics, and personnel. Accounting and budgeting accounts for all bureau funds, makes daily deposits, maintains records of workers' compensation fund investments, maintains a counterbalancing record of the financial transactions of other bureau departments and manages payroll. The unit also produces and reports on expenditures from the biennial budget and provides actuarial services to the bureau, including those provided through a contract with actuarial consultants, managed by this unit. The unit manages the bureau's management information systems. The data processing unit maintains statistical records of all claims for compensation and enters all medical payments into the computer system. The research and statistics unit conducts studies and analyses of all bureau functions and produces narrative and statistical reports of those activities. The personnel unit provides all bureau personnel services~~ coordinates basic administrative support for all departments and units. Its responsibilities include the monitoring of revenue, expenditures, and assets for the bureau. The department prepares bureau financial statements and apprises the executive director and department heads of the fiscal status of each of the units. It also has the responsibility for the personnel and payroll functions.

~~f.~~ e. ~~Underwriting~~ Policyholder services. This department manages employer insurance accounts, develops annual rate and classification structures (in consultation with the bureau's actuarial consultant), rates employer loss experience, determines coverage status, and manages extraterritorial agreements with other states. The department's field representatives audit employer accounts and investigate uninsured employers.

f. Medical and technical services. This department administers the managed care and medical bill audit programs and the medical and hospital fee schedules. The department administers the medical dispute resolution process for disputes arising out of managed care recommendations. The department also provides technical support to the claims and rehabilitation department in the processing of medical bills and in computer and claim form functions.

3. Inquiries. Inquiries regarding functions of the workers compensation bureau may be directed to the executive director, or to the respective operating department.

History: Amended effective February 1, 1982; October 1, 1983; August 1, 1987; October 1, 1987; January 1, 1992; January 1, 1994.
General Authority: NDCC 28-32-02.1
Law Implemented: NDCC 28-32-02.1

CHAPTER 92-01-02

92-01-02-01. Definitions.

1. "Act" means the North Dakota Workmen's Compensation Act ~~and the Uniform Crime Victims Reparations Act~~.

2. "Bureau" means the workers compensation bureau ~~and the uniform crime victims reparations board~~.

History: Amended effective August 1, 1987; January 1, 1994.
General Authority: NDCC 65-02-08, 65-13-05
Law Implemented: NDCC 65-02-08, 65-13-05

92-01-02-11.1. Fees. Fees for legal services provided by employees' attorneys and legal assistants working under the direction of employees' attorneys will be paid ~~following~~ as follows: during a period of constructive denial ~~or~~; when an order reducing or denying benefits ~~if the matter~~ is ~~not~~ submitted to ~~binding arbitration~~ administrative hearing, district court, or supreme court and the employee prevails~~, or in all cases if the matter~~; when an order reducing or denying benefits is submitted to binding arbitration~~,~~; when an informal decision reducing or denying benefits is submitted to binding dispute resolution and the employee prevails; and when the bureau notifies the employee to be available for vocational testing, which is the vocational assessment meeting or any formal standardized testing designed to measure interest, personality, aptitude, or intelligence, subject to the following:

1. Attorneys must be paid at the rate of seventy dollars per hour for all actual and reasonable time other than traveltime when the matter is submitted to binding arbitration and at the rate of eighty-five dollars per hour for all actual and reasonable time other than traveltime when the matter is submitted to formal administrative hearing and the employee prevails. Attorneys must be paid at the rate of seventy dollars per hour for all actual and reasonable time other than traveltime when the matter is submitted to binding dispute resolution and the employee prevails. Traveltime must be paid at the rate of forty dollars per hour.

2. Legal assistants and third year law students or law school graduates with a doctor of laws degree who are not licensed attorneys practicing under the North Dakota senior practice rule acting under the supervision of employees' attorneys must be paid at the rate of forty dollars per hour for all actual and reasonable time other than traveltime. Traveltime must be paid at the rate of twenty dollars per hour. A "legal assistant" means any person with a bachelor's degree, in a legal assistant or paralegal program, from an accredited

college or university, or a legal assistant certified as such by the national association of legal assistants.

3. Subject only to subsection 6, total fees paid by the bureau for all legal services in connection with a claim may not exceed the following:

   a. No fees may be paid prior to any of the following: constructive denial of a claim~~,~~; issuance of a pretermination notice informing ~~a claimant~~ an employee that the bureau intends to discontinue or suspend benefits~~, or~~; issuance of an administrative order~~,~~; or issuance of an informal decision; except as otherwise provided by this section.

   b. The sum of four hundred twenty dollars, plus reasonable costs incurred, for legal services following issuance of a pretermination notice, if an administrative order discontinuing or suspending benefits is not subsequently issued within sixty days or following the issuance of a pretermination notice if benefits are subsequently reinstated without the issuance of an administrative order.

   c. At a rate of seventy dollars per hour, the sum of seven hundred dollars, plus reasonable costs incurred, for legal services in connection with an offer by the bureau to make a lump sum settlement pursuant to North Dakota Century Code section 65-05-25.

   d. At a rate of seventy dollars per hour, the sum of ~~eight~~ five hundred dollars, plus reasonable costs incurred, for legal services when the bureau has notified the employee to be available for vocational testing ~~under North Dakota Century Code section 65-05.1-06.1~~.

   e. The total sum of eighteen hundred dollars, plus reasonable costs incurred, following constructive denial of a claim, or issuance of an administrative order under North Dakota Century Code chapter 28-32 reducing or denying benefits, for services provided if the employee prevails before an evidentiary hearing or deposition is scheduled by the bureau.

   f. The total sum of three thousand six hundred dollars, plus reasonable costs incurred, if the employee prevails after an evidentiary hearing or deposition is scheduled by the bureau or following such hearing or deposition.

   g. The total sum of six thousand dollars, plus reasonable costs incurred, if the employee prevails following a district court appeal.

h. The total sum of seven thousand two hundred dollars, plus reasonable costs incurred, if the employee prevails following an appeal to the North Dakota supreme court.

i. If the bureau has awarded benefits and the employer requests a rehearing, the bureau may, in its discretion, pay the employee's attorney fees and costs in connection with the rehearing. Total fees paid pursuant to this section may not exceed the sum of fifteen hundred dollars.

j. The total sum of two thousand dollars, plus reasonable costs incurred, for services in connection with binding arbitration, if the employee requests binding arbitration. The total sum of eight hundred fifty dollars, plus reasonable costs incurred, for services in connection with binding arbitration, if the employer requests binding arbitration.

k. The total sum of one thousand dollars, plus reasonable costs incurred, if the employee requests binding dispute resolution and prevails. The total sum of five hundred dollars plus reasonable costs incurred, if the employer requests binding dispute resolution.

4. ~~When an employer has timely filed a notice of refusal to consent to arbitration, the employee's attorney fees must be paid at the rate of seventy dollars per hour, subject to subdivision j of subsection 3.~~

~~5.~~ The maximum fees specified in subdivisions e, f, g, and h of subsection 3 include all fees paid by the bureau to one or more attorneys representing the employee in connection with the same claim at all stages in the proceedings, including those fees paid according to subdivisions b, c, and d of subsection 3. A "claim" includes all matters affecting rights of an employee in connection with one or more work injuries that are or reasonably could be included in a single administrative order or application for benefits.

~~6.~~ 5. Upon application of the employee's attorney and a finding by the bureau that the legal or factual issues involved in the dispute are unusually complex, the bureau may approve payment of reasonable fees in excess of the maximum fees provided by subdivisions e and f of subsection 3. If the bureau approves payment of fees in excess of the maximum fees provided by subdivisions e and f of subsection 3, the bureau shall set a new maximum fee, which may not be exceeded. Upon application of the employee's attorney to the appellate court and a finding by the court that the legal or factual issues involved in the appeal were unusually complex, the court may approve payment of reasonable fees in excess of the maximum fee provided by subdivisions g and h of subsection 3. All applications for additional fees in excess of the maximum fees

must contain a concise statement of the reasons for the request, including a summary of the factual or legal issues, or both, justifying such request, and an explanation concerning why the issues are unusually complex. Factors that must be considered in determining whether the factual or legal issues are unusually complex include:

a. The extent of the prehearing and posthearing discovery;

b. The number of depositions;

c. The number of legal or factual issues in dispute; and

d. Whether the legal issues or relevant statutes have been previously interpreted by the North Dakota supreme court.

~~7.~~ 6. All time must be recorded in increments of no more than six minutes (one-tenth of an hour). Contemporaneous time records must be kept and made available to the bureau, upon request made at any time within two years of the date recorded.

~~8.~~ 7. "Minimum" billings in increments greater than six minutes (one-tenth of an hour) are not permitted.

~~9.~~ 8. If the bureau is obligated to pay the employee's attorney fees, the attorney shall submit to the bureau a final statement upon resolution of the matter on forms provided by the bureau for that purpose, or on other forms acceptable to the bureau. An attorney representing an employee in a binding arbitration proceeding may submit monthly fee statements. All statements must show the name of the employee, claim number, date of the statement, date of each service or charge, itemization and a reasonable description of each service or charge, time and amount billed for each item, and total time and amounts billed. The employee's attorney must sign the fee statement. The signature of the attorney constitutes a certificate by the attorney that the attorney has not sought or obtained payment, or will seek payment of any fees or costs from the employee relative to the same services.

~~10.~~ 9. The following costs will be reimbursed:

a. Actual postage.

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

c. Copying charges, at twenty cents per page.

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

expenses may be reimbursed only if approval for such travel is given, in advance, by the bureau.

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

~~11.~~ 10. The following costs are not allowable:

a. Facsimile charges.

b. Express mail.

c. Additional copies of transcripts.

d. Costs incurred to obtain medical records.

e. Online computer-assisted legal research.

f. Copy charges for documents provided by the bureau.

An attorney who accepts compensation from the bureau for services pursuant to North Dakota Century Code section 65-02-08 and this section agrees to binding fee arbitration of all disputes relating to payment or denial of fees.

Fees for reporters must be: The sum of twenty-five dollars per hour, for appearance at hearing or other proceeding; plus, two dollars and fifty cents per page for transcription and original transcript, and twenty cents per page for additional copies. The bureau shall also reimburse reporters for mileage and other expenses, for reasonable and necessary travel, in the amounts that are paid state officials as provided by North Dakota Century Code sections 44-08-04 and 54-06-09.

History: Effective June 1, 1990; amended effective November 1, 1991; January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-02-17, 65-10-03

92-01-02-14. Procedure for penalizing employers accounts for failure to make payroll reports. When an employer fails to make payroll reports, the underwriter shall:

1. Set up an account (including an application listing one employee) for the purpose of assigning a number;

2. Request a payroll report; and

3. If the report is not provided, recommend to the director that a penalty be fixed by order in an amount not to exceed five hundred dollars.

The ~~underwriter~~ policyholder services director is the person appointed by the director to head the department at the bureau which sets rates and collects employers' premiums. The bureau employs one ~~head underwriter~~ policyholder services director and two assistant ~~underwriters~~ policyholder services directors.

History: Effective June 1, 1990; amended effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-04-12
Law Implemented: NDCC 65-04-12

92-01-02-16. Expiration date change. If a riskholder requests a change of expiration date on the riskholder's account, the following procedure will apply: The payroll will be prorated on a basis of the maximum of ~~three hundred dollars~~ one-twelfth of the statutory payroll cap per month per employee for the period of time involved. If the salary paid is less than the maximum amount of ~~three hundred dollars~~ one-twelfth of the statutory payroll cap per month, the full amount is reportable.

History: Effective June 1, 1990; amended effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01

92-01-02-17. Reporting payroll for period of noncompliance. If the noncompliance period of a new account is less than twelve months, the following procedure will apply: The payroll will be prorated on a basis of the maximum of ~~three hundred dollars~~ one-twelfth of the statutory payroll cap per month per employee for the period of time involved. If the salary paid is less than the amount of ~~three hundred dollars~~ one-twelfth of the statutory payroll cap per month, the full amount is reportable. If an employee ceased employment during the noncompliance period, the gross payroll of the employee is prorated over the period of noncompliance up to a maximum of ~~three hundred dollars~~ one-twelfth of the statutory payroll cap per month for the period of noncompliance.

History: Effective June 1, 1990; amended effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01

92-01-02-26. Binding arbitration. Binding arbitration pursuant to North Dakota Century Code ~~section~~ sections 65-02-15 and 65-02-17 ~~and selection and removal of binding arbitration panel members are~~ is governed by this section.

1. A request for binding arbitration may be filed with the North Dakota workers compensation bureau by an aggrieved employee or employer no later than thirty days after notice of an administrative order has been given as required by North Dakota Century Code section 28-32-13 and in lieu of a petition for reconsideration or rehearing or an appeal filed pursuant to North Dakota Century Code chapter 28-32~~, or following constructive denial of a claim~~. The request for binding arbitration must be in writing and must include a statement of the specific grounds upon which relief is requested. An aggrieved employee is an employee whose benefits have been reduced or denied by formal administrative order issued in accordance with North Dakota Century Code section 28-32-13.

2. ~~Upon receipt of a request for binding arbitration, the bureau shall serve notice on the employer by certified mail. In all cases relating to an injury for which the risk or payments are chargeable to an employer with an open account with the bureau, the employer has fifteen days from the date of mailing of the notice to give notice in writing to the bureau if the employer does not agree to submit to binding arbitration. The employer may notify the bureau of its consent to submit to binding arbitration prior to expiration of the fifteen days. An employer that fails to file timely notice in writing of refusal to consent to arbitration is deemed to have consented. If the employer files a timely notice of refusal to consent to arbitration, the matter is deemed submitted for reconsideration and formal rehearing and the employee is not entitled to arbitration. If the risk or payments are not chargeable to any employer, the employee is entitled to binding arbitration upon filing of the request with the bureau.~~ An employee is not entitled to an arbitration proceeding in cases in which the employee seeks a lump sum in lieu of medical expenses, or a lump sum in lieu of disability benefits under North Dakota Century Code section 65-05-25, or in cases where there is dispute concerning medical care, resolution of which is governed by dispute resolution procedures under North Dakota Century Code section 65-02-20, or in any case in which the employee is not responsible for medical charges under subsection 4 of North Dakota Century Code section 65-05-07.

3. ~~If the employee is self-employed or an officer, partner, or owner of all or any share of the employer's business, or if the employee or the employee's spouse is related by consanguinity within the third degree as determined by the common law, including adoptive relationships, to any person who is an officer or owner of any share of the employer's business, the employee and employer may not designate themselves as the employee and employer representatives on the arbitration panel.~~ An employer is not entitled to an arbitration proceeding in any dispute where an employee's claim is not chargeable to the employer.

4. ~~The panel member selected from the list of persons provided by the bureau shall serve as the chair of the panel. No person may act as an arbitrator if that person has any financial or personal interest in the matter, except when the employee and employer designate themselves as the employee and employer representatives according to North Dakota Century Code section 65-02-15 and this section.~~ Upon receipt of a request for binding arbitration, the bureau shall serve notice on the nonrequesting party by certified mail. The nonrequesting party is deemed to have consented to binding arbitration unless the nonrequesting party files a written objection to arbitration within twenty days from the date of mailing of the notice.

   a. If the nonrequesting party files a timely notice of refusal to consent to arbitration, the matter is deemed submitted for formal hearing. If an employer objects to binding arbitration, and the matter proceeds through formal hearing, the employee is entitled to payment of attorneys' fees in the hearing whether or not the employee prevails.

   b. If the employee seeks arbitration, the employer is a party entitled to notice where payments to the employee are chargeable to the employer. If the risk or payments are not chargeable to any employer, the employee is entitled to binding arbitration upon filing of the request with the bureau.

