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TITLE 4

MANAGEMENT AND BUDGET, OFFICE OF

APRIL 2020

CHAPTER 4-07-02
SALARY ADMINISTRATION PROCEDURES

4-07-02-08. Hiring rate.

~~The hiring rate for a newly hired employee must be within the first half of the salary range.~~ When establishing an entry salary, an appointing authority should consider the employee's job-related qualifications, the agency's ability to recruit qualified employees, the overall relationship of state employees' salaries to market salaries, and internal equity with existing employees' salaries. In determining a starting salary for an applicant who is a current employee of another state agency, an appointing authority also should consider equity between the state agencies.

History: Effective March 1, 1991; amended effective July 1, 2004; April 1, 2020.
General Authority: NDCC 54-44.3-12(1)
Law Implemented: NDCC 54-44.3-01, 54-44.3-12(7)

4-07-02-21. Performance bonus.

Repealed effective April 1, 2020.

~~Human resource management services may approve performance bonuses above the twenty-five percent limitation in subsection 4 of North Dakota Century Code section 54-06-30 upon a showing of special circumstances. Agencies must request, in writing, approval from the director or designee of human resource management services by documenting the special circumstances, which may include:~~

~~1. Instances of exceptional performance by employees in the face of a major disaster;~~

~~2. Instances of exceptional performance by employees as a result of federal or state program initiatives; or~~

~~3. Instances of exceptional performance by a team of employees.~~

~~**History:** Effective July 1, 2010.~~
~~**General Authority:** NDCC 54-44.3-12~~
~~**Law Implemented:** NDCC 54-06-30~~

CHAPTER 4-07-03

4-07-03-10. Classification process and notifications.

Upon receipt of a classification or reclassification request, human resource management services shall initiate a review of the position and provide the agency with a determination within thirty calendar days or, if referred to the job evaluation committee, within sixty calendar days. If human resource management services concurs with the agency request, the classification or reclassification shall be implemented. Human resource management services also may determine another classification is more appropriate for the position or none of the existing classifications is appropriate for the position. If human resource management services determines none of the existing classifications is appropriate for the position, human resource management services shall draft an appropriate classification description for evaluation by the job evaluation committee. If ~~either~~the agency or employee does not agree with the determination made by human resource management services~~ or the agency does not concur~~, human resource management services shall ensure ~~that~~the complete job information is gathered and prepared for presentation to the job evaluation committee for a determination. If the review is not completed within ~~sixty days~~the authorized time period, human resource management services shall notify the appointing authority of the reasons for an extension and the anticipated schedule for completion of the review. Human resource management services shall notify the appointing authority and employee in writing of the job evaluation committee's decision within fifteen ~~working~~calendar days. If either the employee or appointing authority disagrees with the job evaluation committee's decision, an appeal may be made as provided in chapter 59.5-03-02.

History: Effective September 1, 1992; amended effective November 1, 1996; July 1, 2004; July 1, 2014; April 1, 2020.
General Authority: NDCC 54-44.3-12
Law Implemented: NDCC 54-44.3-12(1)

4-07-03-10.1. Effective date of classification assignment.

The effective date of a classification assignment is the date specified by the appointing authority. However, the effective date may not be earlier than the month in which the reclassification request is approved pursuant to section 4-07-03-10. An earlier effective date may be applied with written approval from the director of human resource management services.

History: Effective November 1, 1996; amended effective April 1, 2020.
General Authority: NDCC 54-44.3-12(1)
Law Implemented: NDCC 54-44.3-12(1)

4-07-04-09. Pay grade review process, pay grade exceptions, and notifications.

Upon receipt of a pay grade review request, human resource management services will initiate review of the pay grade or classification as appropriate. Human resource management services will ensure that complete job and statistical information is gathered and prepared for presentation to the job evaluation committee for determination. Human resource management services and the job evaluation committee may assign a pay grade that is higher than that determined by the application of the class evaluation system. This may be done when the pay grade assigned to a class has not resolved significant problems in the recruiting or retention of qualified individuals for a class. When a pay grade exception is assigned to a class, the grade must be identified as such and the appointing authority and all employees in the class must be notified. If the review is not completed within sixty calendar days, human resource management services will notify the appointing authority of the reasons for an extension and the anticipated schedule for completion of the review. If either the employee or appointing authority disagree with the job evaluation committee's decision, an appeal may be made as provided in chapter 59.5-03-02.1.

History: Effective September 1, 1992; amended effective November 1, 1996; July 1, 2004; July 1, 2014; April 1, 2020.
General Authority: NDCC 54-44.3-12
Law Implemented: NDCC 54-44.3-12(1)

4-07-04-09.1. Effective date of pay grade assignment.

The effective date of a pay grade assignment is the date specified by the appointing authority. However, the date may not be earlier than the month in which the change is approved pursuant to section 4-07-04-09. An earlier effective date may be applied with written approval from the director of human resource management services.

History: Effective November 1, 1996; amended effective April 1, 2020.
General Authority: NDCC 54-44.3-12
Law Implemented: NDCC 54-44.3-12(1)

CHAPTER 4-07-05
RECRUITMENT AND SELECTION

4-07-05-01.1. Definitions.

The terms used throughout this chapter have the same meaning as those in North Dakota Century Code chapter 54-44.3, except:

1. "Closing date" means a date by which applications must be received or postmarked as specified.

2. "External recruiting" means that applications for filling a vacant position under an appointing authority shall be accepted from current employees of the appointing authority and persons not employed by the appointing authority.

3. "Internal recruiting" means that applications for filling a vacant position under an appointing authority shall only be accepted from current employees of the appointing authority and employees eligible for reinstatement by the appointing authority.

4. "Promotion" means a personnel action that results in the advancement of an employee to a position in a different class that has a higher pay grade than the employee's previous position.

5. "Regular employee" means a person who has completed the probationary period and who is or was in a position classified by human resource management services at the time the personnel action occurs.

6. "Reinstatement" means a personnel action that involves the reemployment of a previous employee of the appointing authority, who resigned or was separated while in good standing in a classified position.

7. "Transfer" means a personnel action that results in the reassignment of an employee from one position to a different position that has the same pay grade as the employee's previous position and that does not result in a break in service.

8. ~~"Underfill" means to fill a classified position by employing, promoting, reinstating, or transferring an individual into a classified position at a lower class than originally announced.~~

~~9.~~ "Vacancy announcement" means an announcement that a particular position is vacant and that the appointing authority intends to recruit to fill it.

History: Effective July 1, 1995; amended effective November 1, 1996; July 1, 2004; April 1, 2020.

General Authority: NDCC 54-44.3-12
Law Implemented: NDCC 54-44.3-12(1)

4-07-05-06. ~~Underfill~~Alternative classification.

When no fully qualified candidates are available after an internal or external recruiting effort, an appointing authority may ~~underfill~~apply an alternative classification when filling a position if each of the following requirements are met:

1. The ~~duration of the underfill does not exceed two years. If special circumstances require a period exceeding two years, an appointing authority shall request written approval from human resource management services~~hiring authority shall include clear language in the position announcement that an alternative classification may be considered and explaining what circumstances will justify an alternative classification.

2. The alternative classification must be one for which human resource management services either has granted specific prior approval for use in the position announcement or has provided delegated authority for position classification assignments to the agency as pursuant to section 4-07-03-06.1.

3. The applicant selected possesses the appropriate license or meets other applicable statutory requirements.

History: Effective July 1, 1995; amended effective November 1, 1996; July 1, 2004; April 1, 2020.
General Authority: NDCC 54-44.3-12
Law Implemented: NDCC 54-44.3-12

4-07-05-08. Vacancy announcement contents.

Each vacancy announcement must include the following information:

1. Class or working title.
2. Position number for internal use only.
3. Salary or projected hiring range.
4. Closing date.
5. Duty location of position (city).
6. Procedures for applying.
7. Summary of work.
8. Minimum qualifications and special requirements.
9. Whether recruitment is internal or external.
10. Status:
    a. Full time or part time; and
    b. Regular or temporary.
11. If a position is exempt from veterans' preference, the advertisement must state that veterans' preference does not apply to the position being advertised.

Additional preferred qualifications may be listed on the vacancy announcement at the discretion of the appointing authority, or a reference to the position description may be made.

History: Effective November 1, 1996; amended effective July 1, 2004; July 1, 2008; January 1, 2012; April 1, 2020.
General Authority: NDCC 54-44.3-12
Law Implemented: NDCC 37-19.1-02(4), 54-44.3-12

4-07-05-09. Vacancy announcement requirements.

1. A vacancy announcement may not contain minimum qualifications that are less than the established minimum qualifications on the class description, but it may contain more specific requirements.

2. When advertising for required education on a vacancy announcement, an appointing authority may:

   a. Narrow the range of appropriate degrees.

   b. Specify the additional training or experience needed for working in an upper level of a class series.

3. An appointing authority shall define the type and length of experience that substitutes for a college degree, if a substitution statement is used in the minimum qualifications of the class description.

4. An appointing authority wishing to consider applicants for ~~underfill~~an alternative classification in the initial vacancy announcement shall indicate such and state the required minimum qualifications for the ~~underfill~~alternative classification.

History: Effective November 1, 1996; amended effective July 1, 2004; April 1, 2020.
General Authority: NDCC 54-44.3-12
Law Implemented: NDCC 54-44.3-12

4-07-13-07. Uses of sick leave.

Sick leave may be used by an employee when:

1. The employee is ill or injured and is unable to work.

2. The employee has an appointment for the diagnosis or treatment of a medically related condition.

3. The employee wishes to attend to the needs of the employee's eligible family members who are ill or to assist them in obtaining other services related to their health or well-being.

   a. Sick leave used for these purposes may not exceed eighty hours per calendar year.

   b. The employee may, per calendar year, take up to an additional four hundred eighty hours of the employee's accrued sick leave to care for the employee's child, spouse, or parent with a serious health condition. The employer may require the employee to provide written verification of the serious health condition by a health care provider.

4. During the first six months following the birth or placement of a child, an employee may use up to six weeks of the employee's accrued sick leave for the employee's newborn child or to care for a child placed with the employee for adoption or placed with the employee as a precondition to adoption. This does not prevent an employee from using sick leave for the employee's illness, medical needs, or health needs following the birth of a child or from using leave under North Dakota Century Code section 54-52.4-03.

5. The employee is seeking services or assisting the employee's spouse, parent, child, or sibling in obtaining services, relating to domestic violence, a sex offense, stalking, or terrorizing. At the discretion of the employee's supervisor, the sick leave hours used for this purpose may be limited to forty hours per calendar year.

6. The employee requests leave to bereave the death of a child. Sick leave for this purpose is limited to one hundred sixty hours and must be taken within six months following the death of the child.

7. It is appropriate as a participant in an employee assistance program.

History: Effective September 1, 1992; amended effective January 1, 2012; January 1, 2017; April 1, 2020.
General Authority: NDCC 54-44.3-12
Law Implemented: NDCC 54-44.3-12(1), 54-52.4-03

TITLE 43

INDUSTRIAL COMMISSION

APRIL 2020

CHAPTER 43-02-03

43-02-03-10. Authority to cooperate with other agencies.

The commission may from time to time enter ~~into arrangements~~agreements with state and federal government agencies, tribal authorities, industry committees, and individuals with respect to special projects, services, and studies relating to conservation of oil and gas.

History: Amended effective April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-14.2. Oil and gas metering systems.

1. **Application of section.** This section is applicable to all allocation and custody transfer metering stations measuring production from oil and gas wells within the state of North Dakota, including private, state, and federal wells. If these rules differ from federal requirements on measurement of production from federal oil and gas wells, the federal rules take precedence.

2. **Definitions.** As used in this section:

   a. "Allocation meter" means a meter used by the producer to determine the volume from an individual well before it is commingled with production from one or more other wells prior to the custody transfer point.

   b. "Calibration test" means the process or procedure of adjusting an instrument, such as a gas meter, so its indication or registration is in satisfactorily close agreement with a reference standard.

   c. "Custody transfer meter" means a meter used to transfer oil or gas from the producer to transporter or purchaser.

   d. "Gas gathering meter" means a meter used in the custody transfer of gas into a gathering system.

   e. "Meter factor" means a number obtained by dividing the net volume of fluid (liquid or gaseous) passed through the meter during proving by the net volume registered by the meter.

f. "Metering proving" means the procedure required to determine the relationship between the true volume of a fluid (liquid or gaseous) measured by a meter and the volume indicated by the meter.

3. **Inventory filing requirements.** The owner of metering equipment shall file with the commission an inventory of all meters used for custody transfer and allocation of production from oil or gas wells, or both. Inventories must be updated on an annual basis, and filed with the commission on or before the first day of each year, or they may be updated as frequently as monthly, at the discretion of the operator. Inventories must include the following:

   a. Well name and legal description of location or meter location if different.

   b. North Dakota industrial commission well file number.

   c. Meter information:

      (1) Gas meters:

         (a) Make and model.

         (b) Differential, static, and temperature range.

         (c) Orifice tube size (diameter).

         (d) Meter station number.

         (e) Serial number.

      (2) Oil meters:

         (a) Make and model.

         (b) Size.

         (c) Meter station number.

         (d) Serial number.

4. **Installation and removal of meters.** The commission must be notified of all custody transfer meters placed in service. The owner of the custody transfer equipment shall notify the commission of the date a meter is placed in service, the make and model of the meter, and the meter or station number. The commission must also be notified of all metering installations removed from service. The notice must include the date the meter is removed from service, the serial number, and the meter or station number. The required notices must be filed with the commission within thirty days of the installation or removal of a meter.

   All allocation meters must be approved prior to installation and use. The application for approval must be on a sundry notice (form 4 or form provided by the commission) and shall include the make and model number of the meter, the meter or station number, the serial number, the well name, its location, and the date the meter will be placed in service.

   Meter installations for measuring production from oil or gas wells, or both, must be constructed to American petroleum institute or American gas association standards or to meter manufacturer's recommended installation. Meter installations constructed in accordance with American petroleum institute or American gas association standards in effect at the time of installation shall not automatically be required to retrofit if standards are revised. The commission will review any revised standards, and when deemed necessary will amend the requirements accordingly.

5. **Registration of persons proving or testing meters.** All persons engaged in meter proving or testing of oil and gas meters must be registered with the commission. Those persons involved in oil meter testing, by flowing fluid through the meter into a test tank and then gauging the tank, are exempted from the registration process. However, such persons must notify the commission prior to commencement of the test to allow a representative of the commission to witness the testing process. A report of the results of such test shall be filed with the commission within thirty days after the test is completed. Registration must include the following:

   a. Name and address of company.

   b. Name and address of measurement personnel.

   c. Qualifications, listing experience or specific training.

   Any meter tests performed by a person not registered with the commission will not be accepted as a valid test.

6. **Calibration requirements.** Oil and gas metering equipment must be proved or tested to American petroleum institute or American gas association standards or to the meter manufacturer's recommended procedure to establish a meter factor or to ensure measurement accuracy. The owner of a custody transfer meter or allocation meter shall notify the commission at least ten days prior to the testing of any meter.

   a. Oil allocation meter factors shall be maintained within two percent of original meter factor. If the factor change between provings or tests is greater than two percent, ~~the~~ meter use must be discontinued until successfully reproven after being repaired or ~~adjusted and tested within forty-eight hours of repair or~~ replaced.

   b. Oil custody transfer meter factors must be maintained within one-quarter of one percent of the previous meter factor. If the factor change between provings or tests is greater than one-quarter of one percent, meter use must be discontinued until successfully reproven after being repaired or replaced.

   c. Copies of all oil allocation meter test procedures are to be filed with and reviewed by the commission to ensure measurement accuracy.

   ~~c.~~d. All gas meters must be tested with a minimum of a three-point test for static and differential pressure elements and a two-point test for temperature elements. The test reports must include an as-found and as-left test and a detailed report of changes.

   ~~d.~~e. Test reports must include the following:

      (1) Producer name.

      (2) ~~Lease~~Well or CTB name.

      (3) Well file number or CTB number.

      (4) Pipeline company or company name of test contractor.

      ~~(4)~~(5) Test personnel's name.

      ~~(5)~~(6) Station or meter number.

   ~~e.~~f. Unless required more often by the director, minimum frequency of meter proving or calibration tests are as follows:

(1) Oil meters used for custody transfer shall be proved monthly for all measured volumes which exceed two thousand barrels per month. For volumes two thousand barrels or less per month, meters shall be proved at each two thousand barrel interval or more frequently at the discretion of the operator.

(2) Quarterly for oil meters used for allocation of production.

(3) Semiannually for gas meters used for allocation of production.

(4) Semiannually for gas meters in gas gathering systems.

(5) For meters measuring more than one hundred thousand cubic feet [2831.68 cubic meters] per day on a monthly basis, orifice plates shall be inspected semiannually, and meter tubes shall be inspected at least every five years to ensure continued conformance with the American gas association meter tube specifications.

(6) For meters measuring one hundred thousand cubic feet [2831.68 cubic meters] per day or less on a monthly basis, orifice plates shall be inspected annually.

~~f.~~g. ~~Meter~~All meter test reports, including failed meter test reports, must be filed within thirty days of completion of proving or calibration tests unless otherwise approved. Test reports are to be filed on, but not limited to, all meters used for allocation measurement of oil or gas and all meters used in crude oil custody transfer.

~~g.~~h. Accuracy of all equipment used to test oil or gas meters must be traceable to the standards of the national institute of standards and technology. The equipment must be certified as accurate either by the manufacturer or an independent testing facility. The certificates of accuracy must be made available upon request. Certification of the equipment must be updated as follows:

(1) Annually for all equipment used to test the pressure and differential pressure elements.

(2) Annually for all equipment used to determine temperature.

(3) Biennially for all conventional pipe provers.

(4) Annually for all master meters.

(5) Five years for equipment used in orifice tube inspection.

7. **Variances.** Variances from all or part of this section may be granted by the commission provided the variance does not affect measurement accuracy. All requests for variances must be on a sundry notice (form 4).

   A register of variances requested and approved must be maintained by the commission.