5. ~~Arbitration proceedings and hearings are governed by the following rules:~~ The bureau will contract with qualified arbitrators to provide arbitration services. Qualified arbitrators are individuals who:

   a. ~~The employee and employer shall select their panel representatives within fifteen days of the day a list of panel members is mailed to them by the bureau. The third panel member must be selected within fifteen days of selection of the first two panel members. In the event a party fails or refuses to make a selection in a timely manner, the bureau shall make the selection on that party's behalf by first selecting the person whose name appears at the top of the appropriate list and thereafter selecting persons in turn in the order their names appear on the appropriate list.~~ Are members of the American arbitration association with experience in adjudicating workers' compensation matters; or

   b. ~~The chair shall schedule a prehearing conference within thirty days of selection of the arbitration panel. The conference must be conducted by telephonic conference call whenever practicable. At the prehearing conference, the parties and the bureau shall identify the issues, identify~~

~~anticipated witnesses, including expert witnesses and their expected testimony, summarize the nature of evidence to be presented at hearing and identify all medical reports and records, deposition transcripts, and affidavits intended to be offered at the hearing. Deposition transcripts may not be admitted unless prior notice of the deposition and opportunity for cross-examination was provided to any interested party and the bureau.~~ Are deemed qualified by the director based upon substantial experience, training, education, fair judgment, independence, and neutrality. Qualified arbitrators will be placed on a register and selection will be sequential from the top name on the register on a rotating basis.

~~c. The parties and the bureau may waive oral hearing before the panel and stipulate to submission to the panel based on briefs and documentary evidence. The parties and the bureau may stipulate as to the procedure. The procedures set forth in this section apply if the parties and the bureau do not stipulate to a different procedure.~~

~~d. Following the prehearing conference, the chair shall schedule a hearing, if the parties and the bureau have not waived oral hearing, and serve notice of the hearing on the parties and the bureau at least twenty days prior to the date of the hearing.~~

~~e. Any party intending to offer any medical report or record, deposition transcript, or affidavit at the hearing must provide the other party and the bureau with a copy at least ten days prior to the hearing. If the bureau intends to offer any medical report or record, deposition transcript, or affidavit at the hearing in addition to documents in the bureau's file previously disclosed to the parties, the bureau shall provide the parties with copies of the additional reports or records at least ten days prior to the hearing. Upon service of any such document, the other party or parties or the bureau may, at any time before the day of the hearing, ask the chair in writing for permission to submit additional rebuttal documents or testimony not previously disclosed. The chair may in his or her discretion, or upon agreement of the parties and the bureau, grant any such request before the hearing, and the panel may in its discretion, or upon agreement of the parties and the bureau, allow the submission of such additional evidence at the hearing or hold the hearing record open for submission of such evidence following the hearing.~~

~~f. At the hearing, the parties may make an opening statement and shall submit their evidence and witnesses, beginning with the employee and followed by the employer and then~~

the bureau. The procedure may be varied upon agreement of the parties and the bureau or in the discretion of the arbitration panel upon request. Following submission of all evidence, the parties may make a closing argument or may, in the discretion of the panel, be required to submit briefs or written arguments within a time specified following the hearing.

g. Only such evidence as is relevant and material to the dispute may be received. The panel is the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence is not required. In the discretion of the panel, the record may be held open following the hearing for the submission of additional evidence as directed by the panel.

h. Witnesses must first be sworn as required by law. The chair is authorized to subpoena witnesses or documents upon request of a party or the bureau. Witnesses must be paid a statutory fee and are entitled to reimbursement for necessary travel as provided by law. The parties and the bureau are responsible for the costs and expenses of their own witnesses, provided that if the bureau offers the opinion of an expert retained by the bureau for the purpose of refuting the opinion of the employee's doctor, the parties are entitled to an opportunity to cross-examine the bureau's expert at the expense of the bureau. The chair may in his or her discretion and for good cause order the bureau to pay statutory witness fees and expenses for a party's witness upon written application by a party.

i. Hearings must be held in the region where the employee resides or, if the employee resides out of state, in the region which is the situs of the employment. Hearings may be conducted by telephonic conference call and any witness may testify by telephonic conference call upon agreement of the parties and the bureau. Hearings need not be recorded, but may be recorded upon agreement of the parties and the bureau or in the discretion of the panel. The party requesting the recording is responsible for the cost of recording the hearing and the cost of any transcript.

j. All decisions of the panel must be by a majority of the panel. The chair must be in the majority in order for the panel to issue a decision. If the panel is unable to reach a majority decision with the chair in the majority relative to any issue, the case must be submitted to a different panel. If the panel is able to reach a majority decision with the chair in the majority with respect to some issues but not all issues before it, the panel shall issue a written order making its decision and a statement

~~of all benefits awarded and denied relative to those issues decided by unanimous vote. The panel shall identify those issues on which the panel is unable to reach a majority decision, and those issues must be submitted to a different panel.~~

~~k. Following the close of the hearing, the panel shall issue a written order, including a brief summary of the case and its decision and a statement of all benefits awarded or denied. The order must be based on and in accordance with applicable substantive law. The panel may not issue a lump sum payment in lieu of medical benefits or in lieu of disability or rehabilitation benefits. The order must be signed by the chair and served on the parties by certified mail.~~

~~l. Any party or the bureau may request reconsideration or correction of an order upon written application filed with the chair and served on the other party and the bureau within ten days of service of the panel's decision. The other party and the bureau may file and serve a response within five days. The panel may deny the request with or without explanation, issue an amended or corrected order, or order that the proceeding be reopened for submission of additional evidence or briefs.~~

6. ~~The director may remove a member of the workers' compensation arbitration panel for cause.~~ One qualified arbitrator shall hear and decide a dispute. The arbitrator may be changed only upon a showing of financial interest, personal involvement, or good cause by the requesting party within fifteen days of the date the bureau notifies the parties of the name of the arbitrator.

~~a. Cause means the panel member has:~~

~~(1) Been convicted of a crime involving fraud or dishonesty or other crime that is substantially related to the qualifications, functions, and duties of a panel member;~~

~~(2) Solicited or received anything of value in connection with service as a panel member except compensation and expenses paid pursuant to this rule; or~~

~~(3) Willfully failed or refused without good cause to perform any duty or function imposed by law or this section or acted with gross negligence or incompetence or committed misconduct or malfeasance in connection with an arbitration proceeding.~~

~~b. Prior to removal of any member, the director shall serve notice of the charges or reasons for removal on the member~~

~~and provide the member with an opportunity to respond to the charges.~~

~~c. Upon removal of any member, the director shall give written notice of removal, a statement of the reasons for the action and a summary of the evidence upon which the decision was made, and notice of an opportunity for a hearing before the director upon request. Upon request, the director shall schedule a hearing at which time the member must be given an opportunity to present evidence and witnesses and cross-examine adverse witnesses. Following the hearing, the director shall affirm, modify, or reverse the decision to remove the member, and issue an order stating the decision and the reasons therefore.~~

7. ~~Panel members are not employees of the bureau or the state and are not entitled to compensation and may not solicit or accept any compensation or anything of value in connection with their services except as provided by this section. In addition to reimbursement for per diem and necessary travel at the rates paid state employees, additional compensation must be paid at a rate established by the bureau.~~ Prehearing conferences may be held upon agreement of the bureau and all parties. However, written filing or stipulation by the parties and the bureau shall be the preferred method for providing the other parties notice of witnesses and new evidence. The issues for resolution must be confined to those in dispute as a result of the bureau's administrative order from which arbitration is requested. The following rules apply to facilitate prehearing procedures:

a. The requesting party shall file with the bureau, and serve upon the nonrequesting party by regular mail, a written statement identifying:

(1) A general statement of the issues in dispute.

(2) The names and addresses of witnesses to be called, and whether the witness will testify at the hearing, or via deposition.

(3) Additional documentary evidence that will be submitted.

(4) The nature of the documents that are required from the claim file or employer file. An objection to introduction of any part of the bureau's file into evidence must be made prior to hearing, or the objection is deemed waived.

(5) Whether the party demands to cross-examine, at bureau expense, the vocational expert who submitted a vocational plan under North Dakota Century Code

section 65-05.1-02.1, or medical experts retained by the bureau for the purpose of providing an independent medical opinion and relied on by the bureau to refute the employee's treating doctor.

b. If the nonrequesting party intends to participate in the hearing, it must also file with the bureau, and serve upon the requesting party, a statement identifying any witnesses to be called, any new documentary evidence that will be submitted, and whether there is an objection to any part of the claim or employer files.

c. The bureau shall serve upon the parties a written statement including:

(1) The specification of issue or issues.

(2) The names and addresses of witnesses the bureau will call, and whether the witness will appear at the hearing or via deposition.

(3) Additional documentary evidence that will be submitted.

(4) The nature of the documents that it will submit from the employee claim file, or the employer file.

8. ~~The panel members may not engage in any ex parte communications with any party to the proceeding.~~ Arbitration hearings must be in accordance with the following procedures:

a. Witness fees and mileage shall be paid by the party or bureau at whose instance the witness appears. The arbitrator may for good cause order the bureau to pay statutory witness fees and expenses for a party's lay witness upon written application of a party. Costs to transcribe a witness's testimony must be paid by the party or bureau at whose instance the witness appears.

b. If timely demanded by the requesting party, and if relevant to the issue or issues to be decided, the bureau must make available for cross-examination, at its expense, the vocational expert who submitted a vocational plan under North Dakota Century Code section 65-05.1-02.1, and medical experts retained by the bureau for the purpose of providing an independent medical opinion and relied on by the bureau to refute the employee's treating doctor.

c. The parties and the bureau have a continuing obligation to disclose the names of witnesses that will be called, and to identify additional documentary evidence that will be submitted. If the requesting party or the bureau did not provide at least ten days' written notice in advance of

the hearing, the arbitrator must grant a motion to postpone the hearing at the instance of the aggrieved party or bureau, or may exclude such evidence or witness. In the event the arbitrator allows the evidence to be submitted, or the witness to testify, the other party or the bureau may submit rebuttal documents or testimony not previously disclosed, but must provide advance notice of its intent to do so.

d. Testimony may be presented to the arbitrator at the arbitration proceeding or via deposition transcript. Deposition transcripts may not be admitted unless prior notice of the deposition and opportunity for cross-examination was provided to any interested party and the bureau.

e. The parties and the bureau may waive oral hearing before the arbitrator, and stipulate to submission to the arbitrator based upon briefs, documentary evidence, and depositions.

f. The arbitration proceeding must be held in the region where the requesting party resides, or, if the requesting party resides out of state, in Bismarck, North Dakota. Hearings may be conducted by telephonic conference call, and any witness may testify by telephonic conference call upon agreement of the parties and the bureau. Hearings need not be recorded, but may be recorded upon instance of any party or the bureau. The party requesting the recording is responsible for the cost of recording the hearing and the cost of any transcript.

g. After the parties and bureau have exchanged written filing, entered a prehearing stipulation, or held a prehearing conference, the bureau will schedule, the date and time of depositions and hearing. Twenty days' advance notice of hearing is required, unless the parties and the bureau waive such notice.

h. The bureau shall provide the interested parties and the arbitrator copies of the relevant documentary evidence from the bureau's file (including any deposition transcripts) at least ten days prior to the arbitration hearing. Upon agreement, or order of the arbitrator, the deposition of an expert may be taken after the lay witnesses testify at the hearing.

i. The employee must bear the burden of proof as provided under North Dakota Century Code section 65-01-11. The employee may make an initial opening statement, followed by the employer, and bureau. The employee shall present its case, or rest upon the record, followed by the employer and bureau. Following submission of all

evidence, the parties may make a closing argument. The employee may make the initial closing statement, with rebuttal after the employer and bureau close, or waive initial closing and make the last closing argument.

j. Only such evidence as is relevant and material to the dispute may be received. The arbitrator is the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence is not required. The arbitrator may direct the submission of additional evidence or briefs following the hearing.

k. Witnesses must be sworn as required by law. The arbitrator may subpoena witnesses or documents upon request of a party or the bureau. If the witness or documents are not forthcoming, the party, bureau, or arbitrator may seek an order of the district court to compel such documents to be submitted, or such witness to testify as provided in subsection 7 of North Dakota Century Code section 28-32-09.

l. Following the close of the hearing, the arbitrator shall issue a written decision, which must be set forth in findings of fact, conclusions of law, and order. The decision must be based upon, and in accordance with, applicable substantive law. The order must be signed by the arbitrator and served upon all parties by certified mail.

m. Any party or the bureau may request reconsideration upon written application filed with the arbitrator and served on the other party and the bureau within ten days of the arbitrator's decision. The arbitrator may deny the request with or without explanation, issue an amended order, or order that the proceedings be reopened for submission of additional evidence or briefs.

n. There shall not be any discovery except by the consent of the parties and the bureau.

o. Should any party fail to appear at a hearing after proper notice under subdivision g, the arbitrator shall proceed with the hearing and shall issue a decision based on the record and evidence adduced at the hearing and the party failing to appear shall be deemed to have waived the right to testify and to present other relevant evidence.

9. The bureau retains continuing jurisdiction over the decision of the arbitrator, pursuant to North Dakota Century Code sections 65-02-18 and 65-05-04. The director of the bureau may review an arbitration decision upon motion of any party or the bureau. The motion must be in writing, and filed with the director within thirty days of the final decision of the

arbitrator. The motion must be accompanied by specific grounds for the review and must be served upon all parties and the bureau. The director will specify whether briefs are required. The director will limit exercise of continuing jurisdiction to reverse the decision of an arbitrator to instances where:

a. The arbitration decision is contrary to law; or

b. The arbitration decision has no rational basis.

The director may refuse to exercise continuing jurisdiction without explanation. Where the director reverses an arbitration decision, the director will issue findings of fact, conclusions of law, and order.

10. These rules govern any petition for arbitration made following issuance of an administrative order after August 1, 1993. In order to facilitate uniformity of decision, and speedy resolution of dispute, these rules will also govern any arbitration request made prior to August 1, 1993, by stipulation of the parties and the bureau provided that an arbitration proceeding had not already been held under the former arbitration rules.

History: Effective November 1, 1991; amended effective January 1, 1994.
General Authority: NDCC 28-32-05, 28-32-05.1, 65-02-08
Law Implemented: NDCC 65-02-15, ~~65-02-16,~~ 65-02-17, 65-02-18

92-01-02-27. Medical and hospital fees. Medical and hospital fees and rules of procedure must be those fees and procedures contained in the ~~1992~~ most current edition of that publication entitled "North Dakota Workers Compensation Medical and Hospital Fees", adopted by reference thereto and incorporated within this section as though set out in full herein. Maximum fees that were in effect in 1992 will be increased by the percentage change in North Dakota's average weekly wage between 1991 and 1993, which is seven and two-tenths percent, to establish maximum fees effective January 1, 1994. The bureau may adjust certain procedures more or less than the percentage change in the state's average weekly wage to correct data base deficiencies.

Maximum allowable fees may be adjusted annually. The fees adopted in this section apply to all services rendered on or after January 1, ~~1992~~ 1994.

This section and schedules apply to all health care providers and practitioners regardless of specialty area, limitation of practice, state, or ~~county~~ country where service is provided.

Services permitted under out-of-state workers' compensation programs, but not allowed under the North Dakota fees and procedures,

may not be reimbursed. Questionable services will be addressed at the bureau's discretion at the request of a provider or practitioner.

Reimbursement for services and procedures not addressed within this section will be determined on a "by report" basis. A description of the nature, extent and need for the procedure or service, including the time, skills, equipment, and any other pertinent facts necessary to furnish the procedure or service, should be furnished the bureau, as well as the following, where appropriate:

1. Postoperative diagnosis.

2. Size, location, and number of lesions or procedures.

3. Major surgical procedure with supplementary procedures.

4. Nearest similar procedure, by code, according to the North Dakota Workers Compensation Medical and Hospital Fees publication.