History: Effective May 1, 1994; amended effective July 1, 1996; September 1, 2000; July 1, 2002; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-15. Bond and transfer of wells.

1. **Bond requirements.** Prior to commencing ~~drilling operations~~construction of a site or appurtenance or road access thereto, any person who proposes to drill a well for oil, gas, injection, or source well for use in enhanced recovery operations, shall submit to the commission, and obtain its approval, a surety bond or cash bond. An alternative form of

security may be approved by the commission after notice and hearing, as provided by law. The operator of such well shall be the principal on the bond covering the well. Each surety bond shall be executed by a responsible surety company authorized to transact business in North Dakota.

2. **Bond amounts and limitations.** The bond shall be in the amount of fifty thousand dollars when applicable to one well only. Wells drilled to a total depth of less than two thousand feet [609.6 meters] may be bonded in a lesser amount if approved by the director. When the principal on the bond is drilling or operating a number of wells within the state or proposes to do so, the principal may submit a bond conditioned as provided by law. Wells utilized for commercial injection operations must be bonded in the amount of ~~fifty~~one hundred thousand dollars. A blanket bond covering more than one well shall be in the amount of one hundred thousand dollars, provided the bond shall be limited to no more than six of the following in aggregate:

   a. A well that is a dry hole and is not properly plugged;

   b. A well that is plugged and the site is not properly reclaimed; ~~and~~

   c. A well that is abandoned pursuant to subsection 1 of North Dakota Century Code section 38-08-04 or section 43-02-03-55 and is not properly plugged and the site is not properly reclaimed; and

   d. A well that is temporarily abandoned under section 43-02-03-55 for more than seven years.

   If this aggregate of wells is reached, all well permits, for which drilling has not commenced, held by the principal of such bond are suspended. No rights may be exercised under the permits until the aggregate of wells drops below the required limit, or the operator files the appropriate bond to cover the permits, at which time the rights given by the drilling permits are reinstated. A well with an approved temporary abandoned status for no more than seven years shall have the same status as an oil, gas, or injection well. The commission may, after notice and hearing, require higher bond amounts than those referred to in this section. Such additional amounts for bonds must be related to the economic value of the well or wells and the expected cost of plugging and well site reclamation, as determined by the commission. The commission may refuse to accept a bond or to add wells to a blanket bond if the operator or surety company has failed in the past to comply with statutes, rules, or orders relating to the operation of wells; if a civil or administrative action brought by the commission is pending against the operator or surety company; or for other good cause.

3. **Unit bond requirements.** Prior to commencing unit operations, the operator of any area under unitized management shall submit to the commission, and obtain its approval, a surety bond or cash bond. An alternative form of security may be approved by the commission after notice and hearing, as provided by law. The operator of the unit shall be the principal on the bond covering the unit. The amount of the bond shall be specified by the commission in the order approving the plan of unitization. Each surety bond shall be executed by a responsible surety company authorized to transact business in North Dakota.

   Prior to transfer of a unit to a new operator, the commission, after notice and hearing, may revise the bond amount for a unit, or in the case when the unit was not previously bonded, the commission may require a bond and set a bond amount for the unit.

4. **Bond terms.** Bonds shall be conditioned upon full compliance with North Dakota Century Code chapter 38-08, and all administrative rules and orders of the commission. It shall be a plugging bond, as well as a drilling bond, and is to endure up to and including approved plugging of all oil, gas, and injection wells as well as dry holes. Approved plugging shall also

include practical reclamation of the well site and appurtenances thereto. If the principal does not satisfy the bond's conditions, then the surety shall satisfy the conditions or forfeit to the commission the face value of the bond.

5. **Transfer of wells under bond.** Transfer of property does not release the bond. In case of transfer of property or other interest in the well and the principal desires to be released from the bond covering the well, such as producers, not ready for plugging, the principal must proceed as follows:

   a. The principal must notify the director, in writing, of all proposed transfers of wells at least thirty days before the closing date of the transfer. The director may, for good cause, waive this requirement.

      (1) The principal shall submit a schematic drawing identifying all lines owned by the principal which leave the constructed pad or facility and shall provide any details the director deems necessary.

      (2) The principal shall submit to the commission a form 15 reciting that a certain well, or wells, describing each well by quarter-quarter, section, township, and range, is to be transferred to a certain transferee, naming such transferee, for the purpose of ownership or operation. The date of assignment or transfer must be stated and the form signed by a party duly authorized to sign on behalf of the principal.

      (3) On said transfer form the transferee shall recite the following: "The transferee has read the foregoing statement and does accept such transfer and does accept the responsibility of such well under the transferee's one-well bond or, as the case may be, does accept the responsibility of such wells under the transferee's blanket bond, said bond being tendered to or on file with the commission." Such acceptance must likewise be signed by a party authorized to sign on behalf of the transferee and the transferee's surety.

   b. When the commission has passed upon the transfer and acceptance and accepted it under the transferee's bond, the transferor shall be released from the responsibility of plugging the well and site reclamation. If such wells include all the wells within the responsibility of the transferor's bond, such bond will be released by the commission upon written request. Such request must be signed by an officer of the transferor or a person authorized to sign for the transferor. The director may refuse to transfer any well from a bond if ~~the~~any well on the bond is in violation of a statute, rule, or order. No abandoned well may be transferred from a bond unless the transferee has obtained a single well bond in an amount equal to the cost of plugging the well and reclaiming the well site.

   c. The transferee (new operator) of any oil, gas, or injection well shall be responsible for the plugging and site reclamation of any such well. For that purpose the transferee shall submit a new bond or, in the case of a surety bond, produce the written consent of the surety of the original or prior bond that the latter's responsibility shall continue and attach to such well. The original or prior bond shall not be released as to the plugging and reclamation responsibility of any such transferor until the transferee shall submit to the commission an acceptable bond to cover such well. All liability on bonds shall continue until the plugging and site reclamation of such wells is completed and approved.

6. **Treating plant bond.** Prior to ~~the commencement of operations~~commencing site or road access construction, any person proposing to operate a treating plant must submit to the commission and obtain its approval of a surety bond or cash bond. An alternative form of security may be approved by the commission after notice and hearing, as provided by law. The person responsible for the operation of the plant shall be the principal on the bond. Each

surety bond shall be executed by a responsible surety company authorized to transact business in North Dakota. The amount of the bond must be as prescribed in section 43-02-03-51.3. It is to remain in force until the operations cease, all equipment is removed from the site, and the site and appurtenances thereto are reclaimed, or liability of the bond is transferred to another bond that provides the same degree of security. If the principal does not satisfy the bond's conditions, then the surety shall satisfy the conditions or forfeit to the commission the face value of the bond.

7. **Saltwater handling facility bond.** Prior to ~~the commencement of operations~~commencing site or road access construction, any person proposing to operate a saltwater handling facility that is not already bonded as an appurtenance shall submit to the commission and obtain its approval of a surety bond or cash bond. An alternative form of security may be approved by the commission after notice and hearing, as provided by law. The person responsible for the operation of the saltwater handling facility must be the principal on the bond. Each surety bond must be executed by a responsible surety company authorized to transact business in North Dakota. The amount of the bond must be as prescribed in section 43-02-03-53.3. It is to remain in force until the operations cease, all equipment is removed from the site, and the site and appurtenances thereto are reclaimed, or liability of the bond is transferred to another bond that provides the same degree of security. If the principal does not satisfy the bond's conditions, the surety shall satisfy the conditions or forfeit to the commission the face value of the bond. Transfer of property does not release the bond. The director may refuse to transfer any saltwater handling facility from a bond if the saltwater handling facility is in violation of a statute, rule, or order.

8. **Crude oil and produced water underground gathering pipeline bond.** The bonding requirements for crude oil and produced water underground gathering pipelines are not to be construed to be required on flow lines, injection pipelines, pipelines operated by an enhanced recovery unit for enhanced recovery unit operations, or on piping utilized to connect wells, tanks, treaters, flares, or other equipment on the production facility.

   a. Any owner of an underground gathering pipeline transferring crude oil or produced water, after April 19, 2015, shall submit to the commission and obtain its approval of a surety bond or cash bond prior to July 1, 2017. Any owner of a proposed underground gathering pipeline to transfer crude oil or produced water shall submit to the commission and obtain its approval of a surety bond or cash bond prior to placing into service. An alternative form of security may be approved by the commission after notice and hearing, as provided by law. The person responsible for the operation of the crude oil or produced water underground gathering pipeline must be the principal on the bond. Each surety bond must be executed by a responsible surety company authorized to transact business in North Dakota. The bond must be in the amount of fifty thousand dollars when applicable to one crude oil or produced water underground gathering pipeline system only. Such underground gathering pipelines that are less than one mile [1609.34 meters] in length may be bonded in a lesser amount if approved by the director. When the principal on the bond is operating multiple gathering pipeline systems within the state or proposes to do so, the principal may submit a blanket bond conditioned as provided by law. A blanket bond covering one or more underground gathering pipeline systems must be in the amount of one hundred thousand dollars. The owner shall file with the director, as prescribed by the director, a geographical information system layer utilizing North American datum 83 geographic coordinate system and in an environmental systems research institute shape file format showing the location of all associated above ground equipment and the pipeline centerline from the point of origin to the termination point of all underground gathering pipelines on the bond. Each layer must include at least the following information:

(1) The name of the pipeline gathering system and other separately named portions thereof;

(2) The type of fluid transported;

(3) The pipeline composition;

(4) Burial depth; and

(5) Approximate in-service date.

b. The blanket bond covering more than one underground gathering pipeline system is limited to no more than six of the following instances of noncompliance in aggregate:

(1) Any portion of an underground gathering pipeline system that has been removed from service for more than one year and is not properly abandoned pursuant to section 43-02-03-29.1; and

(2) An underground gathering pipeline right-of-way, including associated above ground equipment, which has not been properly reclaimed pursuant to section 43-02-03-29.1.

If this aggregate of underground gathering pipeline systems is reached, the commission may refuse to accept additional pipeline systems on the bond until the aggregate is brought back into compliance. The commission, after notice and hearing, may require higher bond amounts than those referred to in this section. Such additional amounts for bonds must be related to the economic value of the underground gathering pipeline system and the expected cost of pipeline abandonment and right-of-way reclamation, as determined by the commission. The commission may refuse to accept a bond or to add underground gathering pipeline systems to a blanket bond if the owner or surety company has failed in the past to comply with statutes, rules, or orders relating to the operation of underground gathering pipelines; if a civil or administrative action brought by the commission is pending against the owner or surety company; if an underground gathering pipeline system has exhibited multiple failures; or for other good cause.

c. The underground gathering pipeline bond is to remain in force until the pipeline has been abandoned, as provided in section 43-02-03-29.1, and the right-of-way, including all associated above ground equipment, has been reclaimed as provided in section 43-02-03-29.1, or liability of the bond is transferred to another bond that provides the same degree of security. If the principal does not satisfy the bond's conditions, the surety shall satisfy the conditions or forfeit to the commission the face value of the bond.

d. Transfer of underground gathering pipelines under bond. Transfer of property does not release the bond. In case of transfer of property or other interest in the underground gathering pipeline and the principal desires to be released from the bond covering the underground gathering pipeline, the principal must proceed as follows:

(1) The principal shall notify the director, in writing, of all proposed transfers of underground gathering pipelines at least thirty days before the closing date of the transfer. The director, for good cause, may waive this requirement.

Notice of underground gathering pipeline transfer. The principal shall submit, as provided by the director, a geographical information system layer utilizing North American datum 83 geographic coordinate system and in an environmental systems research institute shape file format showing the location of all associated above ground equipment and the pipeline centerline from the point of origin to the termination point of all underground gathering pipelines to be transferred to a certain

transferee, naming such transferee, for the purpose of ownership or operation. The date of assignment or transfer must be stated and the form 15pl signed by a party duly authorized to sign on behalf of the principal.

The notice of underground gathering pipeline transfer must recite the following: "The transferee has read the foregoing statement and does accept such transfer and does accept the responsibility of such underground gathering pipelines under the transferee's pipeline bond or, as the case may be, does accept the responsibility of such underground gathering pipelines under the transferee's pipeline systems blanket bond, said bond being tendered to or on file with the commission." Such acceptance must likewise be signed by a party authorized to sign on behalf of the transferee and the transferee's surety.

(2) When the commission has passed upon the transfer and acceptance and accepted it under the transferee's bond, the transferor must be released from the responsibility of abandoning the underground gathering pipelines and right-of-way reclamation. If such underground gathering pipelines include all underground gathering pipeline systems within the responsibility of the transferor's bond, such bond will be released by the commission upon written request. Such request must be signed by an officer of the transferor or a person authorized to sign for the transferor. The director may refuse to transfer any underground gathering pipeline from a bond if the underground gathering pipeline is in violation of a statute, rule, or order.

(3) The transferee (new owner) of any underground gathering pipeline is responsible for the abandonment and right-of-way reclamation of any such underground gathering pipeline. For that purpose the transferee shall submit a new bond or, in the case of a surety bond, produce the written consent of the surety of the original or prior bond that the latter's responsibility shall continue and attach to such underground gathering pipeline. The original or prior bond may not be released as to the abandonment and right-of-way reclamation responsibility of any such transferor until the transferee submits to the commission an acceptable bond to cover such underground gathering pipeline. All liability on bonds continues until the abandonment and right-of-way reclamation of such underground gathering pipeline is completed and approved by the director.

9. **Bond termination.** The commission shall, in writing, advise the principal and any sureties on any bond as to whether the plugging and reclamation is approved. If approved, liability under such bond may be formally terminated upon receipt of a written request by the principal. The request must be signed by an officer of the principal or a person authorized to sign for the principal.

10. **Director's authority.** The director is vested with the power to act for the commission as to all matters within this section, except requests for alternative forms of security, which may only be approved by the commission.

History: Amended effective April 30, 1981; March 1, 1982; January 1, 1983; May 1, 1990; May 1, 1992; May 1, 1994; July 1, 1996; December 1, 1996; September 1, 2000; July 1, 2002; May 1, 2004; January 1, 2006; April 1, 2012; April 1, 2014; October 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-16. Application for permit to drill and recomplete.

Before any person shall begin any well-site preparation for the drilling of any well other than surveying and staking, such person shall ~~file an~~obtain approval from the director. An application for

permit to drill (form 1 or form provided by the commission) must be filed with the director, together with a permit fee of one hundred dollars. Verbal approval may be given for site preparation by the director in extenuating circumstances. ~~No drilling activity shall~~Site construction, or appurtenance or road access thereto, may not commence until such application is approved and a permit to drill is issued by the director. The application must be accompanied by the bond pursuant to section 43-02-03-15 or the applicant must have previously filed such bond with the commission, otherwise the application is incomplete. An incomplete application received by the commission has no standing and will not be deemed filed until it is completed.

The application for permit to drill shall be accompanied by an accurate plat certified by a registered surveyor showing the location of the proposed well with reference to true north and the nearest lines of a governmental section, the latitude and longitude of the proposed well location to the nearest tenth of a second, the ground elevation, and the proposed road access to the nearest existing public road. Information to be included in such application shall be the proposed depth to which the well will be drilled, estimated depth to the top of important markers, estimated depth to the top of objective horizons, the proposed mud program, the proposed casing program, including size and weight thereof, the depth at which each casing string is to be set, the proposed pad layout, including cut and fill diagrams, and the proposed amount of cement to be used, including the estimated top of cement.

For wells permitted on new pads built after July 31, 2013, permit conditions imposed by the commission may include, upon request of the owner of a permanently occupied dwelling within one thousand feet of the proposed well, requiring the location of all flares, tanks, and treaters utilized in connection with the permitted well be located at a greater distance from the occupied dwelling than the well head, if the location can be reasonably accommodated within the proposed pad location. If the facilities are proposed to be located farther from the dwelling than the well bore, the director can issue the permit without comment from the dwelling owner. The applicant shall give any such owners written notice of the proposed facilities personally or by certified mail, return receipt requested, and addressed to their last-known address listed with the county property tax department. The commission must receive written comments from such owner within five business days of the owner receiving said notice. An application for permit must include an affidavit from the applicant identifying each owner's name and address, and the date written notice was given to each owner. The owner's notice must include:

1. A copy of North Dakota Century Code section 38-08-05.
2. The name, telephone number, and if available the electronic mail address of the applicant's local representative.
3. A sketch of the area indicating the location of the owner's dwelling, the proposed well, and location of the proposed flare, tanks, and treaters.
4. A statement indicating that any such owner objecting to the location of the flare, tanks, or treaters, must notify the commission within five business days of receiving the notice.

Prior to the commencement of recompletion operations or drilling horizontally in the existing pool, an application for permit ~~shall~~must be ~~filed with~~approved by the director. Included in such application shall be the notice of intention (form 4) to reenter a well by drilling horizontally, deepening, or plugging back to any source of supply other than the producing horizon in an existing well. Such notice shall include the name and file number and exact location of the well, the approximate date operations will begin, the proposed procedure, the estimated completed total depth, the anticipated hydrogen sulfide content in produced gas from the proposed source of supply, the weight and grade of all casing currently installed in the well unless waived by the director, the casing program to be followed, and the original total depth with a permit fee of fifty dollars. The director may deny any application if it is determined, in accordance with the latest version of ANSI/NACE MR0175/ISO 15156, that the casing currently installed in the well would be subject to sulfide stress cracking.

The applicant shall provide all information, in addition to that specifically required by this section, if requested by the director. The director may impose such terms and conditions on the permits issued under this section as the director deems necessary.

The director shall deny an application for a permit under this section if the proposal would cause, or tend to cause, waste or violate correlative rights. The director of oil and gas shall state in writing to the applicant the reason for the denial of the permit. The applicant may appeal the decision of the director to the commission.

A permit to drill automatically expires one year after the date it was issued, unless the well is drilling or has been drilled below surface casing. A permit to recomplete or to drill horizontally automatically expires one year after the date it was issued, unless such project has commenced.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1992; May 1, 1994; September 1, 2000; July 1, 2002; April 1, 2010; April 1, 2012; April 1, 2014; October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-05
Law Implemented: NDCC 38-08-05

43-02-03-16.2. Revocation and limitation of drilling permits.

1. After notice and hearing, the commission may revoke a drilling, recompletion, or reentry permit or limit its duration. The commission may act upon its own motion or upon the application of an owner in the spacing or drilling unit. In deciding whether to revoke or limit a permit, the factors that the commission may consider include:

   a. The technical ability of the permitholder and other owners to drill and complete the well.

   b. The experience of the permitholder and other owners in drilling and completing similar wells.

   c. The number of wells in the area operated by the permitholder and other owners.

   d. Whether drainage of the spacing or drilling unit has occurred or is likely to occur in the immediate future and whether the permitholder has committed to drill a well in a timely fashion.

   e. Contractual obligations such as an expiring lease.

   f. The amount of ownership the permitholder and other owners hold in the spacing or drilling unit. If the permitholder is the majority owner in the unit or if its interest when combined with that of its supporters is a majority of the ownership, it is presumed that the permitholder should retain the permit. This presumption, even if not rebutted, does not prohibit the commission from limiting the duration of the permit. However, if the amount of the interest owned by the owner seeking revocation or limitation and its supporters are a majority of the ownership, the commission will presume that the permit should be revoked.

2. The commission may suspend a permit that is the subject of a revocation or limitation proceeding. A, although a permit will not be suspended or revoked after operations have commenced.

3. If the commission revokes a permit upon the application of an owner and issues a permit to that owner or to another owner who supported revocation, the commission may limit the duration of such permit. The commission may also, if the parties fail to agree, order the owner acquiring the permit to pay reasonable costs incurred by the former permitholder and the conditions under which payment is to be made. The costs for which reimbursement may be

ordered may include those involving survey of the well site, title search of surface and mineral title, and preparation of an opinion of mineral ownership.

4. If the commission declines to revoke a permit or limit the time within which it must be exercised, it may include a term in its order restricting the ability of the permitholder to renew the permit or to acquire another permit within the same spacing or drilling unit.

History: Effective December 1, 1996; amended effective January 1, 2006; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-16.3. Recovery of a risk penalty.

The following govern the recovery of the risk penalty pursuant to subsection 3 of North Dakota Century Code section 38-08-08 and subsection 3 of North Dakota Century Code section 38-08-09.4:

1. An owner may recover the risk penalty under the provisions of subsection 3 of North Dakota Century Code section 38-08-08, provided the owner gives, to the owner from whom the penalty is sought, a written invitation to participate in the risk and cost of drilling a well, including reentering a plugged and abandoned well, or the risk and cost of reentering an existing well to drill deeper or a horizontal lateral. If the nonparticipating owner's interest is not subject to a lease or other contract for development, an owner seeking to recover a risk penalty must also make a good-faith attempt to have the unleased owner execute a lease.

   a. The invitation to participate in drilling must contain the following:

      (1) The approximate surface location of the proposed or existing well, proposed completion and total depth, objective zone, and completion location if other than a vertical well.

      (2) An itemization of the estimated costs of drilling and completion.

      (3) The approximate date upon which the well was or will be spudded or reentered.

      (4) A statement indicating the invitation must be accepted within thirty days of receiving it.

      (5) Notice that the participating owners plan to impose a risk penalty and that the nonparticipating owner may object to the risk penalty by either responding in opposition to the petition for a risk penalty, or if no such petition has been filed, by filing an application or request for hearing with the commission.

      (6) Drilling or spacing unit description.

   b. An election to participate must be in writing and must be received by the owner giving the invitation within thirty days of the participating party's receipt of the invitation.

   c. An invitation to participate and an election to participate must be served personally, by mail requiring a signed receipt, or by overnight courier or delivery service requiring a signed receipt. Failure to accept mail requiring a signed receipt constitutes service.

   d. An election to participate is only binding upon an owner electing or declining to participate if the well is spudded or reentry operations are commenced on or before ninety days after the date the owner extending the invitation to participate sets as the date upon which a response to the invitation is to be received. It also expires if the permit to drill or reenter expires without having been exercised. If an election to participate

lapses, a risk penalty can only be collected if the owner seeking it again complies with the provisions of this section.

2. An owner may recover the risk penalty under the provisions of subsection 3 of North Dakota Century Code section 38-08-09.4, provided the owner gives, to the owner from whom the penalty is sought, a written invitation to participate in the unit expense. If the nonparticipating owner's interest is not subject to a lease or other contract for development, an owner seeking to recover a risk penalty must also make a good-faith attempt to have the unleased owner execute a lease.

   a. The invitation to participate in the unit expense must contain the following:

      (1) A description of the proposed unit expense, including the location, objectives, and plan of operation.

      (2) An itemization of the estimated costs.

      (3) The approximate date upon which the proposal was or will be commenced.

      (4) A statement indicating the invitation must be accepted within thirty days of receiving it.

      (5) Notice that the participating owners plan to impose a risk penalty and that the nonparticipating owner may object to the risk penalty by either responding in opposition to the petition for a risk penalty, or if no such petition has been filed, by filing an application or request for hearing with the commission.

   b. An election to participate must be in writing and must be received by the owner giving the invitation within thirty days of the participating party's receipt of the invitation.

   c. An invitation to participate and an election to participate must be served personally, by mail requiring a signed receipt, or by overnight courier or delivery service requiring a signed receipt. Failure to accept mail requiring a signed receipt constitutes service.

   d. An election to participate is only binding upon an owner electing or declining to participate if the unit expense is commenced within ninety days after the date the owner extending the invitation request to participate sets as the date upon which a response to the request invitation is to be received. If an election to participate lapses, a risk penalty can only be collected if the owner seeking it again complies with the provisions of this section.

   e. An invitation to participate in a unit expense covering monthly operating expenses shall be effective for all such monthly operating expenses for a period of five years if the unit expense identified in the invitation to participate is first commenced within ninety days after the date set in the invitation to participate as the date upon which a response to the invitation to participate must be received. An election to participate in a unit expense covering monthly operating expenses is effective for five years after operations are first commenced. If an election to participate in a unit expense comprised of monthly operating expenses expires or lapses after five years, a risk penalty may only be assessed and collected if the owner seeking the penalty once again complies with this section.

3. Upon its own motion or the request of a party, the commission may include in a pooling order requirements relating to the invitation and election to participate, in which case the pooling order will control to the extent it is inconsistent with this section.

History: Effective December 1, 1996; amended effective May 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; April 1, 2012; April 1, 2014; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04, 38-08-08

43-02-03-19.3. Earthen pits and receptacles.

Except as otherwise provided in ~~section 43-02-03-19~~sections 43-02-03-19.4, 43-02-03-19.5, and 43-02-03-51.3, no saltwater, drilling mud, crude oil, waste oil, or other waste shall be stored in earthen pits or open receptacles except in an emergency and upon approval by the director.

A lined earthen pit or open receptacle may be temporarily used to retain oil, water, cement, solids, or fluids generated in well plugging operations. A pit or receptacle used for this purpose must be sufficiently impermeable to provide adequate temporary containment of the oil, water, or fluids. The contents of the pit or receptacle must be removed within seventy-two hours after operations have ceased and must be disposed of at an authorized facility in accordance with section 43-02-03-19.2. Within thirty days after operations have ceased, the earthen pit shall be reclaimed and the open receptacle shall be removed. The director may grant an extension of the thirty-day time period to no more than one year for good reason.

The director may permit pits or receptacles used solely for the purpose of flaring casinghead gas. A pit or receptacle used for this purpose must be sufficiently impermeable to provide adequate temporary containment of fluids. Permission for such pit or receptacle shall be conditioned on locating the pit not less than one hundred fifty feet [45.72 meters] from the vicinity of wells and tanks and keeping it free of any saltwater, crude oil, waste oil, or other waste. Saltwater, drilling mud, crude oil, waste oil, or other waste shall be removed from the pit or receptacle within twenty-four hours after being discovered and must be disposed of at an authorized facility in accordance with section 43-02-03-19.2.

The director may permit pits used solely for storage of freshwater used in completion and well servicing operations. Permits for freshwater pits shall be valid for a period of one year but may be reauthorized upon application. Freshwater pits shall be lined and no pit constructed for this purpose shall be wholly or partially constructed in fill dirt unless approved by the director. The director may approve chemical treatment to municipal drinking water standards upon application.

The freshwater pit shall have signage on all sides accessible to vehicular traffic clearly identifying the usage as freshwater only.

The director may permit portable-collapsible receptacles used solely for storage of fluids used in completion and well servicing operations, although no flowback fluids may be allowed. Permits for such receptacles are valid for a period of one year but may be reauthorized upon application. Such receptacles must utilize a sealed inner bladder, erected to conform to American petroleum institute standards, and may not be wholly or partially constructed on fill dirt unless approved by the director. Such receptacles must have signage on all sides accessible to vehicular traffic clearly identifying the fluid contained within.

History: Effective September 1, 2000; amended effective April 1, 2010; April 1, 2012; October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-21. Casing, tubing, and cementing requirements.

All wells drilled for oil, natural gas, or injection shall be completed with strings of casing which shall be properly cemented at sufficient depths to adequately protect and isolate all formations containing water, oil, or gas or any combination of these; protect the pipe through salt sections encountered; and isolate the uppermost sand of the Dakota group.

Drilling of the surface hole shall be with freshwater-based drilling mud or other method approved by the director which will protect all freshwater-bearing strata. The surface casing shall consist of new or reconditioned pipe that has been previously tested to one thousand pounds per square inch [6900 kilopascals]. The surface casing shall be set and cemented at a point not less than fifty feet [15.24 meters] below the base of the Fox Hills formation. Sufficient cement shall be used on surface casing to fill the annular space behind the casing to the bottom of the cellar, if any, or to the surface of the ground. If the annulus space is not adequately filled with cement, the director shall be notified immediately. The operator shall diligently perform remedial work after obtaining approval from the director. All strings of surface casing shall stand cemented under pressure for at least twelve hours before drilling the plug or initiating tests. The term "under pressure" as used herein shall be complied with if one float valve is used or if pressure is otherwise held. Cementing shall be by the pump and plug method or other methods approved by the director. The director is authorized to require an accurate gauge be maintained on the surface casing of any well, not properly plugged and abandoned, to detect any buildup of pressure caused by the migration of fluids.

Surface casing strings must be allowed to stand under pressure until the tail cement has reached a compressive strength of at least five hundred pounds per square inch [3450 kilopascals]. All filler cements utilized must reach a compressive strength of at least two hundred fifty pounds per square inch [1725 kilopascals] within twenty-four hours and at least three hundred fifty pounds per square inch [2415 kilopascals] within seventy-two hours. All compressive strengths on surface casing cement shall be calculated at a temperature of eighty degrees Fahrenheit [26.67 degrees Celsius].

Production or intermediate casing strings shall consist of new or reconditioned pipe that has been previously tested to two thousand pounds per square inch [13800 kilopascals]. Such strings must be allowed to stand under pressure until the tail cement has reached a compressive strength of at least five hundred pounds per square inch [3450 kilopascals]. All filler cements utilized must reach a compressive strength of at least two hundred fifty pounds per square inch [1725 kilopascals] within twenty-four hours and at least five hundred pounds per square inch [3450 kilopascals] within seventy-two hours, although in any horizontal well performing a single stage cement job from a measured depth of greater than thirteen thousand feet [3962.4 meters], the filler cement utilized must reach a compressive strength of at least two hundred fifty pounds per square inch [1725 kilopascals] within forty-eight hours and at least five hundred pounds per square inch [3450 kilopascals] within ninety-six hours. All compressive strengths on production or intermediate casing cement shall be calculated at a temperature found in the Mowry formation using a gradient of 1.2 degrees Fahrenheit per one hundred feet [30.48 meters] of depth plus eighty degrees Fahrenheit [26.67 degrees Celsius]. At a formation temperature at or in excess of two hundred thirty degrees Fahrenheit [110 degrees Celsius], cement blends must include additives to address compressive strength regression.

~~After cementing, the~~Each casing string shall be tested by application of pump pressure of at least one thousand five hundred pounds per square inch [10350 kilopascals] immediately after cementing, while the cement is in a liquid state, or the casing string must be pressure tested after all cement has reached five hundred pounds per square inch [3450 kilopascals] compressive strength. If, at the end of thirty minutes, this pressure has dropped ~~one hundred fifty pounds per square inch [1035 kilopascals] or~~ more than ten percent, the casing shall be repaired after receiving approval from the director. Thereafter, the casing shall again be tested in the same manner. Further work shall not proceed until a satisfactory test has been obtained. The casing in a horizontal well may be tested by use of a mechanical tool set near the casing shoe after the horizontal section has been drilled.

All flowing wells must be equipped with tubing. A tubing packer must also be utilized unless a waiver is obtained after demonstrating the casing will not be subjected to excessive pressure or corrosion. The packer must be set as near the producing interval as practicable, but in all cases must be above the perforations.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1992; July 1, 1996; January 1, 1997; September 1, 2000; July 1, 2002; May 1, 2004; January 1, 2006; April 1, 2010; April 1, 2012; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-23. Blowout prevention.

In all drilling operations, proper and necessary precautions shall be taken for keeping the well under control, including the use of a blowout preventer and high pressure fittings attached to properly cemented casing strings adequate to withstand anticipated pressures. During the course of drilling, the pipe rams shall be functionally operated at least once every twenty-four-hour period. The blind rams shall be functionally operated each trip out of the well bore. The blowout preventer shall be pressure tested at installation on the wellhead, after modification of any equipment, and every thirty days thereafter. For pad drilling operations, moving from one wellhead to another within the thirty days, pressure testing is required on connections when the integrity of a pressure seal is broken or a component appears to be damaged or compromised. The director may postpone such pressure test if the necessity therefor can be demonstrated to the director's satisfaction. All tests shall be noted in the driller's record.

In all workover operations, proper and necessary precautions must be taken for keeping the well under control, including the use of a blowout preventer and high pressure fittings attached to properly cemented casing strings adequate to withstand anticipated pressures.

History: Amended effective January 1, 1983; September 1, 2000; July 1, 2002; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-27.1. Hydraulic fracture stimulation.

1. ~~For~~Prior to performing any hydraulic fracture stimulation ~~performed~~, including refracs, through a frac string run inside the intermediate casing string:

   a. The frac string must be either strung into a liner with the hanger/packer located in cemented casing or run with a packer set at a minimum depth of one hundred feet [30.48 meters] below the top of cement or a minimum depth of one hundred feet [30.48 meters] below the top of the Inyan Kara formation, whichever is deeper.

   b. The intermediate casing-frac string annulus must be pressurized and monitored during frac operations. Prior to performing any refrac, a casing evaluation tool must be run to verify adequate wall thickness of the intermediate casing.

   c. An adequately sized, function tested pressure relief valve must be utilized on the treating lines from the pumps to the wellhead, with suitable check valves to limit the volume of flowback fluid should the relief valve open. The relief valve must be set to limit line pressure to no more than eighty-five percent of the internal yield pressure of the frac string.

   d. An adequately sized, function tested pressure relief valve and an adequate sized diversion line must be utilized to divert flow from the intermediate casing to a pit or containment vessel in case of frac string failure. The relief valve must be set to limit annular pressure to no more than eighty-five percent of the lowest internal yield pressure of the intermediate casing string or no greater than the pressure test on the intermediate casing, less one hundred pounds per square inch gauge, whichever is less.

   e. The surface casing must be fully open and connected to a diversion line rigged to a pit or containment vessel.

f. An adequately sized, function tested remote operated frac valve must be utilized at a location on the christmas tree that provides isolation of the well bore from the treating line and must be remotely operated from the edge of the location or other safe distance.

g. Within sixty days after the hydraulic fracture stimulation is performed, the owner, operator, or service company shall post on the fracfocus chemical disclosure registry all elements made viewable by the fracfocus website.

2. ~~For~~Prior to performing any hydraulic fracture stimulation ~~performed~~, including refracs, through an intermediate casing string:

a. The maximum treating pressure shall be no greater than eighty-five percent of the American petroleum institute rating of the intermediate casing.

b. Casing evaluation tools to verify adequate wall thickness of the intermediate casing shall be run from the wellhead to a depth as close as practicable to one hundred feet [30.48 meters] above the completion formation and a visual inspection with photographs shall be made of the top joint of the intermediate casing and the wellhead flange.

If the casing evaluation tool or visual inspection indicates wall thickness is below the American petroleum institute minimum or a lighter weight of intermediate casing than the well design called for, calculations must be made to determine the reduced pressure rating. If the reduced pressure rating is less than the anticipated treating pressure, a frac string shall be run inside the intermediate casing.

c. Cement evaluation tools to verify adequate cementing of the intermediate casing shall be run from the wellhead to a depth as close as practicable to one hundred feet [30.48 meters] above the completion formation.

(1) If the cement evaluation tool indicates defective casing or cementing, a frac string shall be run inside the intermediate casing.

(2) If the cement evaluation tool indicates the ~~top of the cement behind the intermediate casing is below the top of the Mowry formation~~intermediate casing string cemented in the well fails to satisfy section 43-02-03-21, a frac string shall be run inside the intermediate casing.

d. The intermediate casing and wellhead must be pressure tested to a minimum depth of one hundred feet [30.48 meters] below the top of the Tyler formation for at least thirty minutes with less than five percent loss to a pressure equal to or in excess of the maximum frac design pressure.

e. If the pressure rating of the wellhead does not exceed the maximum frac design pressure, a wellhead and blowout preventer protection system must be utilized during the frac.

f. An adequately sized, function tested pressure relief valve must be utilized on the treating lines from the pumps to the wellhead, with suitable check valves to limit the volume of flowback fluid should be the relief valve open. The relief valve must be set to limit line pressure to no greater than the test pressure of the intermediate casing, less one hundred pounds per square inch [689.48 kilopascals].

g. The surface casing value must be fully open and connected to a diversion line rigged to a pit or containment vessel.

h. An adequately sized, function tested remote operated frac valve must be utilized between the treating line and the wellhead.

i. Within sixty days after the hydraulic fracture stimulation is performed, the owner, operator, or service company shall post on the fracfocus chemical disclosure registry all elements made viewable by the fracfocus website.