5. Estimated followup.

6. Operative time.

"By report" services or procedures must be adjusted as provided in this section.

Inpatient hospital services must be paid on the basis of hospital specific per diem rates, based upon costs reported in the latest available medicare cost report for that hospital. Per diem rates will be established for the following services, if available from the hospital: medical and surgical stay; intensive care unit and coronary care unit stays; psychiatric stays; chemical dependency stays; and rehabilitation stays. Specialty services will also be allocated a per diem rate for a hospital performing that type of service (e.g., a burn unit stay). Per diem rates will be calculated by aggregating salary expenses for routine services, allocated overhead (general services) costs and expenses for ancillary services, and dividing such aggregation by related patient days. Expenses will be adjusted for each hospital to a common base of 1989, using adjustment factors specific to the regions in which hospitals are located.

Rates will be adjusted to 1992 values, using the same inflationary factors applied to adjusting North Dakota workers' compensation temporary disability payments. The maximum payable amount on an inpatient hospital charge will be computed by multiplying the eligible days or units reported on the hospital bill by the appropriate per diem rate. Where the submitted amount is less than the approved amount, payment will be based on the lesser amount. North Dakota and border states' hospitals for which recent medicare cost reports are not available will be paid at the lesser of the median of the per diem rates or the actual billed charges.

Hospital outpatient services charges, for outpatient clinic and emergency room services, will be based on a cost to charge ratio for each hospital. The cost to charge ratio will be computed by comparing the costs to charges for the hospital based on the latest available medicare audited cost report. A maximum payable amount on an outpatient hospital charge will be computed by multiplying the submitted charge by the cost to charge ratio. If a medicare cost report is not available for a hospital, the median cost to charge ratio for all eligible hospitals will be applied. The workers compensation bureau may apply additional percentage discounts from the cost to charge ratio.

History: Effective January 1, 1992; amended effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

STAFF COMMENT: Sections 92-01-02-28 through 92-01-02-47 contain all new material but are not underscored so as to improve readability.

92-01-02-28. Health care advisory board.

1. Membership. The executive director, in consultation with the appropriate medical, chiropractic, or other professional associations, shall appoint a health care advisory board which shall serve at the executive director's pleasure and consist of fourteen members. Membership to this board will be as follows:

   a. The North Dakota state medical association shall nominate eight members from the following specialty groups: family or general practice, orthopedics, neurology or neurosurgery, general surgery, physical medicine and rehabilitation, occupational medicine, psychiatry, and internal medicine.

   b. The North Dakota state chiropractic association shall nominate two members who have completed advanced training in orthopedics or neurology or who have obtained the designation of diplomat in chiropractic.

   c. The North Dakota physical therapy association shall nominate two members who have completed advanced training in physical therapy or who have obtained a masters level training in physical therapy.

   d. The North Dakota hospital association shall nominate two members.

2. Function. The board will function as an advisor to the bureau with respect to policies affecting health care and physical rehabilitation, quality control and supervision of health care, and the establishment of rules and regulations. It shall also advise and assist the bureau in the resolution of controversies, disputes, and problems between the bureau, the bureau's managed care vendor, and the providers of health care through a peer review process. It will also advise and assist the department in the education of members of the health care provider community with regard to the roles of health care providers, the bureau, and the employer in providing the needs and care of injured workers.

3. Meetings and reimbursement. The board shall normally meet on a monthly basis or as necessity dictates. The bureau will reimburse members of the board for each meeting at the same rate state employees are reimbursed expenses.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-29. Medical services - Definitions. The purpose of these rules is to establish uniform guidelines for administering the delivery of and payment for medical services to injured workers within the workers' compensation system. These rules are also intended to prohibit health care providers treating employees with compensable injuries from receiving reimbursement above that allowed by the bureau's fee schedule. These rules define the medical and hospital fee schedules and also define when medical services are not medically necessary.

These rules and fee schedules are adopted under the authority of North Dakota Century Code sections 65-02-08, 65-02-20, and 65-05-07.

These rules are to carry out the provisions of North Dakota Century Code title 65, Workers Compensation Act, and govern all providers of medical services licensed or authorized to provide a product or service who provide medical services on or after the effective date of these rules. The following are subject to these rules and medical and hospital fee schedules: all providers of medical services or supplies for compensable injuries pursuant to subsections 13 and 22 of North Dakota Century Code section 65-01-02.

For purposes of sections 92-01-02-29 through 92-01-02-47, the following terms have the meanings given in the medical service rules and the medical and hospital fee schedules unless the context clearly indicates a different meaning:

1. "Ambulatory review" means the managed care vendor monitors designated services received by the injured employee for medical necessity, appropriateness, and efficiency. Certain ambulatory services require preservice review from the managed

care vendor prior to providing the service. All health care providers are required to cooperate with the managed care vendor for ambulatory review of designated services and are required to provide, without additional charge to the bureau or the managed care vendor, the medical information requested by the managed care vendor in relation to the reviewed service.

2. "Appropriate record" means a legible medical record or report which substantiates the nature and necessity of a service being billed and its relationship to the work injury. Providers must maintain documentation in the employee's medical records adequate to verify the level, type, and extent of services provided to employees.

3. "Attending physician" and "attending doctor" means a doctor who is primarily responsible for the treatment of an employee's compensable injury or illness.

4. "Bill or billing" means a provider's statement of charges and services rendered for treatment of a work-related injury.

5. "Bill review" or "bill audit" means the review of medical bills or associated medical records, or both, by the bureau or the bureau's managed care vendor, which may include review for duplications, omissions, actual delivery of billed services and items, accuracy of charges and associated coding, and improper concurrent billing for services involving evaluation or treatment, or both, of both work-related and nonwork-related problems.

6. "Case management" and "disability management" means the ongoing coordination of medical services provided to an injured employee, including:

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

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

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

   d. Ensuring the injured employee is following the prescribed medical plan; and

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

7. "Charge" means the payment requested by a provider on a bill for a particular service. Nothing in the medical service

rules or fee schedules prohibits a provider from billing usual and customary charges which are in excess of the amount listed in the fee schedule.

8. "Claim" means a written request for compensation from an employee or someone on the employee's behalf, for any compensable injury or illness of which an employer has notice or knowledge.

9. "Claimant" means the employee making a claim.

10. "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records such things as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, functional job limitations, and return to work goals and status.

11. "Code" means the alphabetical or numerical designation, including code modifiers if appropriate, for a particular type of service, or supply, to categorize provider charges on a bill.

12. "Compensable injury" means an injury or condition for which the bureau is liable under subsection 8 of North Dakota Century Code section 65-01-02.

13. "Concurrent review" means that throughout the period of time in which designated medical services are being provided to the injured employee, the managed care vendor monitors the injured employee's condition, treatments, procedures, and length of stay for medical necessity and appropriateness. All health care providers are required to cooperate with the managed care vendor for concurrent review of designated medical services and are required to provide, without additional charge to the bureau or the managed care vendor, the medical information requested by the managed care vendor in relation to the reviewed service.

14. "Consulting doctor" means a licensed doctor who examines an employee, or the employee's medical record, at the request of the attending doctor to aid in diagnosis or treatment. A consulting doctor may, at the request of the attending doctor, provide specialized treatment of the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for an employee's injury.

15. "Current procedural terminology" or "CPT" means the current procedural terminology most recently published by the American medical association.

16. "Customary fee" means a fee that falls within the range of fees normally charged for a given service.

17. "Days" means calendar days and a twenty-four-hour period.

18. "Direct control and supervision" means the doctor is on the same premises, at the same time, as the person providing a medical service ordered by the doctor. The doctor can modify, terminate, extend, or take over the medical service at any time. A medical service provided at a site removed from the doctor, or provided when the doctor is not present on the premises, is not under the direct control and supervision of the doctor.

19. "Director" means the executive director of the workers compensation bureau or designated representatives.

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

21. "Excessive charge" means a charge for a service rendered to treat a compensable injury, which meets any of the following conditions:

    a. If not specified in the fee schedule, the charge exceeds that which prevails in the same geographic community for similar services or treatment;

    b. The charge wholly or partially duplicates another charge for the same service, such that the charge has been paid or will be paid in response to another billing;

    c. The charge exceeds the provider's current charge for the same type of service in cases unrelated to worker's compensation injuries;

    d. The charge does not comply with standards and requirements concerning the cost of treatment pursuant to the medical service rules adopted by the bureau; or

    e. The charge is described by a billing code that does not accurately reflect the actual service provided.

22. "Excessive service" means any service rendered to treat a compensable injury which is excessive to the degree that any of the following standards apply to the service:

    a. The service does not comply with the standards and requirements adopted under the North Dakota medical service rules concerning the reasonableness and necessity, quality, coordination, and frequency of services;

b. The service was performed by a provider prohibited from receiving reimbursement under North Dakota Century Code title 65; or

c. The service is not usual, customary, and reasonably required for the healing or relief of the effects of a compensable injury.

23. "Fee schedule" means North Dakota medical and hospital fees publication which outlines the list of codes, service descriptions, and level of reimbursement allowed pursuant to section 92-01-02-27.

24. "HCFA form 1450" or "UB 82" or "UB 92" means a hospital insurance claim form approved by the federal health care financing administration (HCFA), and other organizations for billing of hospital services.

25. "HCFA form 1500" means a health insurance claim form approved by the federal health care financing administration (HCFA), the American medical association council on medical service, and other organizations for billing of health care services.

26. "HCFA form 2552" (hospital care complex cost report) means the annual report a hospital makes to medicare.

27. "Initial claim" means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the employee is first declared to be medically stationary or at maximum medical improvement by an attending doctor.

28. "Injury" is as defined in subsection 8 of North Dakota Century Code section 65-01-02.

29. "Inpatient" means an injured employee who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

30. "Insurer" means the North Dakota workers compensation bureau.

31. "International classification of diseases (ICD-9-CM) means a set of numerical diagnostic codes based on the standardized coding system published as the International Classification of Diseases, clinical modification, ninth revision, fourth edition, or any revised edition.

32. "Managed care services" and "managed care program" means those services, including fee schedules, utilization review, preservice reviews, disability management services, case management services, ambulatory reviews, concurrent reviews, retrospective reviews, preadmission reviews, and medical bill reviews performed by a managed care vendor.

33. "Managed care vendor" means organizations contracted by the bureau to provide managed care services to injured employees.

34. "Medical service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, and other related services, and drugs, medicine, crutches, and prosthetic appliances, braces, and supports and where necessary, physical restoration services and services outlined in section 92-01-02-30.

35. "Medical service provider" means a doctor, health care provider, a hospital, medical clinic, or vendor of medical services.

36. "Medically necessary" means those medical services which are, in the opinion of the director:

    a. Reasonable, appropriate, proper, and necessary for the diagnosis and healing or rehabilitative treatment of an accepted condition;

    b. Reflective of accepted standards of good practice within the scope of the provider's license or certification;

    c. Not delivered primarily for the convenience of the employee, the employee's attending doctor, or any other provider; and

    d. Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition in section 92-01-02-29.1.

37. "Medically stationary" means that maximum medical improvement as defined in North Dakota Century Code section 65-01-02 has been reached and that no further material improvement would reasonably be expected from medical treatment or the passage of time.

38. "Nonattending doctor" means a doctor who does not have primary responsibility for treating the patient.

39. "Notice of nonpayment" means the form in which an injured employee is notified of charges denied by the bureau and which are the employee's personal responsibility.

40. "Objective findings" means those findings reproducible on examination including range of motion, atrophy, muscle strength, muscle spasm, loss of sensation, and diagnostic evidence (test results) substantiated by clinical findings.

41. "Observation stay" means a hospital stay of less than forty-eight hours with no more than one overnight stay and which the doctor has not classified as an inpatient stay.

42. "Outpatient" means an employee not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments which do not result in admission are also outpatient services.

43. "Palliative care" or "maintenance care" means a medical service rendered to temporarily reduce or moderate the intensity of an otherwise stable medical condition as compared to those medical services rendered to diagnose, heal, or permanently alleviate or eliminate an undesirable medical condition.

44. "Payer" refers to the bureau or its designated representatives.

45. "Peer review" means an individual case-by-case review of services for medical necessity and appropriateness, conducted by a health care provider licensed in the same profession, and preferably in the same specialty, as the health care provider whose services are being reviewed. For purposes of these rules, hospitals are not subject to peer review. However, professional services provided by a health care provider within a hospital setting are subject to peer review.

46. "Physical capacity evaluation" means an objective, directly observed, measurement of an injured employee's ability to perform a variety of physical tasks combined with subjective analyses of abilities by the employee and the evaluator. Physical tolerance screening, Blankenship's functional evaluation, and functional capacity assessment shall be considered to have the same meaning as physical capacity evaluation.

47. "Preadmission review" means the managed care vendor has evaluated a proposed hospital admission for medical necessity, appropriateness, and efficiency and length of stay prior to the provider admitting the injured employee. All health care providers are required to cooperate with the managed care vendor for preadmission review and are required to provide, without additional charge to the bureau or the managed care vendor, the medical information requested by the managed care vendor in relation to the reviewed service.

48. "Preservice review" means the managed care vendor has evaluated a proposed medical service for medical necessity, appropriateness, and efficiency prior to the provider performing the services. All health care providers shall cooperate with the managed care vendor for preservice review and shall provide, without additional charge to the bureau or the managed care vendor, the medical information requested by the managed care vendor in relation to the reviewed service.

49. "Provider" is as defined in North Dakota Century Code section 65-01-02 and the medical service rules adopted by the bureau.

50. "Reasonable charge" means a charge or portion of a charge for treatment of a compensable injury which is not excessive under these rules.

51. "Reasonable service" means a service for treatment of a compensable injury that is reasonable, appropriate, and efficient as defined under these rules.

52. "Remittance advice" means the form used by the bureau to inform providers of the payment, reduction, or denial of medical services.

53. "Report" means medical information transmitted in written form containing relevant subjective and objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

54. "Residual functional capacity" means an employee's remaining ability to perform work-related activities despite medically determinable limitations resulting from the accepted compensable condition. A residual functional capacity evaluation includes capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, stooping, kneeling, crouching, crawling, and reaching.

55. "Retrospective review" means the managed care vendor has reviewed a medical service for medical necessity, appropriateness, and efficiency after treatment has taken place. Retrospective review is limited to those situations where the provider can prove, through a preponderance of the evidence, that the injured employee did not inform the provider the condition was covered under workers' compensation. All health care providers are required to cooperate with the managed care vendor for retrospective review and are required to provide, without additional charge to the bureau or the managed care vendor, the medical information requested by the managed care vendor in relation to the reviewed service.

56. "Service or treatment" means any procedure, operation, consulation, supply, product, or other thing performed or provided for the purpose of healing or relieving an injured employee from the effects of a compensable injury under North Dakota Century Code title 65.

57. "Special report" means a health care provider's preparation of a written response to a specific request from the bureau for information, including information on causation, aggravation, preexisting conditions, and clarification of complex medical

conditions, requiring the creation of a new document or the previously unperformed analysis of existing data. The explanatory reports required for procedures designated as "by report" are not special reports.

58. "Unbundling" means coding and billing separately for procedures that do not warrant separate identification because they are an integral part of a total or principal service for which a corresponding current procedural terminology code exists.

59. "Usual fee" means the fee charged the general public for a given service.

60. "Utilization review" means an evaluation of the necessity, appropriateness, efficiency, and quality of medical services provided to an injured employee, based on medically accepted standards and an objective evaluation of the medical services provided and as defined in North Dakota Century Code section 65-01-02.

61. "Work capacity evaluation" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work tolerance screening shall be considered to have the same meaning as work capacity evaluation.

62. "Work conditioning" and "physical conditioning" means an individualized, graded exercise program, usually supervised and monitored by a physical therapist, which is designed to improve the overall cardiovascular, pulmonary, and neuromuscular condition of the injured employee prior to or in conjunction with the employee's return to any level of work. Such a program may be used to eliminate lost time from work altogether.