3. If during the stimulation, the pressure in the intermediate casing-surface casing annulus exceeds three hundred fifty pounds per square inch [2413 kilopascals] gauge, the owner or operator shall verbally notify the director as soon as practicable but no later than twenty-four hours following the incident.

History: Effective April 1, 2012; amended effective April 1, 2014; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-28. Safety regulation.

During drilling operations all oil wells shall be cleaned into a pit or tank, not less than forty feet [12.19 meters] from the derrick floor and one hundred fifty feet [45.72 meters] from any fire hazard.

All flowing oil wells must be produced through an approved oil and gas separator or emulsion treater of ample capacity and in good working order. No boiler, electric generator, flare, or treater shall be placed nearer than one hundred fifty feet [45.72 meters] to any producing well or oil tank. Placement as close as one hundred twenty-five feet [38.10 meters] may be allowed if a spark or flame arrestor is utilized on the equipment. Any rubbish or debris that might constitute a fire hazard shall be removed to a distance of at least one hundred fifty feet [45.72 meters] from the vicinity of wells and tanks. All waste shall be burned or disposed of in such manner as to avoid creating a fire hazard. All vegetation must be removed to a safe distance from any production or injection equipment to eliminate a fire hazard.

The director may require remote operated or automatic shutdown equipment to be installed on, or shut in for no more than forty days, any well that is likely to cause a serious threat of pollution or injury to the public health or safety.

No well shall be drilled nor production or injection equipment installed nor saltwater handling facility or treating plant constructed less than five hundred feet [152.40 meters] from an occupied dwelling unless agreed to in writing by the owner of the dwelling or authorized by order of the commission.

Subsurface pressure must be controlled during all drilling, completion, and well-servicing operations with appropriate fluid weight and pressure control equipment. The operator conducting any well hydraulic fracture stimulation shall give prior written notice, up to ~~ten~~thirty-one days and not less than ~~seven business~~twenty-one days, to any operator of a well completed in the same or adjacent pool, if publicly available information indicates or if the operator is made aware, if the completion intervals are within ~~one thousand three hundred twenty~~two thousand six hundred and forty feet [~~402.34~~804.67 meters] of one another. Notice must include twenty-four-hour emergency contact information, planned start and end dates, and contact information for scheduling updates.

History: Amended effective January 1, 1983; May 1, 1990; September 1, 2000; January 1, 2006; January 1, 2008; April 1, 2012; April 1, 2014; October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-29.1. Crude oil and produced water underground gathering pipelines.

1. Application of section. This section is applicable to all underground gathering pipelines designed for or capable of transporting crude oil, natural gas, carbon dioxide, or produced water from an oil and gas production facility for the purpose of disposal, storage, or for sale purposes or designed for or capable of transporting carbon dioxide from a carbon capture facility for the purpose of storage or enhanced oil recovery. If these rules differ from the

pipeline manufacturer's prescribed installation and operation practices, the pipeline manufacturer's prescribed installation and operation practices take precedence.

The requirements in this section are not applicable to flow lines, injection pipelines, pipelines operated by an enhanced recovery unit for enhanced recovery unit operations, or on piping utilized to connect wells, tanks, treaters, flares, or other equipment ~~on the~~located entirely within the boundary of a well site or production facility.

2. Definitions. The terms used throughout this section apply to this section only.

a. "Crude oil or produced water underground gathering pipeline" means an underground gathering pipeline designed or intended to transfer crude oil or produced water from a production facility for disposal, storage, or sale purposes.

b. "New construction" means a new gathering pipeline installation project or an alteration or reroute of an existing gathering pipeline where the location, composition, size, design temperature, or design pressure changes.

c. "Pipeline repair" is the work necessary to restore a pipeline system to a condition suitable for safe operations that does not change the design temperature or pressure.

d. "Gathering system" is a group of connected pipelines which are connected which have been designated as a gathering system by the operator. A gathering system must have a unique name and must be interconnected.

e. "In-service date" is the first date fluid was transported down the underground gathering pipeline for disposal, storage, or sale purposes after construction.

3. Notifications.

a. The underground gathering pipeline owner shall notify the commission, as provided by the director, at least seven days prior to commencing new construction of any underground gathering pipeline.

(1) The notice of intent to construct a crude oil or produced water underground gathering pipeline must include the following:

(a) The proposed date construction is scheduled to begin.

(b) A statement that the director will be verbally notified approximately forty-eight hours prior to commencing the construction.

(c) A geographical information system layer utilizing North American datum 83 geographic coordinate system and in an environmental systems research institute shape file format showing the proposed route of the pipeline from the point of origin to the termination point.

~~(c)~~(d) The proposed underground gathering pipeline design drawings, including all associated above ground equipment.

[1] The proposed pipeline composition, specifications (i.e. size, weight, grade, wall thickness, coating, and standard dimension ratio).

[2] The type of fluid to be transported.

[3] The method of testing pipeline integrity (e.g. hydrostatic or pneumatic test) prior to placing the pipeline into service.

[4] Proposed burial depth of the pipeline.

[5] The location and type of all road crossings (i.e. bored and cased or bored only).

[6] The location of all environmentally sensitive areas, such as wetlands, streams, or other surface waterbodies that the pipeline may traverse, if applicable.

b. The underground gathering pipeline owner shall ~~notify~~file a sundry notice (form 4 or form provided by the commission) with the director notifying the commission of any underground gathering pipeline system or portion thereof that has been removed from service for more than one year.

c. If damage occurs to any underground gathering pipeline, flow line, or other underground equipment used to transport crude oil, natural gas, carbon dioxide, or water produced in association with oil and gas, during construction, operation, maintenance, repair, or abandonment of an underground gathering pipeline, the responsible party shall verbally notify the director immediately.

d. The pipeline owner shall file a sundry notice (form 4 or form provided by the commission) within thirty days of the in-service date reporting the date of first service.

4. Design and construction.

The following applies to newly constructed crude oil and produced water underground gathering pipelines, including tie-ins to existing systems:

a. Underground gathering pipelines must be devoid of leaks and constructed of materials resistant to external corrosion and to the effects of transported fluids.

b. Underground gathering pipelines must be designed in a manner that allows for line maintenance, periodic line cleaning, and integrity testing.

c. Installation crews must be trained in all installation practices for which they are tasked to perform.

d. Underground gathering pipelines must be installed in a manner that minimizes interference with agriculture, road and utility construction, the introduction of secondary stresses, and the possibility of damage to the pipe. Tracer wire must be buried with any nonconductive pipe installed.

e. Unless the manufacturer's installation procedures and practices provide guidance, pipeline trenches must be constructed to allow for the pipeline to rest on undisturbed native soil and provide continuous support along the length of the pipe. Trench bottoms must be free of rocks greater than two inches in diameter, debris, trash, and other foreign material not required for pipeline installation. If a trench bottom is over excavated, the trench bottom must be backfilled with appropriate material and compacted prior to installation of the pipe to provide continuous support along the length of the pipe.

The width of the trench must provide adequate clearance on each side of the pipe. Trench walls must be excavated to ensure minimal sluffing of sidewall material into the trench. Subsoil from the excavated trench must be stockpiled separately from previously stripped topsoil.

f. Underground gathering pipelines that cross a township, county, or state graded road must be bored unless the responsible governing agency specifically permits the owner to open cut the road.

g. No pipe or other component may be installed unless it has been visually inspected at the site of installation to ensure that it is not damaged in a manner that could impair its strength or reduce its serviceability.

h. The pipe must be handled in a manner that minimizes stress and avoids physical damage to the pipe during stringing, joining, or lowering in. During the lowering in process the pipe string must be properly supported so as not to induce excess stresses on the pipe or the pipe joints or cause weakening or damage to the outer surface of the pipe.

i. When a trench for an underground gathering pipeline is backfilled, it must be backfilled in a manner that provides firm support under the pipe and prevents damage to the pipe and pipe coating from equipment or from the backfill material. Sufficient backfill material must be placed in the haunches of the pipe to provide long-term support for the pipe. Backfill material that will be within two feet of the pipe must be free of rocks greater than two inches in diameter and foreign debris. Backfilling material must be compacted as appropriate during placement in a manner that provides support for the pipe and reduces the potential for damage to the pipe and pipe joints.

j. Cover depths must be a minimum of four feet [1.22 meters] from the top of the pipe to the finished grade. The cover depth for an undeveloped governmental section line must be a minimum of six feet [1.83 meters] from the top of the pipe to the finished grade.

k. Underground gathering pipelines that traverse environmentally sensitive areas, such as wetlands, streams, or other surface waterbodies, must be installed in a manner that minimizes impacts to these areas. Any horizontal directional drilling plan prepared by the owner or required by the director, must be filed with the commission, prior to the commencement of horizontal directional drilling.

l. Clamping or squeezing as a method of connecting any produced water underground gathering pipeline must be approved by the director. Prior to clamping or squeezing the pipeline, the owner shall file a sundry notice (form 4 or form provided by the commission) with the director and obtain approval of the clamping or squeezing plan. The notice must include documentation that the pipeline can be safely clamped or squeezed as prescribed by the manufacturer's specifications. Any damaged portion of a produced water underground gathering pipeline that has been clamped or squeezed must be replaced before it is placed into service.

5. Pipeline reclamation.

a. When utilizing excavation for pipeline installation, repair, or abandonment, topsoil must be stripped, segregated from the subsoils, and stockpiled for use in reclamation. "Topsoil" means the suitable plant growth material on the surface; however, in no event shall this be deemed to be more than the top twelve inches [30.48 centimeters] of soil or deeper than the depth of cultivation, whichever is greater.

b. The pipeline right-of-way must be reclaimed as closely as practicable to original condition. All stakes, temporary construction markers, cables, ropes, skids, and any other debris or material not native to the area must be removed from the right-of-way and lawfully disposed of.

c. During right-of-way reclamation all subsoils and topsoils must be returned in proper order to as close to the original depths as practicable.

d. The reclaimed right-of-way soils must be stabilized to prevent excessive settling, sluffing, cave-ins, or erosion.

e. The crude oil and produced water underground gathering pipeline owner is responsible for their right-of-way reclamation and maintenance until such pipeline is released by the commission from the pipeline bond pursuant to section 43-02-03-15.

6. Inspection.

All newly constructed crude oil and produced water underground gathering pipelines must be inspected by third-party independent inspectors to ensure the pipeline is installed as prescribed by the manufacturer's specifications and in accordance with the requirements of this section. A list of all third-party independent inspectors and a description of each independent inspector's qualifications, certifications, experience, and specific training must be provided to the commission upon request. A person may not be used to perform inspections unless that person has been trained and is qualified in the phase of construction to be inspected. The third-party independent inspector may not be an employee of the gathering pipeline owner/operator or the contractor hired to construct and install the pipeline.

7. Associated pipeline facility.

No associated above ground equipment may be installed less than five hundred feet [152.40 meters] from an occupied dwelling unless agreed to in writing by the owner of the dwelling or authorized by order of the commission.

All associated above ground equipment used to store crude oil or produced water must be devoid of leaks and constructed of materials resistant to the effects of crude oil, produced water, brines, or chemicals that may be contained therein. The above materials requirement may be waived by the director for tanks presently in service and in good condition. Unused tanks and associated above ground equipment must be removed from the site or placed into service, within a reasonable time period, not to exceed one year.

Dikes must be erected around all produced water or crude oil tanks at any new facility prior to placing the associated underground gathering pipeline into service. Dikes must be erected and maintained around all crude oil or produced water tanks or above ground equipment, when deemed necessary by the director. Dikes as well as the base material under the dikes and within the diked area must be constructed of sufficiently impermeable material to provide emergency containment. Dikes must be of sufficient dimension to contain the total capacity of the largest tank plus one day's fluid throughput. The required capacity of the dike may be lowered by the director if the necessity therefor can be demonstrated to the director's satisfaction. Discharged crude oil or produced water must be properly removed and may not be allowed to remain standing within or outside of any diked areas.

The underground gathering pipeline owner shall take steps to minimize the amount of solids stored at the pipeline facility, although the remediation of such material may be allowed onsite, if approved by the director.

8. Underground gathering pipeline as built.

~~a.~~ The owner of any underground gathering pipeline placed into service after July 31, 2011, shall file with the director, as prescribed by the director, within one hundred eighty days of placing into service, a geographical information system layer utilizing North American datum 83 geographic coordinate system and in an environmental systems research institute shape file format showing the location of all associated above ground equipment and the pipeline

centerline from the point of origin to the termination point. ~~The shape file must have a completed attribute table containing the required data.~~ An affidavit of completion shall accompany each layer containing the following information:

~~(1)~~a. A ~~statement~~third-party inspector certificate that the pipeline was constructed and installed in compliance with section 43-02-03-29.1.

~~(2)~~b. The outside diameter, minimum wall thickness, composition, ~~internal yield pressure,~~ and maximum temperature rating of the pipeline, or any other specifications deemed necessary by the director.

~~(3)~~c. The maximum allowable operating pressure of the pipeline.

~~(4)~~d. The specified minimum yield strength and internal yield pressure of the pipeline if applicable to the composition of pipe.

~~(5)~~e. The type of fluid that will be transported in the pipeline.

~~(6)~~f. Pressure and duration to which the pipeline was tested prior to placing into service.

~~(7)~~g. The minimum pipeline depth of burial from the top of the pipe to the finished grade.

~~(8)~~h. In-service date.

~~(9)~~i. Leak protection and monitoring methods that will be utilized after in-service date.

~~(10)~~j. Any leak detection methods that have been prepared by the owner.

~~(11)~~k. The name of the pipeline gathering system and any other separately named portions thereof.

~~(12)~~l. Accuracy of the geographical information system layer.

~~b. The requirement to submit a geographical information system layer is not to be construed to be required on flow lines, injection pipelines, pipelines operated by an enhanced recovery unit for enhanced recovery unit operations, or on buried piping utilized to connect flares, tanks, treaters, or other equipment located entirely within the boundary of a well site or production facility.~~

9. Operating requirements.

   The maximum operating pressure for all crude oil and produced water underground gathering pipelines may not exceed the manufacturer's specifications of the pipe or the manufacturer's specifications of any other component of the pipeline, whichever is less. The crude oil or produced water underground gathering pipeline must be equipped with adequate controls and protective equipment to prevent the pipeline from operating above the maximum operating pressure.

10. Leak protection, detection, and monitoring.

    All crude oil and produced water underground gathering pipeline owners shall file with the commission any leak protection and monitoring plan prepared by the owner or required by the director, pursuant to North Dakota Century Code section 38-08-27.

    If any leak detection plan has been prepared by the owner, it must be submitted to the director.

All crude oil or produced water underground gathering pipeline owners shall develop and maintain a data sharing plan. The plan must provide for real-time sharing of data between the operator of the production facility, the crude oil or produced water underground gathering pipeline owner, and the operator at the point or points of disposal, storage, or sale. If a discrepancy in the shared data is observed, the party observing the data discrepancy shall notify all other parties and action must be taken to determine the cause. A record of all data discrepancies must be retained by the crude oil or produced water underground gathering pipeline owner. If requested, copies of such records must be filed with the commission.

11. Spill response.

    All crude oil and produced water underground gathering pipeline owners shall maintain a spill response plan during the service life of any crude oil or produced water underground gathering pipeline. The plan should detail the necessary steps for an effective and timely response to a pipeline spill. The spill response plan should be tailored to the specific risks in the localized area. Response capabilities should address access to equipment and tools necessary to respond, as well as action steps to protect the health and property of impacted landowners, citizens, and the environment.

12. Corrosion control.

    a. Underground gathering pipelines must be designed to withstand the effects of external corrosion and maintained in a manner that mitigates internal corrosion.

    b. All metallic underground gathering pipelines installed must have sufficient corrosion control.

    c. All coated pipe must be electronically inspected prior to placement using coating deficiency (i.e. holiday) detectors to check for any faults not observable by visual examination. The holiday detector must be operated in accordance with manufacturer's instructions and at a voltage level appropriate for the electrical characteristics of the pipeline system being tested. During installation all joints, fittings, and tie-ins must be coated with materials compatible with the coatings on the pipe. Coating materials must:

        (1) Be designed to mitigate corrosion of the buried pipeline;

        (2) Have sufficient adhesion to the metal surface to prevent under film migration of moisture;

        (3) Be sufficiently ductile to resist cracking;

        (4) Have enough strength to resist damage due to handling and soil stress;

        (5) Support any supplemental cathodic protection; and

        (6) If the coating is an insulating type, have low moisture absorption and provide high electrical resistance.

    d. Cathodic protection systems must meet or exceed the minimum criteria set forth in the National Association of Corrosion Engineers standard practice Control of External Corrosion on Underground or Submerged Metallic Piping Systems.

    e. If internal corrosion is anticipated or detected, the underground gathering pipeline owner shall take prompt remedial action to correct any deficiencies, such as increased pigging, use of corrosion inhibitors, internal coating of the pipeline (e.g. an epoxy paint or other plastic liner), or a combination of these methods. Corrosion inhibitors must be used in

sufficient quantity to protect the entire part of the pipeline system that the inhibitors are designed to protect.

13. Pipeline integrity.

A crude oil or produced water underground gathering pipeline owner may not operate a pipeline unless it has been pressure tested and demonstrated integrity. In addition, an owner may not return to service a portion of pipeline which has been repaired, replaced, relocated, or otherwise changed until it has demonstrated integrity.

a. The crude oil and produced water underground gathering pipeline owner shall notify the commission at least forty-eight hours prior to commencement of any pipeline integrity test to allow a representative of the commission to witness the testing process and results. The notice must include the pipeline integrity test procedure.

b. ~~An independent inspector's certificate of hydrostatic or pneumatic testing of a crude oil or produced water underground gathering pipeline must be submitted~~The crude oil and produced water underground gathering pipeline owner shall submit within sixty days of the underground gathering pipeline being placed into service ~~and~~the integrity test results which must include the following:

(1) The name of the pipeline gathering system and any other separately named portions thereof;

(2) The date of the test;

(3) The duration of the test;

(4) The length of pipeline which was tested;

(5) The maximum and minimum test pressure;

(6) The starting and ending pressure;

(7) A copy of the chart recorder or digital log results; ~~and~~

(8) A geographical information system layer utilizing North American datum 83 geographic coordinate system and in an environmental systems research institute shape file format showing the location of the centerline of the portion of the pipeline that was tested;

(9) A copy of the test procedure used; and

(10) A third-party inspector certificate summarizing the pipeline has been pressure tested and whether it demonstrated integrity, including the identification of any leaks, ruptures, or other integrity issues encountered, and an explanation for any substantial pressure gain or losses during the integrity test, if applicable.

c. All crude oil and produced water underground gathering pipeline owners shall maintain a pipeline integrity demonstration plan during the service life of any crude oil or produced water underground gathering pipeline. The director, for good cause, may require a pipeline integrity demonstration on any crude oil or produced water underground gathering pipeline.

14. Pipeline repair.

Each owner, in repairing an underground gathering pipeline or pipeline system, shall ensure that the repairs are made in a manner that prevents damage to persons or property.

An owner may not use any pipe, valve, or fitting, for replacement or repair of an underground gathering pipeline, unless it is designed to meet the maximum operating pressure.

a. At least forty-eight hours prior to any underground gathering pipeline repair or replacement, the underground gathering pipeline owner shall notify the commission, as provided by the director, except in an emergency.

b. Within one hundred eighty days of repairing or replacing any underground gathering pipeline the owner of the pipeline shall file with the director a geographical information system layer utilizing North American datum 83 geographic coordinate system and in an environmental systems research institute shape file format showing the location of the centerline of the repaired or replaced pipeline and an affidavit of completion containing the following information:

(1) A statement that the pipeline was repaired in compliance with section 43-02-03-29.1.

(2) The reason for the repair or replacement.

(3) The length of pipeline that was repaired or replaced.

(4) Pressure and duration to which the pipeline was tested prior to returning to service.

c. Clamping or squeezing as a method of repair for any produced water underground gathering pipeline must be approved by the director. Prior to clamping or squeezing the pipeline, the owner shall file a sundry notice (form 4) with the director and obtain approval of the clamping or squeezing plan. The notice must include documentation that the pipeline can be safely clamped or squeezed as prescribed by the manufacturer's specifications. If an emergency requires clamping or squeezing, the owner or the owner's agent shall obtain verbal approval from the director and the notice shall be filed within seven days of completing the repair. Any damaged portion of a produced water underground gathering pipeline that has been clamped or squeezed must be replaced before it is returned to service.

15. Pipeline abandonment.

a. At least forty-eight hours prior to abandoning any underground gathering pipeline, the underground gathering pipeline owner shall notify the director verbally.

b. When an underground gathering pipeline or any part of such pipeline is abandoned as defined under subsection 1 of North Dakota Century Code section 38-08-02 after March 31, 2014, the owner shall leave such pipeline in a safe condition by conducting the following:

(1) Disconnect and physically isolate the pipeline from any operating facility, associated above ground equipment, or other pipeline.

(2) Cut off the pipeline or the part of the pipeline to be abandoned below surface at pipeline level.

(3) Purge the pipeline with fresh water, air, or inert gas in a manner that effectively removes all fluid.

(4) Remove cathodic protection from the pipeline.

(5) Permanently plug or cap all open ends by mechanical means or welded means.

(6) The site of all associated above ground equipment must be reclaimed pursuant to section 43-02-03-34.1.

(7) If the bury depth is not at least three feet below final grade, such portion of pipe must be removed.

~~b.~~c. Within one hundred eighty days of completing the abandonment of an underground gathering pipeline the owner of the pipeline shall file with the director a geographical information system layer utilizing North American datum 83 geographic coordinate system and in an environmental systems research institute shape file format showing the location of the pipeline centerline and an affidavit of completion containing the following information:

(1) A statement that the pipeline was abandoned in compliance with section 43-02-03-29.1.

(2) The type of fluid used to purge the pipeline.

(3) The date of pipeline abandonment.

(4) The length of pipeline abandoned.

History: Effective October 1, 2016; amended effective April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-30. Notification of fires, leaks, spills, or blowouts.

All persons controlling or operating any well, pipeline and associated aboveground equipment, receiving tank, storage tank, treating plant, or any other receptacle or production facility associated with oil, gas, or water production, injection, processing, or well servicing shall verbally notify the director immediately and follow up utilizing the online initial notification report within twenty-four hours after discovery of any fire, leak, spill, blowout, or release of fluid. The initial report must include the name of the reporting party, including telephone number and address, date and time of the incident, location of the incident, type and cause of the incident, estimated volume of release, containment status, waterways involved, immediate potential threat, and action taken. If any such incident occurs or travels offsite of a facility, the persons, as named above, responsible for proper notification shall within a reasonable time also notify the surface owners upon whose land the incident occurred or traveled. Notification requirements prescribed by this section do not apply to any leak or spill involving only freshwater or to any leak, spill, or release of crude oil, produced water, or natural gas liquid that is less than one barrel total volume and remains onsite of a site where any well thereon was spud before September 2, 2000, or on a facility that was constructed before September 2, 2000, and do not apply to any leak or spill or release of crude oil, produced water, or natural gas liquid that is less than ten barrels total volume cumulative over a fifteen-day time period, and remains onsite of a site where all wells thereon were spud after September 1, 2000, or on a facility that was constructed after September 1, 2000. The initial notification must be followed by a written report within ten days after cleanup of the incident, unless deemed unnecessary by the director. Such report must include the following information: the operator and description of the facility, the legal description of the location of the incident, date of occurrence, date of cleanup, amount and type of each fluid involved, amount of each fluid recovered, steps taken to remedy the situation, root cause of the incident unless deemed unnecessary by the director, and action taken to prevent reoccurrence, and if applicable, any additional information pursuant to subdivision e of subsection 1 of North Dakota Century Code section 37-17.1-07.1. The signature, title, and telephone number of the company representative must be included on such report. The persons, as named above, responsible for proper notification shall within a reasonable time also provide a copy of the written report to the surface owners upon whose land the incident occurred or traveled.

The commission, however, may impose more stringent spill reporting requirements if warranted by proximity to sensitive areas, past spill performance, or careless operating practices as determined by the director.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1992; July 1, 1996; January 1, 2008; April 1, 2010; April 1, 2014; October 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-31. Well log, completion, and workover reports.

After the plugging of a well, a plugging record (form 7) shall be filed with the director. After the completion of a well, recompletion of a well in a different pool, or drilling horizontally in an existing pool, a completion report (form 6 or form provided by the commission) shall be filed with the director. In no case shall oil or gas be transported from the lease prior to the filing of a completion report unless approved by the director. The operator shall cause to be run an open hole electrical, radioactivity, or other similar log, or combination of open hole logs, of the operator's choice, from which formation tops and porosity zones can be determined. The operator shall cause to be run a gamma ray log from total depth to ground level elevation of the well bore. Within six months of reaching total depth and prior to completing the well, the operator shall cause to be run a log from which the presence and quality of bonding of cement can be determined in every well in which production or intermediate casing has been set. The obligation to log may be waived or postponed by the director if the necessity therefor can be demonstrated to the director's satisfaction. Waiver will be contingent upon such terms and conditions as the director deems appropriate. All logs run shall be available to the director at the well site prior to proceeding with plugging or completion operations. All logs run shall be submitted to the director free of charge. Logs shall be submitted as one digital TIFF (tagged image file format) copy and one digital LAS (log ASCII) formatted copy, or a format approved by the director. In addition, operators shall file ~~two copies~~one copy of drill stem test reports and charts, formation water analyses, core analyses, geologic reports, and noninterpretive lithologic logs or sample descriptions if compiled by the operator.

All information furnished to the director on permits, except the operator name, well name, location, permit date, confidentiality period, spacing or drilling unit description, spud date, rig contractor, central tank battery number, any production runs, or volumes injected into an injection well, shall be kept confidential ~~for not more than six months if requested~~from the time a request by the operator is received in writing until the six-month confidentiality period has ended. The six-month period shall commence on the date the well is completed or the date the written request is received, whichever is earlier. If the written request accompanies the application for permit to drill or is filed after permitting but prior to spudding, the six-month period shall commence on the date the well is spudded. The director may release such confidential completion and production data to health care professionals, emergency responders, and state, federal, or tribal environmental and public health regulators if the director deems it necessary to protect the public's health, safety, and welfare.

All information furnished to the director on recompletions or reentries, except the operator name, well name, location, permit date, confidentiality period, spacing or drilling unit description, spud date, rig contractor, any production runs, or volumes injected into an injection well, shall be kept confidential for not more than six months if requested by the operator in writing. The six-month period shall commence on the date the well is completed or the date the well was approved for recompletion or reentry, whichever is earlier. Any information furnished to the director prior to approval of the recompletion or reentry shall remain public.

Approval must be obtained on a sundry notice (form 4) from the director prior to perforating or recompleting a well in a pool other than the pool in which the well is currently permitted.

After the completion of any remedial work, or attempted remedial work such as plugging back or drilling deeper, acidizing, shooting, formation fracturing, squeezing operations, setting liner, perforating,

reperforating, or other similar operations not specifically covered herein, a report on the operation shall be filed on a sundry notice (form 4) with the director. The report shall present a detailed account of all work done and the date of such work; the daily production of oil, gas, and water both prior to and after the operation; the shots per foot, size, and depth of perforations; the quantity of sand, crude, chemical, or other materials employed in the operation; and any other pertinent information or operations which affect the original status of the well and are not specifically covered herein.

Upon the installation of pumping equipment on a flowing well, or change in type of pumping equipment designed to increase productivity in a well, the operator shall submit a sundry notice (form 4) of such installation. The notice shall include all pertinent information on the pump and the operation thereof including the date of such installation, and the daily production of the well prior to and after the pump has been installed.

All forms, reports, logs, and other information required by this section shall be submitted within thirty days after the completion of such work, although a completion report shall be filed immediately after the completion or recompletion of a well in a pool or reservoir not then covered by an order of the commission.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1990; May 1, 1992; May 1, 1994; July 1, 1996; September 1, 2000; July 1, 2002; January 1, 2006; January 1, 2008; April 1, 2010; April 1, 2012; October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-34.1. Reclamation of surface.

1. Within a reasonable time, but not more than one year, after a well is plugged, or if a permit expires, has been canceled or revoked, or a treating plant or saltwater handling facility is decommissioned, the site, access road, and other associated facilities constructed shall be reclaimed as closely as practicable to original condition pursuant to North Dakota Century Code section 38-08-04.12. Prior to site reclamation, the operator or the operator's agent shall file a sundry notice (form 4) with the director and obtain approval of a reclamation plan. The operator or operator's agent shall provide a copy of the proposed reclamation plan to the surface owner at least ten days prior to commencing the work unless waived by the surface owner. Verbal approval to reclaim the site may be given. The notice shall include:

   a. The name and address of the reclamation contractor;

   b. The name and address of the surface owner and the date when a copy of the proposed reclamation plan was provided to the surface owner;

   c. A description of the proposed work, including topsoil redistribution and reclamation plans for the access road and other associated facilities; and

   d. Reseeding plans, if applicable.

   The commission will mail a copy of the approved notice to the surface owner.

   All equipment, waste, and debris shall be removed from the site. ~~Flow lines~~All pipelines shall be purged and abandoned pursuant to section 43-02-03-29.1. Flow lines shall be removed if buried less than three feet [91.44 centimeters] below final contour.

2. Gravel or other surfacing material shall be removed, stabilized soil shall be remediated, and the site, access road, and other associated facilities constructed for the well, treating plant, or saltwater handling facility shall be reshaped as near as practicable to original contour.

3. The stockpiled topsoil shall be evenly distributed over the disturbed area and, where applicable, the area revegetated with native species or according to the reasonable specifications of the appropriate government land manager or surface owner.

4. A site assessment may be required by the director, before and after reclamation of the site.

5. Within thirty days after completing any reclamation, the operator shall file a sundry notice with the director reporting the work performed.

6. The director, with the consent of the appropriate government land manager or surface owner, may waive the requirement of reclamation of the site and access road after a well is plugged or treating plant or saltwater handling facility is decommissioned and shall record documentation of the waiver with the recorder of the county in which the site or road is located.

History: Effective April 1, 2012; amended effective April 1, 2014; October 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-38.1. Preservation of cores and samples.

Unless waived by the director, operators shall have a well site geologist or mudlogger on location for at least the first well drilled on a multiwell pad to collect sample cuttings and to create a mudlog and geologic report. Sample cuttings of formations, taken at intervals prescribed by the state geologist, in all wells drilled for oil or gas or geologic information in North Dakota, shall be washed and packaged in standard sample envelopes which in turn shall be placed in proper order in a standard sample box; carefully identified as to operator, well name, well file number, American petroleum institute number, location, depth of sample; and shall be sent free of cost to the state core and sample library within thirty days after completion of drilling operations.

The operator of any well drilled for oil or gas in North Dakota, during the drilling of or immediately following the completion of any well, shall inform the director of all intervals that are to be cored, or have been cored. Unless specifically exempted by the director, all cores taken shall be preserved, placed in a standard core box and the entire core forwarded to the state core and sample library, free of cost, within one hundred eighty days after completion of drilling operations. The director may grant an extension of the one hundred eighty-day time period for good reason. If an exemption is granted, the operator shall advise the state geologist of the final disposition of the core.

This section does not prohibit the operator from taking such samples of the core as the operator may desire for identification and testing. The operator shall furnish the state geologist with the results of all identification and testing procedures within thirty days of the completion of such work. The state geologist may grant an extension of the thirty-day time period for good reason.

The size of the standard envelopes, sample boxes, and core boxes shall be determined by the director and indicated in the cores and samples letter.

History: Effective October 1, 1990; amended effective January 1, 2006; April 1, 2014; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-40. Gas-oil ratio test.

Each operator shall take a gas-oil ratio test within thirty days following the completion or recompletion of an oil well. Each test shall be conducted using standard industry practices unless otherwise specified by the director. The initial gas-oil ratio must be reported on the well completion or recompletion report (form 6 or form provided by the commission). Subsequent gas-oil ratio tests must

be performed on producing wells when the producing pool appears to have reached bubble point. After the discovery of a new pool, each operator shall make additional gas-oil ratio tests as directed by the director or provided for in field rules. During tests each well shall be produced at a maximum efficient rate. The director may shut in any well for failure to make such test until such time as a satisfactory test can be made, or satisfactory explanation given. The results of all gas-oil ratio tests shall be submitted to the director on form 9, which shall be accompanied by a statement that the data on form 9 is true and correct.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1992; September 1, 2000; October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-48.1. Central production facility - Commingling of production.

1. The director shall have the authority to approve requests to consolidate production equipment at a central location. The applicant shall provide all information requested by the director. The director may impose such terms and conditions as the director deems necessary.

2. Commingling of production from two or more wells in a central production facility is prohibited unless approved by the director. There are two types of central production facilities in which production from two or more wells is commingled that may be approved by the director.

   a. A central production facility in which all production going into the facility has common ownership ~~(working interests, royalty interests, and overriding royalties)~~. For purposes of this section, production with common ownership is defined as production from wells that do not have diverse ownership.

   b. A central production facility in which production going into the facility has diverse ownership. For purposes of this section, production with diverse ownership is defined as production from wells that are:

      (1) In different drilling or spacing units; and

      (2) Which have different mineral ownership.

3. The commingling of production in a central production facility from two or more wells having common ownership may be approved by the director provided the production from each well can be accurately determined at reasonable intervals. Commingling of production in a central production facility from two or more wells having diverse ownership may be approved by the director provided the production from each well is accurately metered prior to commingling. Commingling of production in a central production facility from two or more wells having diverse ownership that is not metered prior to commingling may only be approved by the commission after notice and hearing.

   a. Common ownership central production facility. The application for permission to commingle oil and gas in a central production facility with common ownership must be submitted on a sundry notice (form 4) and shall include the following:

      (1) A plat or map showing thereon the location of the central facility and the name, well file number, and location of each well and flow lines from each well that will produce into the facility.

      (2) A schematic drawing of the facility which diagrams the testing, treating, routing, and transferring of production. All pertinent items such as treaters, tanks, flow lines, valves, meters, recycle pumps, etc., should be shown.

(3) An affidavit executed by a person who has knowledge ~~as to the state of title indicating ownership is common~~indicating that common ownership as defined above exists.

(4) An explanation of the procedures or method to be used to determine, accurately, individual well production at periodic intervals. Such procedures or method shall be performed at least once every three months.

A copy of all tests are to be filed with the director on form 11 within thirty days after the tests are completed.

b. Diverse ownership central production facility. The application for permission to commingle oil and gas in a central production facility having diverse ownership must be submitted on a sundry notice (form 4) and shall include the following:

(1) A plat or map showing thereon the location of the central facility and the name, well file number, and location of each well, and flow lines from each well that will produce into the facility.

(2) A schematic drawing of the facility which diagrams the testing, treating, routing, and transferring of production. All pertinent items such as treaters, tanks, flow lines, valves, meters, recycle pumps, etc., should be shown.

(3) The name of the manufacturer, size, and type of meters to be used. The meters must be proved at least once every three months and the results reported to the director within thirty days following the completion of the test.

(4) An explanation of the procedures or method to be used to determine, accurately, individual well production at periodic intervals. Such procedures or method shall be performed monthly.

A copy of all tests are to be filed with the director on form 11 within thirty days after the tests are completed.

4. Any changes to a previously approved central production facility must be reported on a sundry notice (form 4) and approved by the director.

History: Effective May 1, 1992; amended effective September 1, 2000; May 1, 2004; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-49. Oil production equipment, dikes, and seals.

Storage of oil in underground or partially buried tanks or containers is prohibited. Surface oil tanks and production equipment must be devoid of leaks and constructed of materials resistant to the effects of produced fluids or chemicals that may be contained therein. Unused tanks and production equipment must be removed from the site or placed into service, within a reasonable time period, not to exceed one year.