63. "Work hardening" means an individualized, medically prescribed, and monitored, work-oriented treatment process. The process involves the employee participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the employee to a specified job. This program may be completed on the worksite to progress the injured employee from limited to full duty.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-29.1. Medical necessity.

1. The concept of medical necessity is the foundation of all reimbursement made under these rules. For reimbursement to be made, services and supplies must meet the definition of "medically necessary".

2. For the purposes of the workers' compensation program, any medical service or supply used to identify or treat an occupational injury, disease, or work-related illness which is appropriate to the patient's diagnosis, consistent with the location of service and with the level of care provided, is considered medically necessary. The service must also be widely accepted by the practicing peer group, based on scientific criteria, and determined to be reasonably safe. It must not be of an experimental, investigative, or research nature unless specifically approved by the bureau.

3. Services that are inappropriate to the accepted condition or which present hazard in excess of the expected medical benefits may not be considered medically necessary. Services that are controversial, obsolete, experimental, or investigational are presumed to be not medically necessary, and shall be authorized only as preapproved by the bureau or recommended by the bureau's managed care vendor.

4. The bureau will not allow or pay for the following treatment:

   a. Use of diapulse, thermatic (standard model only), spectrowave, superpulse, and medex machines.

   b. Massage therapy except when provided by a licensed physical therapist, chiropractor, or medical doctor.

   c. Thermography; chemonucleolysis; prolotherapy; acupuncture; acupressure; reflexology; rolfing; injections of colchicine except to treat an attack of gout precipitated by a compensable injury; injections of chymopapain; injections of fibrosing or sclerosing agents except where varicose veins are secondary to a compensable injury; and injections of substances other than cortisone, anesthetic, or contrast into the subarachnoid space (intrathecal injections).

   d. Treatment to improve or maintain general health (i.e., prescriptions or injections of vitamins, nutritional supplements, diet and weight loss programs, programs to quit smoking). Over-the-counter medications may be allowed in lieu of prescription medications when approved by the bureau and prescribed by the attending doctor.

   e. Continued treatment beyond medically stationary state (i.e., maintenance or palliative care) except as described under section 92-01-02-40 or when the bureau orders otherwise.

f. After consultation and advice to the bureau, any treatment measure deemed to be dangerous or inappropriate for the injured employee in question.

g. Treatment measures of an unusual, controversial, obsolete, or experimental nature. Under certain conditions, treatment in this category may be approved by the bureau. Approval must be obtained prior to the treatment. Requests must contain a description of the treatment, reason for the request with benefits, and results expected.

5. The bureau employs a managed care vendor to review care for medical necessity. Cooperation with this program is required to maximize reimbursement. This program allows for an appeals process when agreement has not been reached between the provider, the bureau, and the managed care vendor.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-29.2. Acceptance of rules and fees.

1. Pursuant to subsection 7 of North Dakota Century Code section 65-05-07, rendering treatment to an injured employee who comes under the bureau's jurisdiction constitutes acceptance of the bureau's rules and fees.

2. Providers rendering treatment to an injured employee who comes under the bureau's jurisdiction must comply with managed care services as defined by these rules.

3. The bureau's rules and fee schedules are applied regardless of state or country where services are actually provided.

4. When the bureau receives notice that an injured employee is receiving medical treatment out of state, the bureau shall notify the employee and the health care provider of the following:

   a. The North Dakota fee schedule requirements;

   b. The manner in which they can provide compensable medical services to North Dakota's injured employees;

   c. The requirements that billings for compensable services in excess of the maximum allowed under the fee schedule or these rules are not to be paid for by the bureau or the injured employee, the employer, or another insurer; and

d. If the provider does not comply with these requirements, the bureau may object to the worker's choice and select a new provider to render the necessary care under North Dakota Century Code section 65-05-28.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-30. Medical services.

1. Medical services.

   a. Medical services, including diagnostic services, provided to the injured employee shall not be more than the nature of the compensable injury or the process of injury requires. Services that are unnecessary or inappropriate according to accepted professional standards, or to these rules, or which are unrelated to the compensable injury are not reimbursable.

   b. When there is a question regarding the competency or ethical behavior of a medical provider, the director may refer the matter to the appropriate licensing board.

   c. Frequency and extent of treatment may not be more than the nature of the injury or process of recovery requires, and must be provided in accordance with utilization and treatment standards as prescribed by the bureau, or the bureau's managed care vendor. The bureau has the right to require evidence of the efficacy of treatment. Unless otherwise provided for by statutes, utilization and treatment standards established by the bureau or the bureau's managed care vendor, the usual range of the utilization of medical services does not exceed fifteen office visits by any and all attending doctors in the first sixty days from the first date of treatment, and two visits per month thereafter. This statement of fact does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. The process outlined in section 92-01-02-46 should be followed when the bureau believes the treatment plan is inappropriate and the attending doctor disagrees.

2. Chiropractic services.

   a. Chiropractic services may be reimbursed only when carried out under a written treatment plan that must include objectives, modalities, frequency of treatment, and duration. A copy of the treatment plan, signed by the

attending doctor, must be provided to the bureau within fourteen days of beginning the treatment or within fourteen days of learning that the treatment is claimed to be work-related, whichever occurs later.

b. Unless otherwise provided for within utilization and treatment standards prescribed by the bureau or the bureau's managed care vendor, the usual range of therapy visits does not exceed twenty visits in the first sixty days, and four visits per month thereafter. This statement of fact does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. The attending doctor shall document the need for services in excess of these guidelines when submitting a written treatment plan. The process outlined in section 92-01-02-46 should be followed when the bureau believes the treatment plan is inappropriate and the attending doctor disagrees.

3. Ancillary services.

a. Ancillary services including physical therapy or occupational therapy by a medical service provider other than the attending doctor may be reimbursed only when carried out under a written order prescribed prior to the commencement of treatment and signed by the attending doctor within fourteen days of the beginning of treatment or within fourteen days of learning that the treatment is claimed to be work-related, whichever occurs later. A treatment plan, completed by the ancillary service provider, must include:

(1) Objectives - the degree of restoration anticipated;

(2) Measurable goals;

(3) Modalities and specific therapies to be used;

(4) Frequency and duration of treatments to be provided; and

(5) Condition of the employee which may periodically require modification in the plan of care based on:

(a) Improvements in the employee's status.

(b) Failure of the patient to improve as expected.

(c) Intervention of care rendered, including education of the employee, when appropriate.

(d) Specific operative reports, test results, and consultation reports.

The treatment plan must be cosigned by the attending doctor and the plan shall be provided to the bureau within fourteen days of the beginning of treatment or within fourteen days of learning that the treatment is claimed to be work-related, whichever occurs later.

b. Unless otherwise provided for within utilization and treatment standards prescribed by the bureau or the bureau's managed care vendor, the usual range of therapy visits does not exceed twenty visits in the first sixty days, and four visits per month thereafter. This statement of fact does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. The attending doctor shall document the need for services in excess of these guidelines when submitting a written treatment plan. The process outlined in section 92-01-02-46 should be followed when the bureau believes the treatment plan is inappropriate and the attending doctor disagrees.

4. The preparation of a written treatment plan and the supplying of progress notes under this section are integral parts of the fee for the medical service.

5. The treatment plan requirements of this section may be modified or waived in accordance with the contract provisions of the managed care vendor.

6. Dietary supplements including minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured employee. Vitamin B-12 injections are not reimbursable unless necessary because of a malabsorption resulting from a compensable gastrointestinal disorder.

7. X-ray films must be of diagnostic quality. Billings for x-rays are not reimbursable without a report of the findings. Upon request of either the director or the bureau's managed care vendor, original x-ray films must be forwarded to the director or the bureau's managed care vendor. Films must be returned to the vendor. A reasonable charge may be made for the costs of delivery of films.

8. Articles such as beds, hot tubs, chairs, Jacuzzies, and gravity traction devices are not compensable unless a need is clearly justified by a report that establishes that the "nature of the injury or the process of recovery requires" that the item be furnished. The report must specifically set

forth why the patient requires an item not usually considered necessary in the great majority of employees with similar impairments. If the bureau does not feel the report justifies the need for the item in the treatment and recovery of the employee and the sole issue to be addressed in the matter is whether the treatment is inappropriate, ineffective, excessive, or in violation of the rules regarding the performance of medical services, the issue must be resolved as provided by section 92-01-02-46.

9. The bureau, or its designated agent, may request from the provider, any and all necessary records needed to review the efficacy of treatment, frequency and necessity of care, and accuracy of billings. If the evaluation of the records must be conducted onsite, the provider shall furnish a reasonable worksite for the records to be reviewed at no cost. These records must be provided or made available for review within thirty days of a request. Failure to provide the records in a timely manner may result in a penalty as provided in subsection 6 of North Dakota Century Code section 65-05-07.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-31. Who may treat.

1. Only that treatment which falls within the scope and field of the health care provider's license to practice will be allowed as treatment to an injured employee.

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

3. Health care providers may be formally refused permission to treat cases under the jurisdiction of the bureau for reasons that are, in the opinion of the bureau or the health care advisory board, in the best interest of the employees and the fund created for their protection.

4. Reasons for holding a health care provider ineligible to treat workers' compensation cases include any one or a combination of the following:

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

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

c. Failure, neglect, or refusal to observe and comply with the bureau's orders and medical service rules, including cooperation with the bureau's managed care vendor.

d. Persistent failure to notify the bureau immediately and prior to burial in any death where the cause of death is not definitely known or where there is question of death being due to occupational injury.

e. Persistent failure to recognize emotional and social factors impeding recovery of injured employees.

f. Persistent unreasonable refusal to comply with the recommendations of board-certified or qualified specialists who have examined the employee.

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

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

i. Submission of inaccurate or misleading bills.

j. Persistent submission of false or erroneous diagnosis.

k. Knowingly submitting bills to an injured employee for treatment of a work-related condition for which the bureau has accepted liability.

l. Persistent use of:

(1) Treatment of controversial or experimental nature.

(2) Contraindicated or hazardous treatment measures.

(3) Continuation of unreasonable and inappropriate treatment measures past medically stationary status of the occupational condition or after maximum medical improvement has been obtained.

(4) Nonspecific treatment measures.

(5) Treatment terminating in unsatisfactory results.

(6) Treatment with a consistent pattern of disabling injured employees to maximize financial recoveries for the employee or provider.

m. Charging or attempting to charge occupationally injured employees fees in addition to the fee paid by the bureau for care of the occupational injury or billing the difference between the maximum allowable fee set forth in the bureau's fee schedule and usual and customary charges.

n. Conviction in any court of any offense involving moral turpitude, in which case the record of such conviction shall be conclusive evidence.

o. The use, or prescription for use, of narcotic, addictive, habituating, or dependency inducing drugs in any way other than for therapeutic purposes.

p. Repeated acts of gross misconduct in the practice of the profession.

q. Declaration of mental incompetency by a court of competent jurisdiction.

r. The finding of any peer group disciplinary board of reason to suspend or revoke a health care provider's practice privilege temporarily or permanently.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-32. Physician's assistant and nurse practitioner rules.

1. Physician's assistants and nurse practitioners may perform only those medical services in occupational injury cases, for which the physician's assistant, or nurse practitioner is trained and licensed, under the control and supervision of a licensed physician. Such control and supervision may not be construed to require the personal presence of the supervising physician.

2. Physician's assistants and nurse practitioners may perform those medical services that are within the scope of their license for occupational injury cases within the limitations listed in the following section.

3. Advance approval must be obtained from the bureau to treat occupational injury cases. To be eligible to treat occupational injuries, the physician's assistant or nurse practitioner must:

   a. Provide the bureau with a copy of their license;

   b. Provide the name and address and specialty of their supervising physician; and

   c. Provide the bureau with the evidence of a reliable and rapid system of communication with the supervising physician.

4. Physician's assistants; and nurse practitioners may prepare reports of accident, time loss cards, and progress reports for the supervising physician's signature. Physician's assistants and nurse practitioners may not submit such information under their own signatures.

5. The bureau must be notified of any change in supervising physician.

6. Reimbursement for these services will be in accordance with subsection 12 of section 92-01-02-45.1.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-33. Utilization review and quality assurance. To ensure that injured workers receive good quality health care, provided in an efficient cost-effective and appropriate manner and in the most appropriate setting, the bureau has instituted a program of utilization review and quality assurance. This program is designed to monitor and control the use of health care services, and includes the following:

1. Prior authorization for services must be obtained from a qualified representative of the bureau prior to the provision of certain medical treatment, equipment, or supplies at least twenty-four hours or the next business day in advance of the proposed service. Medical services requiring prior authorization or preservice review are outlined in section 92-01-02-34. Emergency medical services may be provided without prior authorization, but notification within twenty-four hours of initiation of emergency treatment or the next business day is required or reimbursement may be withheld, or recovery of prior payments made, if utilization review fails to confirm the medical necessity of such services.

2. Documentation of the need for and efficacy of continued medical care by the health care provider is required at regular intervals while a claim is open. Such documentation enables the bureau to review the plan of treatment, assess the quality and medical necessity of services, authorize or deny reimbursement for continued provisions of services, evaluate eligibility for time loss compensation and pay medical bills.

3. The bureau may require second opinion consultations prior to the authorization of reimbursement for some types of surgery of uncommon nature, and for conservative care which extends past one hundred twenty days following the initial visit.

4. Hospitalization will be reimbursed only when it is determined to be medically necessary for the diagnosis and healing or

rehabilitative treatment of accepted conditions. Hospital bills and supporting medical documents may be audited to verify the accuracy or appropriateness of charges, and recovery of overpayment will be made.

5. Medical treatment, equipment, and supplies provided for the diagnosis and healing or rehabilitative treatment of a condition unrelated to the accepted medical condition will not be reimbursed unless prior authorization has been obtained from the bureau pursuant to subsection 18 of section 92-01-02-45.1.

6. The bureau's outpatient surgery program requires that certain diagnostic and surgical procedures be reimbursed only if they are performed in an outpatient setting. If a worker's medical condition necessitates performance of such a procedure in an inpatient setting, preservice review must be obtained from the bureau's managed care vendor.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

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

1. Certain treatment procedures require prior authorization or preservice review, or both, by the bureau or its managed care vendor. Requests for authorization or preservice review must include a statement of the condition diagnosed; ICD-9-CM codes; their relationship, if any, to the occupational injury or exposure; the medical documentation supporting medical necessity, an outline of the proposed treatment program, its length and components, procedure codes and expected prognosis; and an estimate of when treatment would be concluded and condition stable.

2. Requesting prior authorization or preservice review is the responsibility of the health care provider who wants to provide, prescribe, or perform a treatment, therapy, modality, course of treatment, or program of treatment for which prior authorization or preservice review is required.

3. Health care providers shall request prior authorization from the bureau as to medical necessity, efficacy, reasonableness, efficiency, and appropriateness of treatment in the following circumstances:

   a. Office calls with the attending doctor in excess of the first fifteen visits or sixty days, whichever occurs first.

b. Diagnostic or therapeutic injection. Epidural or caudal injection of substances other than anesthetic or contrast solution may be authorized under the following conditions only:

(1) When the employee has experienced acute low back pain or acute exacerbation of chronic low back pain of not more than six months' duration.