Dikes must be erected around oil tanks, flowthrough process vessels, and recycle pumps at any new production facility prior to completing any well. Dikes must be erected and maintained around oil tanks at all facilities unless a waiver is granted by the director. Dikes as well as the base material under the dikes and within the diked area must be constructed of sufficiently impermeable material to provide emergency containment. Dikes around oil tanks must be of sufficient dimension to contain the total capacity of the largest tank plus one day's fluid production. Dikes around flowthrough process vessels must be of sufficient dimension to contain the total capacity of the vessel. The required capacity of the

dike may be lowered by the director if the necessity therefor can be demonstrated to the director's satisfaction.

Within one hundred eighty days from the date the operator is notified by the commission, a perimeter berm, at least six inches [15.24 centimeters] in height, must be constructed and maintained. The berm must be constructed of sufficiently impermeable material to provide emergency containment and to divert surface drainage away from the site around all storage facilities and production sites that include storage tanks, have a daily throughput of more than one hundred barrels of fluid per day, and include production equipment or load lines that are not contained within secondary containment dikes. The director may consider an extension of time to implement these requirements if conditions prevent timely construction, or a modification of these requirements if other factors are present that provide sufficient protection from environmental impacts. Prior to removing any perimeter berm, the operator or owner shall obtain approval by the director.

Numbered weather-resistant security seals shall be properly utilized on all oil access valves and access points to secure the tank or battery of tanks.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1992; September 1, 2000; July 1, 2002; May 1, 2004; April 1, 2010; April 1, 2012; October 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-51. Treating plant.

No treating plant may be constructed or site or access road construction commenced without obtaining a permit from the commission after notice and hearing. A written application for a treating plant permit shall state in detail the location, type, capacity of the plant contemplated, method of processing proposed, and the plan of operation for all plant waste. The ~~commission~~director shall give the county auditor notice at least fifteen days prior to the hearing of any application in which a request for a treating plant is received.

History: Amended effective January 1, 1983; May 1, 1990; May 1, 1992; September 1, 2000; April 1, 2012; April 1, 2014; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-51.1. Treating plant permit requirements.

1. The treating plant permit application shall be submitted on form 1tp and shall include at least the following information:

   a. The name and address of the operator.

   b. An accurate plat certified by a registered surveyor showing the location of the proposed treating plant and the center of the site with reference to true north and the nearest lines of a governmental section. The plat shall also include the latitude and longitude of the center of the proposed treating plant location to the nearest tenth of a second, and the ground elevation. The plat shall also depict the outside perimeter of the treating plant and verification that the site is at least five hundred feet [152.4 meters] from an occupied dwelling.

   c. A schematic drawing of the proposed treating plant site, drawn to scale, detailing all facilities and equipment, including the size, location, and purpose of all tanks, the height and location of all dikes, the location of all flow lines, and the location of the topsoil stockpile. It shall also include the proposed road access to the nearest existing public road and the authority to build such access.

d. Cut and fill diagrams.

e. An affidavit of mailing identifying each owner of any permanently occupied dwelling within one-quarter mile of the proposed treating plant and certifying that such owner has been notified of the proposed treating plant.

f. Appropriate geological data on the surface geology and its suitability for fluid containment.

g. Schematic drawings of the proposed diking and containment, including calculated containment volume and all areas underlain by a synthetic liner.

h. Monitoring plans and leak detection for all buried or partially buried structures and any concrete structure upon which waste or product is in direct contact with.

i. The capacity and operational capacity of the treating plant.

j. A narrative description of the process and how the waste and recovered product streams travel through the treating plant.

k. A review of the surficial aquifers within one mile of the proposed treating plant site or surface facilities.

l. Any other information required by the director to evaluate the proposed treating plant or site.

2. Permits may contain such terms and conditions as the ~~commission~~director deems necessary.

3. Any permit issued under this section may be revoked by the commission after notice and hearing if the permittee fails to comply with the terms and conditions of the permit, any directive of the ~~commission~~director, or any applicable rule or statute. Any permit issued under this section may be suspended by the director for good cause.

4. Permits are transferable only with approval of the ~~commission~~director.

5. Permits may be modified by the ~~commission~~director.

6. A permit shall automatically expire one year after the date it was issued, unless dirtwork operations have commenced to construct the site.

7. If the treating plant is abandoned and reclaimed, the permit shall expire and be of no further force and effect.

History: Effective April 1, 2014; amended effective October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-51.3. Treating plant construction and operation requirements.

1. Before construction of a treating plant, treating plant site, or access road begins, the operator shall file with the ~~commission~~director a surety bond or cash bond conditioned upon compliance with all laws, rules and regulations, and orders of the commission. The bond amount shall be specified in the commission order authorizing the treating plant and shall be based upon the location, type, and capacity of the plant, processing method, and plan of operation for all plant waste approved in the commission order and shall be payable to the industrial commission. In no case shall the bond amount be set lower than fifty thousand dollars.

2. Treating plant sites and associated facilities or appropriate parts thereof shall be fenced if required by the director. All fences installed within or around any facility must be constructed in a manner that promotes emergency ingress and egress.

3. All storage tanks shall be kept free of leaks and in good condition. Storage tanks for saltwater shall be constructed of, or lined with, materials resistant to the effects of saltwater. Open tanks are allowed if approved by the director.

4. All waste, recovered solids, and recovered fluids shall be stored and handled in such a manner to prevent runoff or migration offsite.

5. Dikes of sufficient dimension to contain the total capacity of the maximum volume stored must be erected and maintained around all storage and processing tanks. Dikes as well as the base within the diked area must be lined with a synthetic impermeable liner to provide emergency containment. All processing equipment shall be underlain by a synthetic impermeable material, unless waived by the director. The site shall be sloped and diked to divert surface drainage away from the site. The operations of the treating plant shall be conducted in such a manner as to prevent leaks, spills, and fires. All discharged fluids and wastes shall be promptly and properly removed and shall not be allowed to remain standing within the diked area or on the treating plant premises. All such incidents shall be properly cleaned up, subject to approval by the director. All such reportable incidents shall be promptly reported to the director and a detailed account of any such incident must be filed with the director in accordance with section 43-02-03-30.

6. A perimeter berm, at least six inches [15.24 centimeters] in height, must be constructed of sufficiently impermeable material to provide emergency containment around the treating plant and to divert surface drainage away from the site if deemed necessary by the director.

7. Within thirty days following construction or modification of a treating plant, a sundry notice (form 4) must be submitted detailing the work and the dates commenced and completed. The sundry notice must be accompanied by a schematic drawing of the treating plant site drawn to scale, detailing all facilities and equipment, including the size, location, and purpose of all tanks; the height and location of all dikes as well as a calculated containment volume; all areas underlain by a synthetic liner; any leak detection system installed; the location of all flowlines; the stockpiled topsoil location and its volume; and the road access to the nearest existing public road.

8. Immediately upon the commencement of treatment operations, the operator shall notify the ~~commission~~director in writing of such date.

9. The operator of a treating plant shall provide continuing surveillance and conduct such monitoring and sampling as the ~~commission~~director may require.

10. Storage pits, waste pits, or other earthen storage areas shall be prohibited unless authorized by an appropriate regulatory agency. A copy of said authorization shall be filed with the ~~commission~~director.

11. Burial of waste at any treating plant site shall be prohibited. All residual water and waste, fluid or solid, shall be disposed of in an authorized facility.

12. The operator shall take steps to minimize the amount of residual waste generated and the amount of residual waste temporarily stored onsite. Solid waste shall not be stockpiled onsite unless authorized by an appropriate regulatory agency. A copy of said authorization shall be filed with the ~~commission~~director.

13. If deemed necessary by the director, the operator shall cause to be analyzed any waste substance contained onsite. Such chemical analysis shall be performed by a certified

laboratory and shall adequately determine if chemical constituents exist which would categorize the waste as hazardous by department of environmental quality standards.

14. Treating plants shall be constructed and operated so as not to endanger surface or subsurface water supplies or cause degradation to surrounding lands and shall comply with section 43-02-03-28 concerning fire hazards and proximity to occupied dwellings.

15. The beginning of month inventory, the amount of waste received and the source of such waste, the volume of oil sold, the amount and disposition of water, the amount and disposition of residue waste, fluid or solid, and the end of month inventory for each treating plant shall be reported monthly on form 5p with the director on or before the first day of the second succeeding month, regardless of the status of operations.

16. Records necessary to validate information submitted on form 5p shall be maintained in North Dakota.

17. All proposed changes to any treating plant must have prior approval by the director.

18. The operator shall comply with all applicable rules and orders of the commission. All rules in this chapter governing oil well sites shall also apply to any treating plant site.

19. The operator shall immediately cease operations if so ordered by the director for failure to comply with the statutes of North Dakota, ~~or~~ commission rules~~,~~ or orders, ~~and~~or directives of the ~~commission~~director.

History: Effective April 1, 2014; amended effective October 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-53. Saltwater handling facilities.

1. A saltwater handling facility may not be constructed without obtaining a permit from the ~~commission~~director. Saltwater handling facilities in existence prior to October 1, 2016, which are not currently bonded as an appurtenance to a well or treating plant, have ninety days from the date notified by the ~~commission~~director that a permit is required to submit the required information in order for the ~~commission~~director to approve such facility.

2. All saltwater liquids or brines produced with oil and natural gas shall be processed, stored, and disposed of without pollution of freshwater supplies.

3. Underground injection of saltwater liquids and brines shall be in accordance with chapter 43-02-05.

4. The permitting and bonding requirements for a saltwater handling facility set forth in sections 43-02-03-53, 43-02-03-53.1, and 43-02-03-53.3 are not to be construed to be required if the facility is bonded as a well or treating plant appurtenance. Such facilities will be considered in the permit application for the well or treating plant.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1992; September 1, 2000; July 1, 2002; May 1, 2004; April 1, 2010; April 1, 2012; October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-53.1. Saltwater handling facility permit requirements.

1. A permit for construction of a saltwater handling facility, saltwater handling facility site, or access road must be approved by the ~~commission~~director prior to construction. The saltwater

handling facility permit application must be submitted on a sundry notice (form 4) and include at least the following information:

a. The name and address of the operator.

b. An accurate plat certified by a registered surveyor showing the location of the proposed saltwater handling facility and the center of the site with reference to true north and the nearest lines of a governmental section. The plat also must include the latitude and longitude of the center of the proposed saltwater handling facility location to the nearest tenth of a second and the ground elevation. The plat also must depict the outside perimeter of the saltwater handling facility and verification that the site is at least five hundred feet [152.4 meters] from an occupied dwelling.

c. A schematic drawing of the proposed saltwater handling facility site, drawn to scale, detailing all facilities and equipment, including the size, location, and purpose of all tanks, the height and location of all dikes, the location of all flow lines, and the location and thickness of the stockpiled topsoil. The schematic drawing also must include the proposed road access to the nearest existing public road and the authority to build such access.

d. Cut and fill diagrams.

e. Schematic drawings of the proposed diking and containment, including calculated containment volume and all areas underlain by a synthetic liner, as well as a description of all containment construction material.

f. The anticipated daily throughput of the saltwater handling facility.

g. A review of the surficial aquifers within one mile of the proposed treating plant site or surface facilities.

h. Any other information required by the director to evaluate the proposed saltwater handling facility or site.

2. Permits may contain such terms and conditions as the ~~commission~~director deems necessary.

3. Any permit issued under this section may be revoked by the commission after notice and hearing if the permittee fails to comply with the terms and conditions of the permit, any directive of the ~~commission~~director, or any applicable rule or statute. Any permit issued under this section may be suspended by the director for good cause.

4. Permits are transferable only with approval of the ~~commission~~director.

5. Permits may be modified by the ~~commission~~director.

6. A permit automatically expires one year after the date it was issued, unless dirtwork operations have commenced to construct the site.

7. If the saltwater handling facility is abandoned and reclaimed, the permit expires and is of no further force and effect.

History: Effective October 1, 2016; amended effective April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-53.3. Saltwater handling facility construction and operation requirements.

1. Bond requirement. Before construction of a saltwater handling facility, saltwater handling facility site, or access road begins, the operator shall file with the ~~commission~~director a surety bond or cash bond conditioned upon compliance with all laws, rules and regulations, and orders of the commission. The bond must be in the amount of fifty thousand dollars and must be payable to the industrial commission. The commission, after notice and hearing, may require a higher bond amount. Such additional amounts for bonds must be related to the economic value of the facility and the expected cost of decommissioning and site reclamation, as determined by the commission. The commission may refuse to accept a bond if the operator or surety company has failed in the past to comply with all laws, rules and regulations, and orders of the commission; if a civil or administrative action brought by the commission is pending against the operator or surety company; or for other good cause.

2. Saltwater handling facility sites or appropriate parts thereof must be fenced if required by the director. All fences installed within or around any facility must be constructed in a manner that promotes emergency ingress and egress.

3. All waste, recovered solids, and fluids must be stored and handled in such a manner to prevent runoff or migration offsite.

4. Surface tanks may not be underground or partially buried, must be devoid of leaks, and constructed of, or lined with, materials resistant to the effects of produced saltwater liquids, brines, or chemicals that may be contained therein. The above materials requirement may be waived by the director for tanks presently in service and in good condition. Unused tanks and equipment must be removed from the site or placed into service, within a reasonable time period, not to exceed one year.

5. Dikes must be erected and maintained around saltwater tanks at any saltwater handling facility. Dikes must be erected around saltwater tanks at any new facility prior to introducing fluids. Dikes as well as the base material under the dikes and within the diked area must be constructed of sufficiently impermeable material to provide emergency containment. Dikes must be of sufficient dimension to contain the total capacity of the largest tank plus one day's fluid throughput. The required capacity of the dike may be lowered by the director if the necessity therefor can be demonstrated to the director's satisfaction. The operations of the saltwater handling facility must be conducted in such a manner as to prevent leaks, spills, and fires. Discharged liquids or brines must be properly removed and may not be allowed to remain standing within or outside of any diked areas. All such incidents must be properly cleaned up, subject to approval by the director. All such reportable incidents must be promptly reported to the director and a detailed account of any such incident must be filed with the director in accordance with section 43-02-03-30.

6. Within one hundred eighty days from the date the operator is notified by the commission, a perimeter berm, at least six inches [15.24 centimeters] in height, must be constructed of sufficiently impermeable material to provide emergency containment around the facility and to divert surface drainage away from the site. The director may consider an extension of time to implement these requirements if conditions prevent timely construction or a modification of these requirements if other factors are present that provide sufficient protection from environmental impacts.

7. The operator shall take steps to minimize the amount of solids stored at the facility.

8. Within thirty days following construction or modification of a saltwater handling facility, a sundry notice (form 4) must be submitted detailing the work and the dates commenced and completed. The sundry notice must be accompanied by a schematic drawing of the saltwater handling facility site drawn to scale, detailing all facilities and equipment, including the size,

location, and purpose of all tanks; the height and location of all dikes as well as a calculated containment volume; all areas underlain by a synthetic liner; any leak detection system installed; the location of all flowlines; the stockpiled topsoil location and its volume; and the road access to the nearest existing public road.

9. Immediately upon the commissioning of the saltwater handling facility, the operator shall notify the ~~commission~~director in writing of such date.

10. The operator of a saltwater handling facility shall provide continuing surveillance and conduct such monitoring and sampling as the ~~commission~~director may require.

11. Storage pits, waste pits, or other earthen storage areas must be prohibited unless authorized by an appropriate regulatory agency. A copy of said authorization must be filed with the ~~commission~~director.

12. Burial of waste at any saltwater handling facility site is prohibited. All residual water and waste, fluid or solid, must be disposed of in an authorized facility.

13. If deemed necessary by the director, the operator shall cause to be analyzed any waste substance contained onsite. Such chemical analysis must be performed by a certified laboratory and must adequately determine if chemical constituents exist which would categorize the waste as hazardous by department of environmental quality standards.

14. Saltwater handling facilities must be constructed and operated so as not to endanger surface or subsurface water supplies or cause degradation to surrounding lands and must comply with section 43-02-03-28 concerning fire hazards and proximity to occupied dwellings.

15. All proposed changes to any saltwater handling facility are subject to prior approval by the director.

16. Any salable crude oil recovered from a saltwater handling facility must be reported on a form 5 SWD.

17. The operator shall comply with all laws, rules and regulations, and orders of the commission. All rules in this chapter governing oil well sites also apply to any saltwater handling facility site.

18. The operator shall immediately cease operations if so ordered by the director for the failure to comply with the statutes of North Dakota, ~~or~~commission rules~~,~~ or orders, ~~and~~or directives of the ~~commission~~director.

History: Effective October 1, 2016; amended effective April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-55. Abandonment of wells, treating plants, or saltwater handling facilities - Suspension of drilling.

1. The removal of production equipment or the failure to produce oil or gas, or the removal of production equipment or the failure to produce water from a source well, for one year constitutes abandonment of the well. The removal of injection equipment or the failure to use an injection well for one year constitutes abandonment of the well. The failure to plug a stratigraphic test hole within one year of reaching total depth constitutes abandonment of the well. The removal of treating plant equipment or the failure to use a treating plant for one year constitutes abandonment of the treating plant. The removal of saltwater handling facility equipment or the failure to use a saltwater handling facility for one year constitutes abandonment of the saltwater handling facility. An abandoned well must be plugged and its site must be reclaimed, an abandoned treating plant must be removed and its site must be

reclaimed, and an abandoned saltwater handling facility must be removed and its site must be reclaimed, pursuant to sections 43-02-03-34 and 43-02-03-34.1. A well not producing oil or natural gas in paying quantities for one year may be placed in abandoned-well status pursuant to subsection 1 of North Dakota Century Code section 38-08-04. If an injection well is inactive for extended periods of time, the commission may, after notice and hearing, require the injection well to be plugged and abandoned.

2. The director may waive for one year the requirement to plug and reclaim an abandoned well by giving the well temporarily abandoned status for good cause. This status may only be given to wells that are to be used for purposes related to the production of oil and gas within the next seven years. If a well is given temporarily abandoned status, the well's perforations must be isolated, the integrity of its casing must be proven, and its casing must be sealed at the surface, all in a manner approved by the director. The director may extend a well's temporarily abandoned status and each extension may be approved for up to one year. A fee of one hundred dollars shall be submitted for each application to extend the temporary abandonment status of any well. A surface owner may request a review of a well temporarily abandoned for at least seven years pursuant to subsection 1 of North Dakota Century Code section 38-08-04.

3. In addition to the waiver in subsection 2, the director may also waive the duty to plug and reclaim an abandoned well for any other good cause found by the director. If the director exercises this discretion, the director shall set a date or circumstance upon which the waiver expires.

4. The director may approve suspension of the drilling of a well. If suspension is approved, a plug must be placed at the top of the casing to prevent any foreign matter from getting into the well. When drilling has been suspended for thirty days, the well, unless otherwise authorized by the director, must be plugged and its site reclaimed pursuant to sections 43-02-03-34 and 43-02-03-34.1.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1990; May 1, 1992; August 1, 1999; January 1, 2008; April 1, 2010; April 1, 2012; April 1, 2014; October 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-66. Application for allowable on new oil wells.

No well shall be placed on the proration schedule until a completion report (form 6 or form provided by the committee) has been filed with the director.

The discovery well of any pool hereafter discovered shall be allowed to produce at a maximum efficient rate until such time as proper spacing is set for the pool, and shall produce thereafter, only pursuant to the general proration rules and regulations of the commission.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1992; September 1, 2000; January 1, 2008; April 1, 2020.
General Authority: NDCC 38-08-04, 38-08-06
Law Implemented: NDCC 38-08-04, 38-08-06

CHAPTER 43-02-05

43-02-05-04. Permit requirements.

1. No underground injection may be conducted, or site or access road construction commenced, without obtaining a permit from the ~~commission~~director after notice and hearing. The application shall be on a form 14 or form provided by the ~~commission~~director and shall include at least the following information:

   a. The name and address of the operator of the injection well.

   b. The surface and bottom hole location.

   c. Appropriate geological data on the injection zone and the ~~top~~upper and ~~bottom~~lower confining zones including geologic names, lithologic descriptions, thicknesses, and depths.

   d. The estimated bottom hole fracture pressure of the ~~top~~upper confining zone.

   e. Average and maximum daily rate of fluids to be injected.

   f. Average and maximum requested surface injection pressure.

   g. Geologic name and depth to base of the lowermost underground sources of drinking water which may be affected by the injection.

   h. Existing or proposed casing, tubing, and packer data.

   i. Existing or proposed cement specifications, including amounts and actual or proposed top of cement.

   j. A plat and maps depicting the area of review, (one-quarter-mile [402.34-meter] radius) and detailing the location, well name, and operator of all wells in the area of review. The plat ~~should~~and maps must include all injection wells, producing wells, plugged wells, abandoned wells, drilling wells, dry holes, ~~and~~permitted wells, water wells~~. The plat should also depict faults, if known or suspected~~, surface bodies of water, and other pertinent surface features, such as occupied dwellings and roads.

   ~~j. The need for corrective action on wells penetrating the injection zone in the area of review.~~

   k. A review of the surficial aquifers within one mile of the proposed injection well site or surface facilities.

   l. A tabulation of data on all wells within the area of review that penetrate the proposed injection zone. Such data must include a description of each well's type, construction, date drilled, location, depth, record of plugging and completion, and any additional information the director may require. A detail of any corrective action necessary for any of the wells not properly cemented or plugged to prevent the movement of fluid out of the injection zone must also be included.

   m. If faults are known or suspected, a cross section that includes a depiction of the fault at depth.

   n. Proposed injection program, including method of transportation of the fluid to the injection facility and the injection well.

~~l.~~o. ~~Quantitative~~A tabulation of all freshwater wells and domestic freshwater sources within the area of review. Each freshwater well and domestic freshwater source must be identified by owner, location by quarter-quarter, section, township, and range, type of well or source, depth, and current status. A quantitative analysis from a state-certified laboratory of freshwater from the two nearest freshwater wells within a one-mile [1.61-kilometer] radius~~. Location of the wells by quarter-quarter, section, township, and range must also be submitted~~ must be submitted. This requirement may be waived by the director in certain instances.

~~m.~~p. Quantitative analysis from a state-certified laboratory of a representative sample of water to be injected. A compatibility analysis with the receiving formation may also be required.

~~n.~~q. List identifying all source wells or sources of injectate.

~~o.~~r. A legal description of the land ownership within the area of review in both tabular and plat form.

~~p.~~s. An affidavit of mailing, and proof of service, certifying that all landowners within the area of review have been notified of the proposed injection well. A copy of the letter sent to each landowner must be attached to the affidavit.

If the proposed injection well is within an area permit authorized by a commission order, the notice shall inform the landowners within the area of review that comments or objections may be submitted to the commission within thirty days and must include a contact person and phone number for the applicant and a contact person and phone number for the commission.

If the proposed injection well is not within an area permit authorized by a commission order, the notice shall inform the landowners within the area of review that a hearing will be held at which comments or objections may be directed to the commission~~. A copy of the letter sent to each landowner must be attached to the affidavit~~, and written comments or objections to the application may be submitted prior to the hearing date, received by the commission no later than five p.m. on the last business day prior to the hearing date.

t. An affidavit of mailing, and proof of service, certifying that all owners or operators of any usable oil and gas exploration and production well or permit within the area of review have been notified of the proposed injection well. A copy of the letter sent to each owner or operator must be attached to the affidavit.

If the proposed injection well is within an area permit authorized by a commission order, the notice must include the proposed surface and bottom hole locations of the proposed injection well and inform the owner or operator of any oil and gas exploration- and production-related well within the area of review that comments or objections may be submitted to the commission within thirty days and must include a contact person and phone number for the applicant and a contact person and phone number for the commission.

If the proposed injection well is not within an area permit authorized by a commission order, the notice must include the proposed surface and bottom hole locations of the proposed injection well and inform the owner or operator of any oil and gas production-related well within the area of review that a hearing will be held at which comments or objections may be directed to the commission, and that written comments or objections to the application may be submitted prior to the hearing date, received by the commission no later than five p.m. on the last business day prior to the hearing date.

~~q.~~u. All logging and testing data on the well which has not been previously submitted.

~~r.~~v. Schematic or other appropriate drawings and tabulations of the ~~injection system, including current and proposed well bore construction, surface facility construction~~wellhead and surface facilities, including the size, location, construction, and purpose of all tanks, the height and location of all dikes and containment, including a calculated containment volume, all areas underlain by a synthetic liner, and the location of all flow lines and a tabulation of any pressurized flow line specifications. It ~~shall~~must also include the proposed road access to the nearest existing public road and the authority to build such access.

~~s.~~w. A schematic drawing of the well detailing the proposed well bore construction, including the size of the borehole; the total depth and plug back depth; the casings and tubing sizes, weights, grades, and top and bottom depths; the perforated interval top and bottom depths; the packer depth; the injection zone and upper and lower confining zones' top and bottom depths.

x. Traffic flow diagram of the site, depicting sufficient area to contain all anticipated traffic.

~~t.~~y. ~~A review of the surficial aquifers within one mile of the proposed injection well site or surface facilities.~~A detailed drilling prognosis, including a drilling, casing, cementing, logging, testing, and coring program, if applicable.

~~u.~~z. ~~Sundry notice detailing~~A detailed description of the proposed completion or conversion procedure.

aa. Any additional information necessary to demonstrate that injection into the proposed injection zone will not initiate fractures in the confining zone that could allow fluid movement out of the injection zone.

bb. Any other information required by the director to evaluate the proposed well.

2. Permits may contain such terms and conditions as the ~~commission~~director deems necessary.

3. The corrective action plan for any well in the area of review which is not properly cemented or plugged to prevent the movement of fluid out of the injection zone must be incorporated into the permit as a condition if the plan is deemed adequate by the director. If the director deems the plan inadequate, the director shall require the applicant to revise the plan, prescribe a plan for corrective action as part of the permit, or deny the application. Before injection commences in an injection well, the applicant shall complete any needed corrective action on wells penetrating the injection zone in the area of review to the satisfaction of the director.

4. Any permit issued under this section may be revoked by the commission after notice and hearing if the permittee fails to comply with the terms and conditions of the permit or any applicable rule or statute. Any permit issued under this section may be suspended by the director for good cause.

~~4.~~5. Before a permit for underground injection will be issued, the applicant must satisfy the ~~commission~~director that the proposed injection well will not endanger any underground source of drinking water.

~~5.~~6. No person shall commence construction of an underground injection well ~~or~~, site, or access road without prior approval of the director.

~~6.~~7. Permits are transferable only with approval of the ~~commission~~director.

~~7.~~8. Permits may be modified by the ~~commission~~director.

~~8. Before injection commences in an underground injection well, the applicant must complete any needed corrective action on wells penetrating the injection zone in the area of review.~~

9. All injection wells permitted before November 1, 1982, shall be deemed to have a permit for purposes of this section; however, all such prior permitted wells are subject to all other requirements of this chapter.

10. A permit shall automatically expire one year after the date it was issued, unless operations have commenced to complete the well as an injection well.

11. If the permitted injection zone is plugged and abandoned, the permit shall expire and be of no further force and effect.

History: Effective November 1, 1982; amended effective May 1, 1992; May 1, 1994; July 1, 1996; May 1, 2004; January 1, 2006; April 1, 2014; October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

43-02-05-06. Construction requirements.

1. All injection wells shall be cased and cemented to prevent movement of fluids into or between underground sources of drinking water or into an unauthorized zone. The casing and cement used in construction of each new injection well shall be designed for the life expectancy of the well. A well to be converted to a saltwater disposal well must have surface casing set and cemented at a point not less than fifty feet [15.24 meters] below the base of the Fox Hills formation. In determining and specifying casing and cementing requirements, all of the following factors shall be considered:

   a. Depth to the injection zone and lower confining zone. Long string casing must be set at least to the top of the injection zone and cemented at least to the top of the upper confining zone, or to a point approved by the director.

   b. Depth to the bottom of all underground sources of drinking water.

   c. Estimated maximum and average injection pressures.

   d. Fluid pressure.

   e. Estimated fracture pressure.

   f. Physical and chemical characteristics of the injection zone.

2. Appropriate logs and other tests shall be conducted during the drilling and construction of injection wells. Any well drilled or converted to an injection well shall have a log run from which the quality of the cement bond can be determined. Cement bond logs shall contain at least the following elements: a gamma ray curve; a casing collar locator curve; a transit time curve; an amplitude curve; and a variable density curve. A descriptive report interpreting the results of these logs and tests shall be prepared by a qualified log analyst and submitted to the commission if deemed necessary by the ~~director~~director.

3. All injection wells must be equipped with injection tubing and a packer set in the long string casing within one hundred feet measured depth of the top perforation, or at a depth approved by the director.

4. After an injection well has been completed, approval must be obtained on a sundry notice (form 4) ~~from~~or form provided by the director prior to any subsequent perforating.

5. Surface facilities must be constructed pursuant to sections 43-02-03-53, 43-02-03-53.1, 43-02-03-53.2, and 43-02-03-53.3.

History: Effective November 1, 1982; amended effective May 1, 1992; July 1, 1996; May 1, 2004; January 1, 2006; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

43-02-05-07. Mechanical integrity.

1. Prior to commencing operations, the operator of a new injection well must demonstrate the mechanical integrity of the well. Prior to performing any workover project on an existing well, during which the packer or other means of annular isolation could be affected, the operator shall obtain approval from the director. All existing injection wells must demonstrate continual mechanical integrity and be tested at least once every five years. Following the completion of any remedial work, the operator shall demonstrate the mechanical integrity of the well. The director may require further mechanical integrity tests or other remedial work to ensure the mechanical integrity of the well to prevent the movement of fluid into an underground source of drinking water or an unauthorized zone. Mechanical integrity pressure tests must be performed at one thousand pounds per square inch [6900 kilopascals] for a minimum of fifteen minutes. A mechanical integrity test pressure of less than one thousand pounds per square inch [6900 kilopascals] may be approved by the director. Once an injection well is determined to lack mechanical integrity, within ninety days of the determination, it must be repaired and retested or plugged and abandoned.

   An injection well has mechanical integrity if:

   a. There is no significant leak in the casing, tubing, or packer; and

   b. There is no significant fluid movement into an underground source of drinking water or an unauthorized zone through vertical channels adjacent to the injection bore.

2. One of the following methods must be used to evaluate the absence of significant leaks:

   a. Pressure test with liquid or gas.

   b. Monitoring of positive annulus pressure following a valid pressure test.

   c. Radioactive tracer survey.

3. One of the following methods must be used to establish the absence of significant fluid movement:

   a. A log from which cement can be determined or well records demonstrating the presence of adequate cement to prevent such migration.

   b. Radioactive tracer survey, temperature log, or noise log.

4. The operator of an injection well immediately shall shut-in the well if mechanical failure indicates fluids are, or may be, migrating into an underground source of drinking water or an unauthorized zone, or if so directed by the director.

History: Effective November 1, 1982; amended effective May 1, 1990; July 1, 1996; May 1, 2004; October 1, 2016; April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

43-02-05-08. Plugging of injection wells.

The proper plugging of an injection well requires the well be plugged with cement or other types of plugs, or both, in a manner which will not allow movement of fluids into an underground source of drinking water. The operator shall file a notice of intention to plug (form 4) ~~with the oil and gas division of the industrial commission~~or form provided by the director and shall obtain the director's approval of the plugging method prior to the commencement of plugging operations.

History: Effective November 1, 1982; amended effective May 1, 1992; May 1, 1994; April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

43-02-05-09. Pressure limitations.

Injection pressure at the wellhead shall not exceed a maximum authorized injection pressure which shall be calculated so as to assure that the pressure in the injection zone during injection does not initiate new fracture or propagate existing fractures in the confining ~~zone adjacent to the freshwater resource~~zones. In no case shall injection pressure initiate fractures in the confining ~~zone~~zones or cause the movement of injection or formation fluids into an unauthorized zone or underground source of drinking water.

History: Effective November 1, 1982; amended effective May 1, 1992; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

43-02-05-10. Corrective action.

If any monitoring indicates the movement of injection or formation fluids into an unauthorized zone or underground sources of drinking water, the ~~commission~~director shall prescribe such additional requirements for construction, corrective action, operation, monitoring, or reporting as are necessary to prevent such movement.

History: Effective November 1, 1982; amended effective April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

43-02-05-12. Reporting, monitoring, and operating requirements.

1. The operator of an injection well shall meter or use an approved method to keep records and shall report monthly to the ~~industrial commission, oil and gas division~~director, the volume and nature, i.e., produced water, pit water, makeup water, etc., of the fluid injected, the average operating and maximum injection ~~pressure~~pressures, the maximum injection rate, and such other information as the ~~commission~~director may require. The operator of each injection well shall, on or before the fifth day of the second month succeeding the month in which the well is capable of injection, file with the director the aforementioned information for each well ~~upon form 16, 16a, 17, or 17a, or approved computer sheets. The operator shall retain all records required by the industrial commission for at least six years~~in a format provided by the director.

2. Immediately upon the commencement or recommencement of injection, the operator shall notify the ~~oil and gas division~~director of the injection date verbally and in writing.

3. The operator shall place accurate gauges on the tubing and the tubing-casing annulus. Accurate gauges shall also be placed on any other annuluses deemed necessary by the director.

4. The operator of an injection well shall keep the well, surface facilities, and injection system under continuing surveillance and conduct such monitoring, testing, and sampling as the

~~commission~~director may require to verity the integrity of the surface facility, gathering system, and injection well to protect surface and subsurface waters. Prior to commencing operations, the saltwater disposal injection pipeline must be pressure tested. All existing saltwater disposal injection pipelines where the pump and the wellhead are not located on the same site are required to be pressure tested annually.

5. The operator of an injection well shall report any noncompliance with regulations or permit conditions to the director ~~orally~~verbally within twenty-four hours followed by a written explanation within five days. The operator shall cease injection operations if so directed by the director.

6. Within ten days after the discontinuance of injection operations, the operator shall notify the ~~oil and gas division~~director of the date of such discontinuance and the reason therefor.

7. Upon the completion or recompletion of an injection well or the completion of any remedial work or attempted remedial work such as plugging back, deepening, acidizing, shooting, formation fracturing, squeezing operations, setting liner, perforating, reperforating, tubing repairs, packer repairs, casing repairs, or other similar operations not specifically covered herein, a report on the operation shall be filed ~~on a form 4 sundry notice~~ with the director within thirty days. The report shall present a detailed account of all work done, including the reason for the work, the date of such work, the shots per foot and size and depth of perforations, the quantity of sand, crude, chemical, or other materials employed in the operation, the size and type of tubing, the type and location of packer, the result of the packer pressure test, and any other pertinent information or operations which affect the status of the well and are not specifically covered herein.

8. Annular injection of fluids is prohibited.

History: Effective November 1, 1982; amended effective May 1, 1992; May 1, 1994; July 1, 1996; May 1, 2004; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

43-02-05-13. Access to records.

The industrial commission and the ~~commission's authorized agents~~director shall have access to all injection well records wherever located. All owners, operators, drilling contractors, drillers, service companies, or other persons engaged in drilling, completing, operating, or servicing injection wells shall permit the industrial commission, or ~~its authorized agents~~the director, to come upon any lease, property, well, or drilling rig operated or controlled by them, complying with state safety rules and to inspect the records and operation of wells and to conduct sampling and testing. Any information so obtained shall be public information. If requested, copies of injection well records must be filed with the commission or director.

History: Effective November 1, 1982; amended effective May 1, 1992; May 1, 1994; April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

43-02-05-14. Area permits.

1. The ~~commission~~director, after notice and hearing, may issue an area permit providing for the permitting of individual injection wells if the proposed injection wells are:

   a. Within the same field, facility site, reservoir, project, or similar unit in the same state;

   b. Of similar construction;

c. Of the same class; and

d. Operated by a single owner or operator.