(2) The employee will receive no more than three injections in an initial thirty-day period, followed by a thirty-day evaluation period. If significant pain relief is demonstrated one additional series of three injections may be authorized. No more than six injections may be authorized per acute episode.

c. Home nursing or convalescent center care must be authorized per provisions outlined in section 92-01-02-43.

d. Durable medical equipment must be authorized in accordance with section 92-01-02-42.

e. Biofeedback programs, pain clinics, psychotherapy, and physical rehabilitation programs, including health club memberships and work hardening programs, chronic pain management programs, and other programs designed to treat special problems must be authorized prior to beginning the service.

f. Injections of anesthetic or antiinflammatory agents, or both, into the vertebral facet joints will be authorized to qualified specialists in orthopedics, neurology, and anesthesia, or other doctors who can demonstrate expertise in the procedure and who can provide certification that their facility privileges include the procedure requested under the following conditions:

(1) Rationale for procedure, treatment plan, and request for authorization must be presented in writing to the bureau;

(2) Procedure must be performed in an accredited facility under radiographic control;

(3) Not more than four facet injection procedures will be authorized in any one patient.

g. Intramuscular and trigger point injections of steroids and other nonscheduled medications are limited to a series of three injections in each location per patient. The attending doctor must submit justification for an additional series of three injections if indicated with a

maximum of six injections to be authorized per acute episode.

4. Health care providers shall request preservice review from the bureau's managed care vendor as to medical necessity, efficiency, and appropriateness of treatment in the following circumstances:

   a. All nonemergent inpatient hospital admissions or nonemergent inpatient surgery, (a surgery or hospitalization is considered inpatient if the patient spends at least one night in the facility, or has a stay greater than twenty-four hours providing it is not designated as an observation stay); inpatient physical therapy; and outpatient surgical procedures, including arthroscopic procedures and carpal tunnel release. Hernia repairs and hardware removal procedures scheduled on an outpatient basis do not require preservice review.

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

   c. All nonemergent major surgery must be authorized prior to surgery date. Some surgical procedures require concurring opinions prior to authorization. See section 92-01-02-36, relating to elective surgery, for details.

   d. All high-tech imaging procedures including CAT scan, magnetic resonance imaging, myelogram, and discogram require preservice review. Tomograms, bonescans, and EMGs are reviewable if requested in conjunction with one of the above imaging procedures.

   e. All physical therapy treatment beyond two weeks when the injured employee is working when the treatment begins or immediately when the injured employee is off work when the treatment begins. The evaluation to determine a treatment plan is not subject to review.

   f. All chiropractic treatment beyond twelve treatments when the injured employee is working when the treatment begins or immediately when the injured employee is off work when the treatment begins. The evaluation to determine a treatment plan is not subject to review.

5. The bureau may designate those diagnostic and surgical procedures that can be performed in other than a hospital inpatient setting. If an employee has a medical condition that necessitates a hospital admission, preservice review or approval of the bureau must be obtained.

6. If a health care provider fails to request preservice review as required in subsection 4, with knowledge that the treatment is related to a work-related condition, the health care provider may not be paid for the treatment under any circumstances and may not request retrospective review unless the provider can prove, by a preponderance of the evidence, that the injured employee did not inform the provider that the condition was covered under workers' compensation. If, after reviewing the evidence, the bureau denies retrospective review, the health care provider may request binding dispute resolution in accordance with section 92-01-02-46.

7. The bureau's contracted managed care vendor must respond orally to the health care provider and the bureau within twenty-four hours, or the next business day, of receiving the necessary information to complete a review and make a recommendation on the service. Within the twenty-four hours the managed care vendor must either recommend approval or denial of the request, request additional information, request the employee obtain a second opinion, or request an examination by the employee's doctor. A recommendation to deny medical services must specify the reason for the denial recommendation. The managed care vendor must respond in writing to the bureau to a request for preservice review of medical services within seven days of receiving the necessary information to complete a review and make a recommendation.

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

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-35. Determining medically stationary status.

1. An injured employee's condition must be determined to be medically stationary when the attending doctor or a preponderance of medical opinion declares the employee either "medically stationary", "medically stable", or uses other language meaning the same thing.

2. When there is a conflict in the medical opinions as to whether or not an employee is medically stationary, more weight must be given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

3. When there is not a preponderance of medical opinion stating an employee is or is not medically stationary, deference must generally be given to the opinion of the attending doctor.

However, in cases in which expert analysis is important, deference must be given to the opinion of the doctor with the greatest expertise in, and understanding of, the employee's condition.

4. If there is a conflict as to the date upon which an employee became medically stationary, the following conditions govern the determination of the medically stationary date. The date an employee is medically stationary is the earliest date that a preponderance is established under this section. The date of examination, not the date of the report, controls the medically stationary date.

5. A concurrence with another doctor's report is an agreement in every particular, including the medically stationary impression and date, unless the concurring doctor expressly states to the contrary.

6. An employee is medically stationary on the date specified by a doctor. When a specific date is not indicated but the opinion states the employee is medically stationary, an employee is presumed medically stationary on the date of the last examination.

7. The employee will be presumed to be medically stationary when the employee no longer requires medical services, or when:

   a. The employee has not sought medical care for a period in excess of sixty days, unless so instructed by the attending doctor; and

   b. The bureau has notified the employee, by regular mail to the last known address of the employee, that inactive status of the claim may be requested for failure to seek medical services.

8. Unless the attending doctor has declared, or a preponderance of medical opinion is that, the employee is medically stationary on an earlier day, the employee is presumed to be medically stationary ten days from the expected date of response to the bureau's notification letter pursuant to subsection 7, unless subsequent medical evidence based on actual examination of the employee affirmatively and persuasively establishes that the employee was not and could not have been medically stationary on that date.

9. If the employee is incarcerated or confined in some other manner and unable to freely seek medical treatment, the bureau shall arrange for medical examinations to be completed at the facility where the employee is located or at some other location accessible to the employee.

History: Effective January 1, 1994.

General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-36. Elective surgery.

1. When the attending doctor or consulting doctor believes elective surgery is needed to treat a compensable injury or illness, the attending doctor or the consulting doctor with the approval of the attending doctor, shall give the bureau's managed care vendor actual notice at least twenty-four hours prior to the date of the proposed surgery. Notification must give the medical information that substantiates the need for surgery, an estimate of the surgical date and the postsurgical recovery period, and the hospital where surgery is to be performed.

2. When elective surgery is recommended, the bureau or the bureau's managed care vendor may require an independent consultation with a doctor of the bureau's choice. The bureau shall notify the doctor who requested approval of the elective surgery, whether or not a consultation is desired. When requested, the consultation must be completed within thirty days, if possible, after notice to the attending doctor.

3. Within seven days of the consultation, the bureau shall notify the surgeon of the consultant's findings. If the attending doctor and consultant disagree about the need for surgery, the bureau may request a third independent opinion pursuant to North Dakota Century Code section 65-05-28. If, after reviewing the third opinion, the bureau believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the attending doctor, the requesting doctor may request binding dispute resolution in accordance with section 92-01-02-46.

4. An attending doctor or health care provider who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements of this rule, may not be reimbursed for the services and may not request retrospective review of those services unless the attending doctor or health care provider can prove, by preponderance of the evidence, that the injured employee did not inform the provider the condition was covered under workers' compensation. If after reviewing the evidence, the bureau denies retrospective review, the health care provider may request binding dispute in accordance with section 92-01-02-46.

5. Surgery that must be performed promptly, i.e., before twenty-four hours, because the condition is life threatening or there is rapidly progressing deterioration without surgical intervention, is not considered elective surgery. In such cases, the attending doctor should endeavor to notify the

bureau's managed care vendor of the need for emergency surgery.

6. Elective surgery for an unrelated condition is not normally permitted during hospitalization for a compensable injury. Under some circumstances unrelated elective surgery may be permitted through prior agreement and approval by the bureau provided the unrelated surgery is not more extensive than the procedure for the compensable injury. The requesting doctor must submit a written request and identify which services are needed due to the compensable injury and which are needed due to the unrelated conditions, along with an estimate of what effect, if any, the unrelated surgery will have on the compensable injury and recovery time from surgery. Charges associated with the unrelated procedure may not be reimbursed by the bureau unless the bureau had ordered otherwise.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-37. Concurrent care.

1. In some cases, treatment by more than one practitioner may be allowed. The bureau will consider concurrent treatment when the accepted conditions resulting from the injury involve more than one system or require specialty or multidisciplinary care.

2. When requesting consideration for concurrent treatment, the attending doctor must provide the bureau with the following:

   a. The name, address, discipline, and specialty of all other practitioners assisting in the treatment of the injured employee; and

   b. An outline of their responsibility in the case and an estimate of the length of the period of concurrent care.

3. When concurrent treatment is allowed, the bureau will recognize one primary attending doctor, who will be responsible for prescribing all medications; directing the overall treatment program; providing copies of all reports and other data received from the involved practitioners; and, in time loss cases, providing adequate certification evidence of the employee's ability, or inability, to perform work.

4. The bureau will approve concurrent care on a case-by-case basis. Consideration will be given to all factors in the case including availability of providers in the worker's geographic location. The bureau's managed care vendor must be notified of all requests for concurrent care. Except for emergency

services as otherwise provided for in these rules, all treatments must be authorized by the injured employee's attending doctor to be reimbursable.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-38. Changes of doctors.

1. All changes from one doctor to another must be approved by the bureau. Normally, changes will be allowed only after the employee has been under the care of the attending doctor for sufficient time for the doctor to complete necessary diagnostic studies, establish an appropriate treatment regimen, and evaluate the efficacy of the therapeutic program.

2. North Dakota Century Code section 65-05-28 governs choice of doctor. For purposes of this rule, the following are not considered changes of doctor by the employee:

   a. Emergency services by a doctor;

   b. Examinations at the request of the bureau;

   c. Consultations or referrals initiated by the attending doctor;

   d. Referrals to radiologists and pathologists for diagnostic studies;

   e. When employees are required to change doctors to receive compensable medical services, palliative care or time loss authorization because their health care provider is no longer qualified as an attending doctor; or

   f. Changes of attending doctor required due to conditions beyond the employee's control. This would include when the doctor terminates practice or leaves the area.

3. Except as provided under this subsection, no reasonable request for a change will be denied. The injured employee must be advised when and why a change is denied. The bureau reserves the right to require an employee to select another doctor or specialist for treatment under the following conditions:

   a. When more conveniently located doctors, qualified to provide the necessary treatment, are available;

   b. When the attending doctor fails to cooperate in observance and compliance with the bureau's rules;

c. In time loss cases where reasonable progress towards return to work is not shown;

d. Cases requiring specialized treatment, which the attending doctor is not qualified to render, or is outside the scope of the attending doctor's license to practice;

e. Where the bureau finds the change of doctor to be appropriate and has requested the employee to change in accordance with this rule, the bureau may select a new attending doctor if the employee unreasonably refuses or delays in selecting another attending doctor; or

f. In cases where the attending doctor is not qualified to treat each of several accepted conditions. This does not preclude concurrent care where indicated as outlined in section 92-01-02-37.

4. Changes will be authorized for the foregoing reasons or where the bureau in its discretion finds that a change is in the best interest of returning the injured employee to a productive role in society.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-39. Hospitalization.

1. Hospitalization will be paid when medically necessary for treatment of the compensable injury. Unless the employee's condition requires special care, ward or semiprivate accommodations will be paid. When the employee's condition requires special nurses, a private room, or intensive care, the attending doctor may order these services subject to documentation supporting this need.

2. Hospitalization solely for physical therapy, bed rest, or administration of injectable drugs will be paid only when such admission has been recommended as approved by the bureau's managed care vendor.

3. Discharge from the hospital must be at the earliest date possible consistent with proper health care. If transfer to a convalescent center or nursing home is indicated, prior arrangements should be made with the bureau or the bureau's managed care vendor.

4. The bureau may designate those diagnostic and surgical procedures that will be reimbursed only if performed in an outpatient setting. When procedures so designated must be performed in an inpatient setting for reasons of medical

necessity, preservice review must be obtained through the bureau's managed care vendor.

5. Medical equipment, supplies, or hardware will be reimbursed at the actual cost of the item. In addition, a handling fee of ten percent of the actual cost will be paid. Upon request of the bureau, hospitals must supply a copy of their original invoice showing actual cost of the item.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-40. Palliative care.

1. For the purposes of this rule, employees are medically stationary or at maximum medical improvement or recovery when determined to be so by the employee's attending doctor or as established in accordance with section 92-01-02-35. After the employee has become medically stationary, palliative care is compensable without prior approval by the bureau in the following instances:

   a. When necessary to monitor administration of prescription medication required to maintain the employee in a medically stationary condition; or

   b. To monitor the status of a prosthetic device.

2. Review of disputes relating to palliative care provided in accordance with subsection 1, where the bureau, employer, or the bureau's managed care vendor believes the palliative care is excessive, inappropriate, ineffectual, or in violation of the rules regarding the performance of medical services, must be processed in accordance with section 92-01-02-46.

3. When the employee's doctor believes that palliative care, which would otherwise not be compensable, is appropriate to enable the employee to continue current employment, authorization for such treatment may be requested. To obtain such authorization, the attending doctor shall first mail a written request for approval of such treatment to the bureau. The written request must be in a form and format as prescribed by the director and submitted to the bureau prior to the commencement of the treatment. If the palliative care request is approved, services are payable from the date the approved treatment begins. The request must:

   a. Contain all objective findings, and specify if there are none;

b. Identify the medical condition by ICD-9-CM diagnosis for which the palliative treatment is proposed;

c. Provide a proposed treatment plan that includes the specific treatment modalities, the name of the provider who will perform the treatment, and the frequency and duration of the care to be given, not to exceed one hundred eighty days;

d. Describe how the requested palliative care is related to the accepted compensable condition;

e. Describe how the proposed treatment will enable the injured employee to continue employment and the adverse effect on the injured employee if the palliative care is not approved; and

f. Any other information the director, by bulletin, may prescribe.

4. The bureau shall date stamp all palliative care requests upon receipt. Within thirty days of the receipt of a written request from the attending doctor to provide palliative care as described in subsection 3, the bureau shall send written notification to the doctor, the employee, and the employee's attorney approving or disapproving the request.

5. If the attending doctor does not receive written notice from the bureau approving or disapproving the care within thirty days as set forth in subsection 4, the attending doctor may request approval from the director in the manner prescribed in subsection 9.

6. Subsequent requests for palliative care are subject to the same process as the initial request. However, the bureau may waive the requirement that the attending doctor submit a supplemental palliative care request.

7. When the palliative care request is approved, the bureau is responsible for providing payment for palliative care provided as prescribed in the proposed treatment plan or in the modified plan as approved by the bureau.

8. When the request for palliative care is not approved, the bureau shall provide specific reasons for not approving the care. The bureau, in writing, shall do any or all of the following:

a. Identify any disagreement with the attending doctor's diagnosis for which the palliative treatment is proposed.

b. Provide any reasons why the proposed treatment plan is not acceptable.

c. Identify why the proposed treatment will not enable the injured employee to continue current employment.

d. Provide any other reasons they believe the proposed palliative care is not appropriate.

9. When the bureau disapproves the requested palliative care, the attending doctor may request binding dispute resolution in accordance with section 92-01-02-46. Such requests must be submitted within thirty days of the date of the bureau's notice of disapproval. The request must include an explanation as to why the bureau's stated reasons for disapproval are incorrect, and may include any other supporting information the attending doctor wishes to present.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

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

1. The bureau may request an independent medical examination (IME) pursuant to North Dakota Century Code section 65-05-28. Reasons for requesting an independent medical examination include the following:

   a. To establish or clarify a diagnosis. Prior diagnosis may be controversial or ill-defined;

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

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

   d. To determine the extent and duration of aggravation of a preexisting medical condition by an occupational injury or exposure;

   e. To establish when the compensable medical condition has reached maximum medical improvement or when medical stationary status has been reached;

   f. To establish a percentage rating for impairment, based on the loss of, or loss of use of, body function when maximum medical improvement is reached;

   g. To determine the medical indications for reopening of a claim for further treatment on the basis of aggravation of a compensable injury or significant change in medical condition, based upon objective findings;

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

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

j. To determine whether treatment is necessary if the employee appears not to be making progress in recuperation; or

k. In instances when the attending doctor has not provided current medical reports.

2. It is the bureau's intention to purchase objective examinations to ensure that sure and certain determinations are made of all benefits to which the injured employee might be entitled.

3. A report of an independent medical examination must include the following items:

a. A detailed chronology of the injury or condition including mechanism of injury, diagnostic studies, and treatments attempted. The chronology must mention the results of treatments and diagnostic studies;

b. An opinion as to whether treatment actual or proposed is or will be healing or palliative in nature;

c. An assessment of whether the condition is caused by the claimed injury, on a more probable than not basis;

d. Specific diagnoses sorted into the following categories:

(1) The compensable injury;

(2) Preexisting conditions, and a statement as to whether they are worsening on their own or are aggravated by the compensable condition; and

(3) Conditions acquired after the work injury.

e. Answers to written questions posed by the bureau, or a description of what would be needed to address the questions; and

f. Conclusions and a summary statement of the objective medical findings upon which the conclusions are based.

4. Examiners must be willing to testify or be deposed on behalf of the employee, employer, or the bureau.

5. The bureau must provide a minimum of fourteen days' notice to the injured employee regarding an independent medical examination. The bureau must also reimburse the injured employee's expenses for attending the independent medical examination pursuant to North Dakota Century Code section 65-05-28.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-42. Durable medical equipment.

1. The bureau will authorize and pay rental fee for equipment or devices if the need for the equipment will be for a short period of treatment during the acute phase of the condition.

2. The decision to grant or deny authorization for reimbursement of selected services or items will be based on the following criteria:

   a. The employee is eligible for coverage; and

   b. The service or item prescribed is appropriate and medically necessary for treatment of the compensable injury.

3. Rental extending beyond thirty days requires prior authorization from the bureau.

4. If the equipment will be needed on a long-term basis, the bureau will consider purchase of the equipment or device. The bureau's decision to rent or purchase an item of medical equipment will be based on a comparison of the projected rental costs of the item with its purchase price. The bureau will decide whether to rent or purchase certain items, provided they are appropriate and medically necessary for treatment of the compensable injury. Decisions to rent or purchase items will be based on the following information:

   a. Purchase price of the item.

   b. Monthly rental fee.

   c. The prescribing doctor's estimate of how long the item will be needed.

5. The bureau reserves the right to purchase the equipment or item from the most cost-efficient source.

6. The bureau will authorize and pay for prosthetics and orthotics as needed by the injured employee and when

substantiated by the attending doctor. If such items are furnished by the attending doctor or another provider, the bureau will reimburse the doctor or the provider the actual cost for the item. In addition, a handling fee, not to exceed ten percent of the wholesale cost of the item, will be paid. Providers and doctors must supply the bureau with a copy of their original invoice showing actual cost of the item upon request of the bureau.

7. The bureau will repair or replace originally provided damaged, broken, or wornout prosthetics, orthotics, or special equipment devices upon documentation and substantiation from the attending doctor. Prior authorization for such replacements is required.

8. Equipment not requiring prior authorization includes crutches, cervical collars, lumbar and rib belts, and other commonly used orthotics of minimal cost, usually less than fifty dollars.

9. Personal appliances such as vibrators, heating pads, home furnishings, hot tubs, waterbeds, exercise bikes, exercise equipment, Jacuzzies, and similar appliances, will not be authorized or paid unless the bureau orders otherwise.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-43. Home nursing care.

1. When the attending doctor believes special or attendant (home nurse) care is needed the following information must be submitted:

   a. A description of the special or home nursing care required to include estimated time required (i.e., catheterization, three times per day, thirty minutes; bathing, two times per day, one hour; toilet transfers as needed; dressing change, four times per day, two hours).

   b. The skill level or special training required to administer care (i.e., R.N., L.P.N.; family member who has received special training; no special training required).

   c. If known, the name and address of a person or facility willing to provide care.

   d. The length of time special or home nursing care will be required.

2. Approval of fees for home nurse or attendant care is negotiable based upon the care provided, and the level of training of the provider.

3. The bureau may authorize and pay for visiting nurse care necessary for evaluation or instruction of a home health care provider.

4. When the injured employee or injured employee's family makes arrangements for caregivers, reimbursement will be issued directly to the injured employee who is responsible for reimbursing those providing the home nursing care.

5. Payment to individuals for services pursuant to this rule does not constitute an employer and employee relationship between the bureau and the provider of care.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-44. Special programs.

1. The bureau may from time to time enter into special agreements for services provided by, or under the direction of, licensed providers authorized to bill the bureau. Special agreements are for services other than routine services covered under the fee schedule, and may include multidisciplinary or interdisciplinary programs such as pain management, work hardening, and physical conditioning.

2. The bureau shall establish payment rates for special agreements, and may establish outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, special reporting requirements, and such other criteria as will ensure injured employees receive good quality and effective services at a prudent cost.

3. Special agreements may be purchased at the discretion of the bureau. The bureau may terminate special programs upon thirty days' notice to the provider.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-45. Bureau responsibilities.

1. These rules and the fee schedules do not require the bureau to pay a charge for a service that is not for the treatment of a

compensable injury or a charge that is the primary responsibility of another payer.

2. Determinations of excessiveness and medical necessity are subject to a determination of the director or the director's representatives and must be determined by evaluating the charge and service according to the conditions of excessiveness and medical necessity as specified in the medical service rules.

3. As soon as reasonably possible after receiving a bill the bureau shall do any or all of the following:

   a. Pay the charge or any portion of the charge that is not denied.

   b. Deny all or a portion of a charge on the basis that the injury is not compensable, or the service or charge is excessive or not medically necessary.

   c. Request specific additional information to determine whether the charge or service is excessive or not medically necessary or whether the condition is compensable.

4. If a service is not included in the fee schedule and the charge is not otherwise excessive and is medically necessary the bureau shall evaluate the charge against the usual and customary charges prevailing in the same geographic community for similar services.

5. If the charge submitted is less than or equal to the prevailing and customary charges, the bureau shall pay the charge in full. If the charge exceeds the usual and customary charges, the bureau shall pay an amount equal to the usual and customary charge for similar services.

6. The bureau shall provide written notification through a notice of nonpayment to the employee when the employee is personally responsible for the payment of a charge and to the provider through a remittance advice of denial of part or all of a charge, or to the provider for any request for additional information. Written notification must include:

   a. The basis for denial of all or part of a charge that the payer has determined is not for a compensable injury under North Dakota Century Code title 65.

   b. The basis for denial or reduction of each charge and the specific amounts being denied or reduced for each charge meeting the conditions of excessive charge.

c. The basis for denial of each charge meeting the conditions of an excessive service.

d. The basis for denial of each charge not meeting the conditions of medically necessary.

e. A request for an appropriate record or the specific information requested to allow proper determination of the bill, or both.

7. Any payment made to a provider which is determined to be wholly or partially excessive or not medically necessary, according to the conditions prevailing at the time of payment, may be collected from the provider by the bureau in the amount that the reimbursement was excessive.

8. If the bureau requests a special report as defined in section 92-01-02-29, asking the health care provider or doctor to respond to specific questions regarding causation, aggravation, preexisting conditions, or to clarify complex conditions, or other issues not required to be included in standard reports, the bureau will pay a reasonable fee for responding to such requests. The health care provider or doctor should include in the special report the time involved in responding to such requests. Both time factors and complexity of the issues will be considered when determining the reasonableness of fees for such service. Such services should be billed under current procedural terminology code 99080 with a descriptor of "special report".

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

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

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

2. All bills must be fully itemized, including ICD-9-CM codes, and services identified by code numbers and descriptions found in the fee schedules or as otherwise provided for in these rules. The definitions of commonality in the guidelines found in the current procedural terminology must be used as guides governing the descriptions of services, except as otherwise provided in the fee schedules or in these rules.

3. All health care providers shall submit bills referring to one claim only for medical services on current form UB 82 or form HCFA 1500, except for dental billings which must be submitted

on American dental association J512 dental claim forms. Bills and reports must include:

a. The employee's full name and address;

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

c. Date and nature of injury;

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

e. Date of service;

f. Place of service;

g. Type of service;

h. Appropriate procedure code or hospital revenue code;

i. Description of service;

j. Charge for each service;

k. Units of service;

l. If dental, tooth numbers;

m. Total bill charge;

n. Name of practitioner providing service along with the provider's tax identification number;

o. Date of bills; and

p. Submission of supporting documentation or chart notes documenting services that have been billed.

4. Any correspondence received must be legible and reproducible. Legible copies of office or progress notes are required for all followup visits. Office notes are not acceptable in lieu of requested narrative reports. Communications should refer to one claim only.

5. Providers must supply a copy of an appropriate record that adequately documents the service and substantiates the nature and necessity of the service or charge. The following supporting documentation is required when billing for services:

a. Laboratory and pathology reports;

b. X-ray findings;

c. Operative reports;

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

e. Consultation reports;

f. History, physical examination, and discharge summaries;

g. Special diagnostic study reports; and

h. Special or other requested narrative reports.

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

7. Pursuant to subsection 4 of North Dakota Century Code section 65-05-07, a provider may not collect or attempt to collect payment from an injured employee, the employer, or any other insurer or government for an excessive charge or a charge deemed not medically necessary. A charge must be removed by the provider from subsequent bill statements if the bureau has determined the charge is excessive or not medically necessary. Disputes arising out of reduced or denied reimbursement are handled in accordance with section 92-01-02-46. In all cases of accepted compensable injury or illness under the jurisdiction of the workers' compensation law, the injured employee is not liable for payment for any services for the treatment of that injury or illness, with the following exceptions:

a. When the injured employee seeks treatment for conditions not related to the accepted compensable injury or illness;

b. When the injured employee seeks treatment that has not been prescribed by the employee's attending doctor. This would include ongoing treatment by nonattending doctors;

c. When the injured employee seeks palliative care, except as provided in section 92-01-02-40, after the employee has been provided notice that the employee is medically stationary;

d. When the injured employee seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental; and

e. When the injured employee did not follow the requirements of subsection 1 of North Dakota Century Code section 65-05-28 regarding change of doctors.

8. A health care provider may not bill for services not provided to the worker. A health care provider may not bill multiple charges for the same service. Rebilling must indicate that the charges have been previously billed.

9. Pursuant to North Dakota Century Code section 65-05-33, a health care provider may not submit false or fraudulent billings. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation issued with the knowledge that the deception could result in unauthorized benefit to the provider or some other person.

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

11. When an employee is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to the admission must be considered part of the inpatient treatment.

12. Physician assistant or nurse practitioner fees will be paid at the rate of eighty percent of a doctor's fee for a comparable service. The bills for these services must be marked with modifier NP.

13. A physical medicine modality or manipulation, when applied to two or more areas at one visit, must be reimbursed at one hundred percent of the maximum allowable fee for the first area treated, fifty percent for the second area treated, and twenty-five percent for all subsequent areas treated.

14. When ultrasound, diathermy, microwave, infrared, and hot packs are used in combinations of two or more during one treatment session, only one may be reimbursed, unless two separate effects are demonstrated.

15. When multiple areas are examined using CAT scan or magnetic resonance imaging, the first area examined must be reimbursed at one hundred percent, the second area at fifty percent, and the third and all subsequent areas at twenty-five percent of the allowable fee schedule amount.

16. When a health care provider is asked to review records or reports prepared by another health care provider, the provider should bill for its review of the records utilizing current procedural terminology code 99080 with a descriptor of "record review". The billing should include the actual time spent reviewing the records or reports and should list the health

care provider's normal hourly rate for such review. This would include records reviewed for independent medical examination reports.

17. When there is a dispute over the amount of a bill or the necessity of services rendered, the bureau shall pay the undisputed portion of the bill and provide specific reasons for nonpayment or reduction of each medical service code. Resolution of treatment disputes and fee disputes must be made in accordance with section 92-01-02-46.

18. Conditions preexisting or unrelated to the compensable injury are not the responsibility of the bureau. If medical documentation outlines that another condition is being treated concurrently with the compensable injury and the unrelated condition has no effect on the compensable injury, the bureau may reduce the charges submitted for treatment. When an unrelated condition is being treated concurrently with the occupational condition, the attending doctor must notify the bureau immediately and submit the following:

    a. Diagnosis or nature of unrelated condition.

    b. Treatment being rendered.

    c. The effect, if any, on the occupational condition.

    A thorough explanation of how the unrelated condition is affecting the compensable injury must be included with any request for authorization to treat the unrelated condition. Temporary treatment of an unrelated condition may be allowed, upon prior approval by the bureau, provided these conditions directly retard recovery of the compensable condition. The bureau will not approve or pay for treatment for a known preexisting unrelated condition for which the employee was receiving treatment prior to the occupational injury or disease, which is not retarding recovery of the occupational condition. The bureau may not pay for treatment of an unrelated condition when it no longer exerts any influence upon the compensable injury. When treatment of an unrelated condition is being rendered, reports must be submitted monthly outlining the effect of treatment on both the unrelated and the compensable injury conditions.

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

20. The bureau does not pay for the cost of duplicating records when covering the treatment received by the injured employee.

In cases where the bureau requests additional records to those listed in subsection 5 or records prior to the date of injury, the bureau will pay a minimum charge of five dollars for five or less pages and the minimum charge of five dollars plus thirty-five cents per page for every page after the first five pages.

21. The provider shall undertake professional judgment to assign the correct approved billing code for the service rendered using the appropriate provider group designation. Bills received without codes must be returned to the provider.

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

23. Pursuant to subsection 6 of North Dakota Century Code section 65-05-07, providers shall comply within thirty calendar days with the bureau's request for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the bureau's determination of compensability, medical necessity, or excessiveness or the bureau may assess a one hundred dollar penalty for failure to comply.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

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

1. Dispute resolution is mandated by these rules under North Dakota Century Code section 65-02-20 when an aggrieved party raises a bona fide dispute, concerning the bureau's determination that an employee has received, is receiving, or is proposed to receive medical treatment for a compensable condition that is excessive, inappropriate, ineffectual, or in violation of the medical rules regarding the performance of medical services. Dispute resolution is also mandated under these rules where the aggrieved party is an employer who disputes an award of medical services.

2. The bona fide dispute must involve medical services including the following:

   a. Medical services performed by doctors;

   b. Ancillary services that are prescribed by an attending doctor;

c. Any services that cannot be obtained without a doctor's prescription;

d. Those services that qualify for review under this rule pursuant to section 92-01-02-30;

e. Braces, splints, and physical restorative devices will be reviewed under the provisions of this rule only if the sole issue is whether the treatments are excessive, inappropriate, ineffectual, or in violation of the rules regarding the performance of medical services;

f. Requests for palliative care; and

g. Denials or reductions in payment to the health care provider arising out of medical bill review or application of the bureau's fee schedules or medical service rules.

3. An aggrieved party is an employee, employer, or health care provider who raises a bona fide dispute.

4. The bureau may dismiss the petition for dispute resolution, at any time during the proceedings, if it finds there is no bona fide dispute. In such case the bureau will issue an administrative order denying application of these rules to the dispute.

5. In order to show a bona fide dispute:

a. An employer must show that the charges affect the employer's premium payment to the bureau.

b. An employee must show that the reduction or denial of care will oblige the employee to personally pay for the service (e.g., application of the fee schedules reducing a payment to a provider may not be contested by the employee because subsection 4 of North Dakota Century Code section 65-05-07 does not allow the provider to bill the employee for services rendered to treat a compensable injury).

c. Any party must show that the dispute concerns a question of fact. Any dispute that is solely a question of law is not subject to binding dispute resolution under this section. In such case, the bureau shall issue an administrative order. The sole remedy for an aggrieved party is appeal to the appropriate district court. A fact hearing may not be conducted in such case, absent order of a court.

d. Any party must show that the dispute does not concern the compensability of an entire condition (e.g., an employee alleges that diabetes was triggered by injury. The correct issue is whether there is a causal relationship

between injury and condition. In such case the employee's remedy is for formal hearing under North Dakota Century Code chapter 28-32 or binding arbitration under North Dakota Century Code section 65-02-15 et seq.). However, this section does not preclude denial of single medical charges as unrelated.

6. A petition for binding dispute resolution stays payment of the health care provider's bills pending final outcome of the reviews.

7. An aggrieved party must first exhaust the dispute resolution procedures of the managed care vendor prior to filing a request with the bureau for informal review, reconsideration, or for binding dispute resolution on any issue related to managed care services as defined by these rules. The managed care vendor's dispute resolution process must be completed within thirty days of receipt of the necessary information to process the request. The managed care vendor must orally notify the aggrieved party and the bureau of the results of the additional review and notify the bureau in writing within seven days of completion of the additional review.

8. After the aggrieved party exhausts the dispute resolution procedures of the managed care vendor, the bureau shall undertake an informal investigation, review the medical evidence, including any new evidence the aggrieved party submits, and the recommendations of the managed care vendor.

   The bureau shall issue an informal decision within thirty days after receiving written notification of the managed care vendor's dispute resolution results and shall serve a copy of the informal decision to the parties by regular mail. The informal decision must summarize the reason for the determination, but need not make findings of fact and conclusions of law. If the aggrieved party does not file a formal petition for binding dispute resolution under these rules within thirty days of issuance of the bureau's informal decision, that decision is final, subject only to reopening under North Dakota Century Code section 65-05-04.

9. The aggrieved party shall file a formal petition for binding dispute resolution within thirty days of issuance of the bureau's informal decision. The formal petition for binding dispute resolution must be in a form and format as prescribed by the director and must:

   a. Identify the employee's name, date of injury, and claim number;

   b. Certify that the relatedness of ongoing treatment to the work-related injury is not at issue at the time of the

request, except that denial of single medical charges as unrelated may be decided under these rules;

c. Specify the treatment in question along with the time period of the treatment in dispute. When the treatment is proposed, the requesting party shall provide the director with documentation of the specific treatment plan proposed by the attending doctor;

d. Provide all relevant and pertinent medical information along with any medical documentation which indicates that the treatment in question conforms to accepted medical standards of care;

e. Identify any harm that has befallen, or might befall the employee;

f. If applicable, provide specific examples of how the treatment complies with the medical service rules; and

g. Identify the specific relief sought.

10. Similarly, formal petition for binding dispute resolution regarding denial or reductions in fees must be in a form and format as prescribed by the director and must:

a. Be filed within thirty days of issuance of the bureau's informal decision;

b. State specific code and dates of service in dispute;

c. State the grounds for questioning the disputed amount;

d. State the request for correction and relief; and

e. Include specific documentation to support the review request, including copies of original health care financing administration bills, chart notes, remittance advice, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute.

11. The director shall review the formal petition for binding dispute resolution and notify the aggrieved party by regular mail if a bona fide dispute was found to exist. If the director determines that a bona fide dispute exists, an investigation of the petition and evidence must be conducted. The investigation may include request for and review of pertinent medical treatment and payment records, interviews with the parties to the dispute, or consultation with an appropriate health care provider or committee of the provider's peers.

12. The bureau shall arrange all relevant and pertinent medical information in chronological order, with the oldest documents on top, and numbered in Arabic numerals in the lower right-hand corner of each page, beginning with the document of the earliest date. The documents must have an index that includes the document numbers, descriptions of each document, author, number of pages, and date of the document. The bureau shall provide the aggrieved party with a copy of the index.

    If additional information is necessary, the director shall so advise the parties. Upon receipt of a written request for additional information, the parties have fourteen days to respond. If the party does not provide the information requested by the director, the director may issue an order resolving or dismissing the dispute based on available information.

    If the aggrieved party believes that relevant medical information has not been provided, the party shall either provide that information, or identify the report by date, name of provider, and address so that the bureau may obtain the missing medical record. If the aggrieved party submits new evidence, the party shall arrange the evidence in chronological order, with the oldest documents on top, and numbered in Arabic numerals in the lower right-hand corner of each page, beginning with the document of the earliest date.

13. The director shall determine whether it is necessary to appoint medical care providers to examine the records or employee. The director may determine that peer review is not required, and enter a final administrative order based upon the investigation.

14. If the director determines it is necessary to appoint appropriate health care providers to review the case, the providers may:

    a. Examine the medical records; and

    b. If necessary, perform any reasonable and necessary medical tests, other than invasive tests, pursuant to North Dakota Century Code section 65-05-28.

15. The appropriate health care providers are those appointed by the director provided further that:

    a. The director may select a health care provider or convene a panel of health care providers to conduct the review in accordance with subsection 3 of North Dakota Century Code section 65-05-07;

b. When a doctor is selected to conduct a review, the doctor must be a practitioner of the healing art of the health care provider whose treatment is being reviewed; and

c. When a panel of doctors is selected, at least one member of any such panel must be a practitioner of the healing art of the health care provider whose treatment is being reviewed.

16. When an examination of an employee is necessary, the director shall inform the employee of the date, time, and location of the examination with copies to the attending doctor and the selected health care providers, doctor, or panel members. The examination may include:

a. A review of all medical records and x-rays submitted;

b. An interview and examination with the employee; and

c. Performance of any necessary tests, except invasive tests, laboratory studies, or x-rays.

17. If the employee does not attend the examination, without good cause, the director may issue an order resolving or dismissing the dispute based on available information.

18. When an examination of an employee or a review of the employee's medical records is conducted, the doctor or panel of doctors shall mail a report to the director in writing within five days of the examination, with copies mailed to the employee and attending doctor. The report may include:

a. Reason for the examination;

b. Past medical history;

c. Current medical problem;

d. Current treatment;

e. Results of the examination;

f. Results of any tests performed;

g. Diagnosis identified by ICD-9 code or DSM III-R code;

h. Whether the employee is medically stationary;

i. Whether current treatment is excessive, inappropriate, ineffectual, or in violation of the rules; and

j. Whether or not the current treatment should be continued, modified, or terminated.

19. Upon conclusion of the review, those performing peer review shall issue a summary of the pertinent facts, and reasons for the decision as outlined in subsection 18. The director retains continuing jurisdiction pursuant to North Dakota Century Code section 65-05-04, and may affirm, modify, or reverse the decision of those performing peer review. The director shall limit exercise of continuing jurisdiction to reverse or modify the decision of those performing peer review to instances in which:

    a. The peer review decision is contrary to law or the medical service rules; or

    b. The peer review decision has no rational basis.

    The director may refuse to exercise continuing jurisdiction without explanation. The director shall issue a final administrative order in reviewable form containing findings of fact, conclusions of law, and order. The decision that is reviewable by the courts is that of the director.

20. An appeal of the director's order must be taken to the district court specified in North Dakota Century Code section 65-10-01. The provisions of North Dakota Century Code chapter 28-32 are applicable to govern any appeals, except that in accordance with North Dakota Century Code section 65-02-20, the standard of review is whether there has been an abuse of discretion by the director. The provisions of North Dakota Century Code chapter 28-32 which conflict with these rules do not apply by virtue of North Dakota Century Code section 65-02-20.

21. These rules govern any informal request or formal petition for medical services dispute resolution made following a managed care recommendation that occurs on or after January 1, 1994. In order to facilitate uniformity of decision, and speedy resolution of dispute, these rules will also govern any such qualifying request made prior to January 1, 1994, by stipulation of the aggrieved party and the bureau, provided that dispute resolution had not already taken place in any other proceeding regarding the issue in dispute.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20
Law Implemented: NDCC 65-02-20

92-01-02-47. Providers performing peer review.

1. In consultation with the workers compensation bureau's health care advisory board, the director shall establish and maintain a list of appropriate doctors and health care providers or

panel of health care providers and doctors, to review medical services disputes.

2. Doctors and health care providers, and panels of doctors and health care providers, will be selected by the director. To be eligible to receive reimbursement for treating injured employees, all North Dakota doctors and health care providers must be available for peer review upon the request of the director. Peer review members may not include any North Dakota health care providers or doctors whose examination or treatment is the subject of the review, or any health care provider whose license is under suspension by the provider's licensing board.

3. Doctors and health care providers performing peer review and appointed pursuant to this rule and acting pursuant to the authority of the director are agents of the department. The findings of those performing peer review, all of the records and all communications to or before the reviewers are privileged and are not discoverable or admissible in any proceeding other than those under this chapter.

4. Any person performing binding dispute resolution under these rules is immune from any civil liability pursuant to North Dakota Century Code section 65-02-20 so long as that person acts in good faith, without malice, and not for improper personal enrichment.

5. When an employee is required to attend an examination pursuant to section 92-01-02-46, the director shall send notice of the examination to the employee and all affected parties. The notice must inform all parties of the time, date, location, and purpose of the examination.

6. Those performing peer review pursuant to this rule must be paid as follows:

   a. A single health care provider, other than a doctor, shall receive seventy-five dollars to be billed under North Dakota specific code BDR01. In addition, the person shall receive twenty-five dollars for the report to the director, to be billed under North Dakota specific code BDR02. These fees apply to evaluations by all single health care providers, other than doctors.

   b. A single doctor selected pursuant to section 92-01-02-46 to review records, review treatment, perform reasonable and appropriate tests, or examine the employee, shall receive one hundred fifty dollars per hour up to a maximum of four hours for record review and examination. The doctor will also receive one hundred dollars for preparation and submission of the report. Billings for services by a single doctor must be billed under North

Dakota specific code BDR03 for the examination and BDR04 for the report.

c. Health care providers, other than doctors, selected to a panel of reviewers shall each receive seventy-five dollars for record review and the examination. The health care provider who prepares and submits the report shall receive an additional twenty-five dollars. Billings by each panel member selected must be billed under North Dakota specific code BDR05. Billing for the panel report must be billed under North Dakota specific code BDR06.

d. Doctors selected to serve on a panel of doctors to review records, review treatment, perform reasonable and appropriate tests, or examine the employee shall each receive one hundred fifty dollars per hour up to a maximum of four hours for record review and examination. The panel member who prepares and submits the panel report shall receive an additional one hundred dollars for preparation and submission of the report. Billings by each doctor selected to a panel must be billed under North Dakota specific code BDR07 for the examination and BDR08 for the report.

e. Notwithstanding the provisions of this subsection, the director may in a complex case requiring extensive review preauthorize additional fees of up to two hundred dollars above the amounts specified. Billings for that additional amount must be billed under North Dakota specific code BDR09.

7. The costs related to record review, examinations, and reports pursuant to this rule shall be paid by the bureau and charged to the appropriate claim file. If additional diagnostic tests are required, the costs for these tests must be reimbursed in accordance with the North Dakota fee schedules. The bureau shall also pay the employee for travel within the parameters of North Dakota Century Code section 65-05-28.

8. If an employee fails to appear for a required examination under this section, without providing the doctor with at least twenty-four hours' notice, each selected doctor shall receive one hundred dollars. Billings for cancellations in these circumstances must be billed under North Dakota specific code BDR10.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-48. Elements of filing.

1. For purposes of this section, the following terms have the meanings given unless the context clearly indicates a different meaning:

   a. "Appropriate record" means a legible medical record or report from a provider, or any other relevant and material information, substantiating the type, nature, extent, and work-relatedness, if any, of an injury, and adequate to verify the level, type, and extent of services provided.

   b. "Bill" or "billing" means a provider's statement of charges and services rendered for treatment of a work-related injury.

   c. "Bill review" means the review or audit of medical bills and any associated medical records by a contractor for the North Dakota workers compensation bureau and may include review for duplications, omissions, actual delivery of billed services and items, accuracy of charges and associated coding, and improper concurrent billing for services involving evaluation or treatment, or both, of both work-related and nonwork-related problems.

   d. "Claim application" means the worker's claim for injury (SFN 2828), form C1.

   e. "Employer's report" means the employer's report of injury (SFN 13660), form C2.

   f. "Doctor's report" means the doctor's report of injury (SFN 10015), form C3 or other appropriate record that includes the information requested on form C3.

   g. "Provider" is as defined in subsections 13 and 22 of North Dakota Century Code section 65-01-02.

   h. "Reapplication" means worker's notice of reapplication (SFN 16829), form C4, or correspondence signed by the injured employee requesting additional benefits.

   i. "Wage verification" means federal and state income tax returns; W-2 forms; daily, weekly, biweekly, semimonthly, or monthly employer payroll statements; and income statements prepared in accordance with generally accepted accounting practices.

2. The elements of filing for an application for workers' compensation are deemed satisfied when the bureau has received the following items:

   a. Form C1 completed and signed by the employee;

b. Form C2 completed and signed by the employer or the employer's report is deemed admitted pursuant to North Dakota Century Code section 65-01-14;

c. Form C3 or appropriate record completed and signed by the provider;

d. Wage verification as requested by the bureau, if disability benefits are claimed;

e. Appropriate records from the provider; and

f. The claim has been assigned to the appropriate rate classification and proper coverage verified by the policyholder services department.

3. The elements of filing for a reapplication are deemed to be satisfied when the bureau is in receipt of the following items:

a. Form C4 or correspondence requesting benefits signed by the employee;

b. Wage verification as requested by the bureau, if disability benefits are claimed; and

c. Appropriate records from the provider.

4. The elements of filing for payment of a medical bill are deemed satisfied when the bureau is in receipt of the following items:

a. A bill or billing from the provider or employee;

b. Appropriate records from the provider or employee; and

c. A bill review has been completed.

5. If the bureau requests additional material information from the employee in order to process the claim reapplication and the employee does not provide the information as requested, elements of filing are not deemed satisfied until the employee provides the information as requested.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

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

1. Any service performed for another for remuneration under any agreement or contract of hire express or implied is presumed

to be employment unless it is shown that the individual performing the service is an independent contractor as determined by the "common law" test.

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

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

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

(2) Training. Training a person by requiring an experienced employee to work with the person, by

corresponding with the person, by requiring the person to attend meetings, or by using other methods, indicates that the person or persons for whom the services are performed want the services performed in a particular method or manner.

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

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

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

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

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

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

(9) Doing work on the premises of the person or persons for whom the services are performed. If the work is

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

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

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

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

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

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

(15) Significant investment. If the person invests in facilities that are used by the person in performing services and are not typically maintained by employees (such as the maintenance of an office rented at fair value from an unrelated party), that factor tends to indicate that the person is an independent contractor. Lack of investment in facilities indicates dependence on the person or persons for whom the services are performed for such facilities and indicates the existence of an employer-employee relationship.

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

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

(18) Making service available to general public. If a person makes the person's services available to the

general public on a regular and consistent basis that indicates an independent contractor relationship.

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

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

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

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-03

STAFF COMMENT: Chapter 92-05-01 contains all new material but is not underscored so as to improve readability.

ARTICLE 92-05

NORTH DAKOTA WORKERS' COMPENSATION RISK MANAGEMENT PROGRAM

CHAPTER 92-05-01
GENERAL PROVISIONS

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

1. "Accident" means an unplanned event, not necessarily injurious or damaging to property, interrupting the work activity in progress.

2. "Bureau" means the North Dakota workers compensation bureau as described in North Dakota Century Code section 65-01-02.

3. "Coordinator" means a designated person synchronizing, adjusting, integrating, and organizing workers' compensation risk management program efforts.

4. "Employer" means as described in North Dakota Century Code section 65-01-02.

5. "Ergonomics" means the study of human characteristics for the appropriate design of living and work environments.

6. "Essential job functions" means the basic job duties that an employee must be able to perform with or without reasonable accommodation.

7. "Hazard" means an unsafe condition that, if left uncontrolled, may contribute to an accident.

8. "Near miss" means an incident resulting in neither an injury nor property damage which has the potential to inflict injury or property damage.

9. "Premium" means the actual premium determined at the end of the policy period, which is determined by applying the actual yearend payroll of an employer to the rates in effect when the prepaid (or deposit premium) is charged.

10. "Program" means the written workers' compensation risk management program as described in section 92-05-01-04.

11. "Recognized hazard" means an acknowledged unsafe condition that, if left uncontrolled, may contribute to an accident.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-02. Premium discount for approved risk management program. An employer who implements or maintains a program approved by the bureau is entitled to a five percent discount in the annual premium the employer must pay to the bureau for the year following the year in which the program is implemented or maintained.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-03. Procedures for applying for approval of program. The written program must be sent to the bureau no later than thirty days before the end of the premium year. The program must be approved by the bureau and implemented before the end of the first premium year to receive a five percent discount on the premium for the following year.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-04. Written workers' compensation risk management program. A written program as described in the bureau's "North Dakota Workers Compensation Risk Management Program" publication must be submitted to the bureau and must include the following:

1. Safety policy meeting the requirements of section 92-05-01-10.
2. Accident investigation and near miss programs meeting the requirements of section 92-05-01-11.
3. General safety rules meeting the requirements of section 92-05-01-12.
4. Safe operating procedures meeting the requirements of section 92-05-01-13.
5. Workers' compensation claims management program meeting the requirements of section 92-05-01-14.
6. Essential job functions meeting the requirements of section 92-05-01-15.
7. Ergonomics program meeting the requirements of section 92-05-01-16.
8. Self-inspection or hazard recognition program meeting the requirements of section 92-05-01-17.
9. Training program meeting the requirements of section 92-05-01-18.
10. Risk management coordinator meeting the requirements of section 92-05-01-19.
11. Designated medical provider meeting the requirements of section 92-05-01-20.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-05. Risk management seminars. Once the program has been approved, the employer's management representative and the designated risk management coordinator must annually attend one seminar on workplace safety or workers' compensation claims management.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-06. Maintenance of program approval. If an employer maintains program approval, the employer will receive the five percent premium discount on the premium for the premium year following the premium year in which the program was properly implemented or maintained. To maintain program approval an employer must comply with the workers' compensation risk management program designed by the employer and approved by the bureau.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-07. Bureau program certification committee. A committee shall meet to evaluate the program submitted. The committee must consist of the:

1. Bureau policyholder services representative.

2. Bureau claims department representative.

3. Bureau loss prevention director.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-08. Initial and annual approved program review. The bureau shall review each program initially and annually to determine compliance with the employer's program. The bureau's review procedure must be done by one or any combination of the following:

1. Phone.

2. Letter.

3. Physical review.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-09. Bureau assistance and responsibility.

1. Employers who wish to develop an approved program may consult with the bureau or any vendor. The bureau may not be involved in the writing of the program, but will assist the employer to define necessary elements of the program.

2. The bureau has the following responsibilities:

   a. The bureau shall send a list of all losses to employers that have approved programs.

   b. The bureau shall send annual aggregate workers' compensation safety program loss runs to employers that have approved programs.

   c. The bureau shall maintain a current list of employers that have approved programs as well as a loss ratio history on these employers.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-10. Safety policy. A written safety policy must exist which includes the signature of the employer's top management. Included in this policy must be the following:

1. The prevention of accidents is a high priority of management.

2. The reduction of claims costs is a goal of management.

3. The safety responsibilities of all levels of management and the employees must be identified and defined in the policy.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-11. Accident investigation and near miss program. The written accident investigation and near miss program must include the following:

1. Procedures for the investigation of all accidents and near misses.

2. Procedures providing for the review of reports by the employer's management representative and coordinator for corrective action to prevent accident occurrence or reoccurrence.

3. Copies of the following reports used in the accident and near miss program must be available for bureau review:

   a. An initial report of an accident or near miss.

   b. An accident or near miss investigation report, including identification of causes and corrective action recommended and taken.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-12. General safety rules. Written general safety rules for the employer must be posted in a conspicuous manner at fixed worksites and, wherever feasible, at mobile worksites. The employer shall periodically review and update the general safety rules.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-13. Safe operating procedures. Written safe operating procedures must be developed for operations and tasks that involve recognized hazards. A provision must be made by the employer for training as described in section 92-05-01-18 in safe operating procedures.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-14. Claims management program. The written program must address the following:

1. Procedures for training as described in section 92-05-01-18 on claims management program.

2. A return to work plan that includes modified duty.

3. Procedures for informing the injured employee on how to file for benefits and nature of benefits.

4. Immediate report of injury by injured employee.

5. A procedure to identify to the bureau all program-approved claims.

6. The employer's plan for communication among the injured employee, medical provider, and the bureau to facilitate the

return to work and continual progress of the injured employee as described in section 92-05-01-20.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-15. Essential job function. For employers with fifteen or more employees, the essential functions of each job category shall be identified and available for bureau review.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-16. Ergonomics program. A written program must be developed to address musculoskeletal injuries caused by exertions, repetitive motions, or sustained postures. These injuries include back injuries, sprains, strains, carpal tunnel syndrome, and other cumulative trauma disorders. This program must consist of training as described in section 92-05-01-18 to inform workers of ergonomic hazards and enable them to participate in their own protection.

Two years from initial program certification, the following must be implemented:

1. Workplace analysis to determine the recognized ergonomic hazards.

2. Procedures to correct or control ergonomic hazards through engineering, work practices, or administrative controls.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-17. Self-inspection or hazard recognition program. A written program must exist which develops an internal self-inspection program that identifies hazards that exist in the work place. It must outline procedures that will provide for regular and periodic inspection of all work stations. The self-inspection or hazard recognition program must include the following:

1. Description of the types of inspection.

2. Frequency of inspections.

3. Designation of the individuals responsible.

4. Documentation of inspection which includes an allowance for inclusion of the corrective action taken.

5. Review and signature of management.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-18. Training program.

1. A written program identifying training needs and objectives must be developed. This written program must include the following:

   a. New employee orientation program consisting of the following:

      (1) General safety rules.

      (2) Safe operating procedures.

      (3) Ergonomic hazards.

      (4) Claims management program.

   b. Periodic regular training on at least an annual basis of the following:

      (1) General safety rules.

      (2) Safe operating procedures.

      (3) Ergonomic hazards.

      (4) Claims management program.

   c. Training, if procedures are added or changed.

   d. Updated training when new equipment is introduced.

2. Documentation of all training must be done and must include the date of training, topics covered, name of the person providing the training, and participant's acknowledgment of attendance. This documentation must be available for bureau review.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-19. Risk management coordinator. The employer shall designate a risk management coordinator. Any manager or the employer may be assigned these responsibilities. The duties and responsibilities of the coordinator may include the following:

1. Liaison between management and employees, with advice and guidance being given in workplace safety issues.

2. Workers' compensation claims management.

3. Knowledge of current federal, state, local, and industry safety standards that apply to the employer.

4. Training program.

5. Full implementation and development of the risk management program.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

92-05-01-20. Designated medical provider. If feasible, employers must have prearranged medical care for injured employees. The name of the provider must be posted and well publicized by the employer. An injured employee should be encouraged, but cannot be required, to have care provided by this provider. The employer should encourage providers to review the workplace ahead of time to build understanding and assist in early return to work. Normally, the employer's designated provider will treat the employer's injured employee. However, there may be circumstances where this is not possible. Regardless of who the provider is, a relationship must exist which provides the following information:

1. Full reports after treatment which determine the nature and extent of injury. A "release of information" should be signed by all employees and furnished to the medical provider in the event of injury.

2. Estimated course of recovery.

3. Plan to return the injured employee to work.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.1

MARCH 1994

CHAPTER 92-01-02

92-01-02-18. Experience rating system. The following system is established for the experience rating of risks of employers contributing to the fund:

1. Basis for experience rating. A merit rating system must be applied at the termination of the twelve-month insurance period for all employers' accounts of the fund meeting the following qualifications:

   a. The account has completed two consecutive twelve-month insurance periods.

   b. The employer's account, excluding optional coverage, has developed an annual premium of ~~twenty five~~ one hundred dollars or more on its last actual payroll.

   Employer's coverage shall not be eligible for merit rating. No minimum premium shall be eligible for merit rating. When computing merit rating discount, an employer may not pay less than the minimum premium for the highest classification rate of that employer for merit rating purposes. The date claims are accepted must be the controlling factor for the five succeeding years.

2. Basic compensation allowance. The premium allowance is established by adding the total earned premium for each account based on the period within the first five of the six years immediately preceding the twelve-month insurance period times fifty percent of the accumulated earned premium for the

stated five-year period, which equals the premium allowance for a stated twelve-month period.

3. **Merit rate discount.** Percentage of merit rate discount is computed as follows:

   a. The four-year premium and the current year's base premium obtained from the current payroll report are added together.

   b. Take fifty percent of this total, which is the five-years' premium, and arrive at the allowance.

   c. If the losses on the experience rating sheet exceed the allowance arrived at in subdivision b, the allowance figure is subtracted from the loss figure.

   d. This difference is divided by the allowance figure to obtain the percentage of difference.

   e. The percentage of difference is multiplied by ~~forty~~ the maximum percent of charge based upon the amount of premium billed to the individual account.

   f. This figure is the percentage of merit rate charged to be applied on the current estimated portion of the payroll report.

   g. If the allowance figure exceeds the loss figure on the experience rating sheet, the loss figure is subtracted from the allowance figure.

   h. This difference is divided by the allowance figure to obtain the percentage of difference.

   i. This percentage of difference is multiplied by ~~forty~~ the maximum percent of discount based upon the amount of premium billed to the individual account.

   j. This figure is the percentage of merit rate discount to be applied on the current estimated portion of the payroll report.

4. **Percentage charge or discount.** In no instance may the employer's base premium be added to, for charge, or subtracted from, for discount, by more than forty percent. For payroll periods ending July 31, ~~1989~~ 1994, and after, the percentage or merit rate may not change more than forty percent on an individual account of twenty-five thousand dollars or more, thirty-five percent on accounts of five thousand dollars to twenty-four thousand nine hundred ninety-nine dollars, and thirty percent on accounts from one hundred dollars to five thousand dollars.

History: Effective June 1, 1990; amended effective July 1, 1993.
General Authority: NDCC 65-02-08, 65-04-17
Law Implemented: NDCC 65-04-17

92-01-02-20. Classification of employments - Premium rates. Classifications and premium rates, taking into consideration hazards and risks of different occupations, must be those classifications and premium rates contained in the ~~1992 edition of that publication~~ document entitled, "~~North Dakota~~ ND Workers Compensation Bureau ~~Rates and Classifications~~ Summary of Premium/Loss Information" which is hereby adopted by reference thereto and incorporated within this section as though set out in full herein.

Premium rates must be adjusted annually as recommended by the bureau's actuaries based upon the criteria set forth in North Dakota Century Code section 65-04-01.

The minimum premium charge for all classifications will be ~~twenty five~~ one hundred dollars per year except for the following volunteer classifications:

Classification No.	
7710	Fire department, volunteer - minimum will be fifty dollars
7715	Civil defense volunteer disaster - minimum will be fifty dollars
9830	Civil air patrol, volunteer - minimum will be one hundred ten dollars
9385	Volunteer programs - minimum will be one hundred fifty dollars
9840	Vocational training and work evaluation programs, volunteer - minimum will be one hundred fifty dollars

History: Effective June 1, 1990; amended effective July 1, 1990; July 1, 1991; July 1, 1992; July 1, 1993.
General Authority: NDCC 65-02-08, 65-04-01
Law Implemented: NDCC 65-04-01

TITLE 98

Office of Administrative Hearings

JANUARY 1994

CHAPTER 98-02-02

98-02-02-02. Proceedings other than complaint and specific-named respondent - ~~Noncontested cases~~ Notice of hearing.

1. This section does not apply to proceedings pursuant to subsection 1 of North Dakota Century Code section 28-32-05, or proceedings complying with another statute or rule of practice or procedure adopted pursuant to statute by an administrative agency.

2. No hearing may be held unless all the parties have been served notice of the hearing at least ~~fifteen~~ twenty days before the hearing.

3. In an emergency a hearing officer, in the hearing officer's discretion, may give notice of hearing by giving less than ~~fifteen~~ twenty days' notice. Every party to an emergency hearing must be given a reasonable time to prepare for the hearing, which may be extended by the hearing officer upon good cause being shown.

4. The hearing officer shall designate the time and place for the hearing. Service of the notice must be by certified mail or personally. Service may be waived in writing by a party, and the parties may agree on a definite time and place for hearing with the consent of the agency having jurisdiction.

5. The notice for hearing must state the time and place for the hearing, the name and address of the hearing officer, and shall generally inform the parties about the nature of the hearing. In lieu of, or in addition to, a general explanation

about the nature of the hearing contained in the notice, the hearing officer may attach to the notice other pleadings or documents which adequately inform the parties about the nature of the hearing.

History: Effective January 1, 1992; amended effective January 1, 1994.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-05

STAFF COMMENT: Sections 98-02-02-15 and 98-02-02-17 contain all new material but are not underscored so as to improve readability.

98-02-02-15. Disqualification of hearing officer. This section applies only if a party has first petitioned the hearing officer for disqualification under North Dakota Century Code section 28-32-08.1, and the hearing officer has refused to disqualify himself or herself.

1. If the hearing officer whose disqualification is sought has been appointed or designated by the director of the office of administrative hearings, the party may petition the director, requesting appointment or designation of a different hearing officer. Upon receipt of the petition, the director, upon good cause shown, may appoint or designate a different hearing officer.

2. If the hearing officer whose disqualification is sought is the director of the office of administrative hearings, the party may petition the agency head of the agency for which the hearing officer is presiding, requesting appointment or designation of a different hearing officer. Upon receipt of the petition, the agency head, upon good cause shown, may require the director to appoint or designate a different hearing officer.

3. If the hearing officer whose disqualification is sought is an agency hearing officer, i.e., a person assigned, appointed, or designated by the agency head, the agency supervising hearing officer, or another agency official to preside, the party may petition the agency head, requesting appointment or designation of a different hearing officer. Upon receipt of the petition, the agency head, upon good cause shown, may appoint or designate a different hearing officer.

History: Effective January 1, 1994.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-08.1, 54-57-05

98-02-02-17. Request for auxiliary aids or services. A party requesting auxiliary aids or services that may be required for an administrative agency's hearing or related proceeding, whether for the party or a witness of the party, must make the request to the administrative agency prior to the hearing or related proceeding. The administrative agency must respond to the request and provide the aid or service if it is required to do so by federal or state law. However, the agency must be given notice sufficiently prior to the hearing or related proceeding to reasonably enable it to provide the aid or service. If the request is made to the hearing officer, the hearing officer shall inform the agency that the request has been made and refer the request to the agency. If the agency will not provide the requested aid or service, the agency must notify the requesting party and the hearing officer, in writing, that the request is denied and state the reasons for the denial, including whether the request was denied because of the timeliness of the request. If necessary, the hearing officer may reschedule the hearing or related proceeding to allow for provision of the requested aid or service by the agency.

History: Effective January 1, 1994.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-11.1, 28-32-12, 54-57-05

STAFF COMMENT: Section 98-02-03-09 contains all new material but is not underscored so as to improve readability.

CHAPTER 98-02-03

98-02-03-09. The record. Requests by a party, or any other person allowed to participate in the proceeding, for the furnishing of a copy of the record, or a part thereof, under either North Dakota Century Code section 28-32-12 or 28-32-17, shall be made to the administrative agency. If the record is in the possession of the hearing officer, the hearing officer may temporarily return it to the administrative agency for preparation of the transcript, or a part thereof, to furnish to the requesting party or person, or the hearing officer may retain all or a part of the record until the issuance of the hearing officer's order.

History: Effective January 1, 1994.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-12, 28-32-17