2. An area permit application shall include at least the following information:

a. The name and address of the operator.

b. A plat and maps depicting the area permit and one-quarter mile [402.34 meters] adjacent detailing the location of all anticipated injection wells and the location, well name, and operator of all ~~current~~ producing wells, saltwater disposal wells, injection wells, plugged wells, abandoned wells, drilling wells, dry holes, ~~and~~permitted wells, water wells~~. The plat should also depict faults if known or suspected~~, surface bodies of water, and other pertinent surface features, such as occupied dwellings and roads.

c. A review of the surficial aquifers within the proposed area permit boundary and one mile adjacent.

d. Appropriate geological data on the injection zone and the upper and lower confining zones, including geologic names, lithologic descriptions, thicknesses, and depths.

~~d.~~e. Estimated fracture pressure of the ~~top~~upper confining zone.

~~e.~~f. Estimated maximum injection pressure.

~~f.~~g. Geologic name and depth to base of the lowermost underground source of drinking water which may be affected by the injection.

~~g.~~h. A reference well log, displaying at least a gamma ray curve, from a nearby well.

i. If faults are known or suspected, a cross section that includes a depiction of the fault at depth.

j. Proposed injection program, including method of transportation of the fluid to the injection facilities and wells.

~~h.~~k. List identifying all source wells or sources of injectate.

~~i.~~l. Quantitative analysis from a state-certified laboratory of a representative sample of water to be injected. A compatibility analysis with the receiving formation may also be required.

~~j.~~m. Legal description of the land ownership within and one-quarter mile [402.34 meters] adjacent to the proposed area permit in both tabular and plat form.

~~k.~~n. ~~Affidavit~~An affidavit of mailing, and proof of service, certifying that all landowners within the proposed area permit and one-quarter mile adjacent have been notified of the proposed area permit. A representative copy of the letters sent must be attached to the affidavit. The notice must inform the landowners that a hearing will be held at which comments or objections may be directed to the commission, and that written comments or objections to the application may be submitted prior to the hearing date, received by the commission no later than five p.m. on the last business day prior to the hearing date.

~~l. Representative example of landowner letter sent.~~

~~m.~~o. Schematic of the proposed injection system, including facilities and pipelines.

~~n.~~p. ~~Schematic~~A schematic drawing of a typical proposed injection well bore construction, including the size of the borehole; the total depth and plug back depth; the casings and

tubing sizes, weights, grades, and top and bottom depths; the perforated interval top and bottom depths; the packer depth; the injection zone and upper and lower confining zones' top and bottom depths.

3. An area permit authorizes the director to approve individual injection well permit applications within the permitted area. The application shall be ~~on a form 14~~made in a format provided by the ~~commission~~director and shall include at least the following information:

   a. The name and address of the operator of the injection well.

   b. The surface and bottom hole location.

   c. Average and maximum daily rate of fluids to be injected.

   d. Existing or proposed casing, tubing, and packer data.

   e. Existing or proposed cement specifications, including amounts and actual or proposed top.

   f. A plat and maps depicting the area of review (one-quarter-mile [402.34-meter] radius) and detailing the location, well name, and operator of all wells in the area of review. The plat ~~should~~, maps, or both must include all producing wells, saltwater disposal wells, injection wells, ~~producing~~abandoned wells, drilling wells, plugged wells, ~~abandoned wells, drilling wells,~~ dry holes, ~~and~~permitted wells, water wells~~. The plat should also depict faults if known or suspected~~, surface bodies of water, and other pertinent surface features, such as occupied dwellings and roads.

   ~~f. The need for corrective action on wells penetrating the injection zone in the area of review.~~

   g. A review of the surficial aquifers within one mile of the proposed injection well site or surface facilities.

   h. A tabulation of data on all wells within the area of review which penetrate the proposed injection zone. Such data must include a description of each well's type, construction, date drilled, location, depth, record of plugging and completion, and any additional information the director may require. A detail of any corrective action necessary for any of the wells not properly cemented or plugged to prevent the movement of fluid out of the injection zone must also be included.

   i. ~~Location of the two nearest freshwater wells by quarter-quarter, section, township, and range within a one-mile [1.61-kilometer] radius and the dates sampled.~~A tabulation of all freshwater wells and domestic freshwater sources within the area of review. Each freshwater well and domestic freshwater source must be identified by owner, location by quarter-quarter, section, township, and range, type of well or source, depth, and current status. A quantitative analysis from a state-certified laboratory of ~~the samples~~freshwater from the two nearest freshwater wells within a one-mile radius must be submitted ~~with the application or within thirty days of sampling~~. This requirement may be waived by the director in certain instances.

   ~~h.~~j. All logging and testing data on the well which has not been previously submitted.

   ~~i.~~k. ~~Schematic drawings of the current well bore construction and proposed well bore and surface facility construction.~~A schematic drawing of the well detailing the proposed well bore construction, including the size of the borehole; the total depth and plug back depth; the casings and tubing sizes, weights, grades, and top and bottom depths; the perforated

interval top and bottom depths; the packer depth; the injection zone and upper and lower confining zones top and bottom depths.

l. A schematic or other appropriate drawings and tabulations of the wellhead and surface facilities, including the size, location, construction, and purpose of all tanks, the height and location of all dikes and containment, including a calculated containment volume, all areas underlain by a synthetic liner, the location of all flow lines, and a tabulation of any pressurized flow line specifications. It also must include the proposed road access to the nearest existing public road and the authority to build such access.

m. Traffic flow diagram of the site, depicting sufficient area to contain all anticipated traffic, if applicable.

n. A detailed drilling prognosis including a drilling, casing, cementing, logging, testing, and coring program, if applicable.

~~j.~~o. ~~Sundry notice detailing~~A detailed description of the proposed completion or conversion procedure.

p. Any additional information necessary to demonstrate that injection into the proposed injection zone will not initiate fractures in the confining zone that could allow fluid movement out of the injection zone.

q. Any other information required by the director to evaluate the proposed well.

4. The director is authorized to approve individual injection well permit applications within an area permit provided:

   a. The additional well meets the area permit criteria.

   b. The cumulative effects of drilling and operating additional injection wells are acceptable to the director.

5. If the director determines that any additional well does not meet the area permit requirements, the director may modify or terminate the permit or take enforcement action.

6. If the director determines the cumulative effects are unacceptable, the permit may be modified.

7. Area and individual injection well permits may contain such terms and conditions as the ~~commission~~director deems necessary.

8. The corrective action plan for any well in the area of review which is not properly cemented or plugged to prevent the movement of fluid out of the injection zone must be incorporated into the permit as a condition if the plan is deemed adequate by the director. If the director deems the plan inadequate, the director shall require the applicant to revise the plan, prescribe a plan for corrective action as part of the permit, or deny the application. Before injection commences in an injection well, the applicant shall complete any needed corrective action on wells penetrating the injection zone in the area of review to the satisfaction of the director.

9. Any permit issued under this section may be revoked by the commission after notice and hearing if the permittee fails to comply with the terms and conditions of the permit or any applicable rule or statute. Any permit issued under this section may be suspended by the director for good cause.

~~9.~~10. Before a permit for underground injection will be issued, the applicant must satisfy the ~~commission~~director that the proposed injection well will not endanger any underground source of drinking water.

~~10.~~11. No person shall commence construction of an underground injection well, site, or access road until the ~~commission~~director has issued a permit for the well.

~~11.~~12. Area and individual injection well permits are transferable only with approval of the ~~commission~~director.

~~12.~~13. Individual injection well permits may be modified by the ~~commission~~director.

~~13. Before injection commences in an underground injection well, the applicant must complete any needed corrective action on wells penetrating the injection zone in the area of review.~~

14. Individual injection well permits shall automatically expire one year after the date issued, unless operations have commenced to complete the well as an injection well.

15. If the permitted injection zone is plugged and abandoned, the permit shall expire and be of no further force and effect.

History: Effective November 1, 1982; amended effective May 1, 1992; May 1, 2004; January 1, 2006; April 1, 2020.
General Authority: NDCC 38-08-04(2)
Law Implemented: NDCC 38-08-04(2)

CHAPTER 43-02-06

43-02-06-01. Royalty owner information statement.

Whenever payment is made for oil or gas production to an interest owner, whether pursuant to a division order, lease, servitude, or other agreement, all of the following information must be included on the check stub or on an attachment to the form of payment, unless the information is otherwise provided on a regular monthly basis:

1. The lease, property, or well name or any lease, property, or well identification number used to identify the lease, property, or well; provided, that if a lease, property, or well identification number is used, the royalty owner must initially be provided the lease, property, or well name to which the lease, property, or well name refers.

2. The month and year during which sales occurred for which payment is being made.

3. One hundred percent of the corrected volume of oil, regardless of ownership, which is sold measured in barrels, and one hundred percent of the volume of either wet or dry gas, regardless of ownership, which is sold or removed from the premises for the purpose of sale, or sale of its contents and residue, measured in thousand cubic feet.

4. Price.

   a. Oil. Weighted average price per barrel received by the producer for all oil sold during the period for which payment is made. The price must be the net price received by the producer after all deductions. ~~All deductions are to be explained pursuant to subsection 6.~~

   b. Gas and natural gas liquids. Weighted average price per thousand cubic feet [28.32 cubic meters] received by the producer for all gas sold and weighted average price per gallon received by the producer for all natural gas liquids sold during the period for which payment is made. The price must be the net price received by the producer after all deductions. ~~All deductions are to be explained pursuant to subsection 6.~~

5. Total amount of state severance and other production taxes.

6. Producer's net value of total sales after taxes and deductions.

7. The amount and purpose of each owner deduction made, identified as transportation, processing, compression, or administrative costs.

~~7.~~8. The amount and purpose of each owner adjustment or correction made.

~~8. Net value of total sales after deductions.~~

9. Owner's interest in sales from the lease, property, or well expressed as a decimal.

10. Owner's share of the total value of sales prior to removing any ~~tax deductions~~taxes. The value can be calculated before or after removing owner's deductions if it is clearly noted on the royalty statement or included on an attachment to the royalty statement.

11. Owner's share of sales value less taxes and deductions.

12. An address where additional information may be obtained and any questions answered. If information is requested by certified mail, the answer must be mailed by certified mail within thirty days of receipt of the request.

History: Effective November 1, 1983; amended effective April 1, 1984; November 1, 1987; May 1, 1992; April 1, 2018; April 1, 2020.
General Authority: NDCC 38-08-06.3
Law Implemented: NDCC 38-08-06.3

43-02-06-01.1. Ownership interest information statement.

Within one hundred twenty days after the end of the month of the first sale of production from a well or change in the spacing unit of a well or a decimal interest in a mineral owner, the operator or payor shall provide the mineral owner with a statement identifying the spacing unit for the well, and the effective date of the spacing unit change or decimal interest change if applicable, the net mineral acres owned by the mineral owner, the gross mineral acres in the spacing unit, and the mineral owner's decimal interest that will be applied to the well.

History: Effective April 1, 2018; amended effective April 1, 2020.
General Authority: NDCC 38-08-06.3
Law Implemented: NDCC 38-08-06.3

TITLE 56

OPTOMETRY, BOARD OF

APRIL 2020

CHAPTER 56-02-07

56-02-07-01. Optometrist prescribers and use of the prescription drug monitoring program.

Subject to the exceptions described in section 56-02-07-02, prior to the initial prescribing of any controlled substance, including samples, an optometrist authorized by the drug enforcement administration to prescribe, administer, sign for, dispense, or procure pharmaceuticals shall authorize an employee to review or personally request and review the prescription drug monitoring program report for all available prescription drug monitoring program data on the patient within the previous twelve months, and shall do all of the following:

1. Assess a patient's drug monitoring program data every twelve months during the patient's treatment with a controlled substance.
2. Review the patient's prescription drug monitoring program data if the patient requests early refills or demonstrates a pattern of taking more than the prescribed dosage.
3. Review the patient's prescription drug monitoring program data if there is a suspicion of or a known drug overuse, diversion, or abuse by the patient.
4. Document the assessment of the patient's prescription drug monitoring program data.
5. Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence.
6. Request and review prescription drug monitoring program data on the patient if the practitioner becomes aware a patient is receiving controlled substances from multiple prescribers.
7. Request and review the patient's prescription drug monitoring program data if the prescriber has a reasonable belief the patient may be seeking the controlled substance, in whole or in part, for any reason other than the treatment of an existing medical condition.

History: Effective January 1, 2020.
General Authority: NDCC 43-13-01(5); 43-13-13
Law Implemented: NDCC 19-03.5-09; 43-13-13(2)

TITLE 59.5

STATE PERSONNEL BOARD

APRIL 2020

CHAPTER 59.5-03-02

59.5-03-02-02. Classification appeal procedure.

1. A regular employee or an appointing authority may appeal a classification decision made by human resource management services if one of the following is alleged:

   a. Human resource management services did not give due consideration to information presented.

   b. Human resource management services did not follow chapter 4-07-03.

   c. The decision of human resource management services was made in a discriminatory manner as defined in North Dakota Century Code section 14-02.4-01.

   The appeal to the state personnel board must be received by human resource management services staff by the close of business fifteen working days from the date of the written decision of the division. The appeal must be in writing and state the reason for the appeal.

2. Upon receipt of a written appeal, the director, human resource management services, as secretary to the board, shall schedule the appeal for hearing before the board. The director, on behalf of the state personnel board, shall notify the employee and appointing authority in writing of the board hearing date at least ten working days prior to the board hearing date.

3. Human resource management services shall provide each member of the state personnel board, the employee, and the agency appointing authority with a copy of each document to become a part of the appeal file. The appeal file must consist of, but is not limited to, copies of the following:

   a. The original classification/reclassification request under appeal and all attachments and responses.

   b. The appeal form and all attachments.

   c. All written correspondence relating to the original classification request and appeal, including written requests for extension and notices of extensions granted or denied.

   d. The written appeal commencing the appeal before the state personnel board.

   e. Other directly relevant and significant documents submitted by the employee, appointing authority, or human resource management services.

4. Human resource management services shall disseminate the appeal file to all participating parties at least ten working days prior to the board hearing date. Documents submitted by any participant after the appeal file is disseminated may cause the board to delay the hearing, generally to the next scheduled board meeting date.

5. The employee, appointing authority, and their representatives may appear at the board meeting for the hearing of their classification appeal. The employee, appointing authority, or their representatives shall first make an oral presentation relative to the matter under appeal followed by human resource management services. The board chairperson shall ensure that all parties have ample opportunity to present their views relating to the classification appeal. New information presented at the hearing may delay the decision of the board.

6. If the board determines by a preponderance of the evidence that the appeal has merit based on reasons stated in subsection 1, the board shall:

   a. Remand the appeal to human resource management services for further review; or

   b. Uphold the decision of human resource management services~~; or~~

   ~~c. Change the classification of the subject position based on the record and information before it~~.

7. Human resource management services shall notify the employee and appointing authority in writing of the board's decision within five working days following the date the board makes its decision regarding the appeal. Decisions which result in a classification either higher or lower than that previously established by human resource management services are effective on the date specified by the appointing authority, though not earlier than the month of human resource management services approval. An earlier effective date may be applied with written approval from the director of human resource management services. The board's decision regarding a classification appeal is final.

8. The employee's agency shall reimburse the appealing employee for the required time, travel, meals, and lodging expenses to appear before the board. The reimbursement may not exceed the amounts allowed state employees.

History: Effective December 1, 1985; amended effective May 1, 1994; November 1, 1996; July 1, 2004; April 1, 2020.
General Authority: NDCC 54-44.3-07(1)
Law Implemented: NDCC 54-44.3-07(3)

CHAPTER 59.5-03-02.1

59.5-03-02.1-03. Pay grade appeal procedure.

1. A regular employee or an appointing authority may appeal to the state personnel board the pay grade assigned to a class by human resource management services if one of the following is alleged:

   a. Human resource management services did not give due consideration to information presented.

   b. Human resource management services did not follow chapter 4-07-03.

   c. The decision of human resource management services was made in a discriminatory manner as defined in North Dakota Century Code section 14-02.4-01.

   The appeal to the state personnel board must be received by human resource management services staff by the close of business fifteen working days from the date of the written decision of the division. The appeal must be in writing and state the reason for the appeal.

2. Upon receipt of a written appeal, the director, human resource management services, as secretary to the board, shall schedule the appeal for hearing before the board. The director, on behalf of the state personnel board, shall notify the employee and appointing authority in writing of the board hearing date at least ten working days prior to the board hearing date.

3. Human resource management services shall provide each member of the state personnel board, the employee, and the agency appointing authority a copy of each document to become a part of the appeal file. The appeal file must include copies of the following:

   a. The original pay grade review request under appeal and all attachments and responses.

   b. The written appeal and all attachments.

   c. All written correspondence relating to the original request and appeal, including written requests for extension and notices of extensions granted or denied.

   d. The written appeal commencing the appeal before the state personnel board.

   e. Other directly relevant and significant documents submitted by the employee, appointing authority, or human resource management services.

4. Human resource management services shall disseminate the appeal file to all participating parties at least ten working days prior to the board hearing date. Documents submitted by any participant after the appeal file is disseminated may cause the board to delay the hearing, generally to the next scheduled board meeting date.

5. The employee, appointing authority, and their representatives may appear at the board meeting for the hearing of the pay grade appeal. The employee, appointing authority, or their representatives shall first make an oral presentation relative to the matter under appeal, followed by human resource management services. The board chairperson shall ensure that all parties have ample opportunity to present their views relating to the pay grade appeal. New information presented at the hearing may delay the decision of the board.

6. If the board determines by a preponderance of the evidence that the appeal has merit based on reasons stated in subsection 1, the board shall:

   a. Remand the appeal to human resource management services for further review; or

b. Uphold the decision of human resource management services~~; or~~

~~c. Change the pay grade of the subject class based on the record and information before it~~.

7. Human resource management services shall notify the employee and appointing authority in writing of the board's decision within five working days following the date the board makes its decision regarding the appeal. A decision that results in a pay grade either higher or lower than that previously established by human resource management services is effective on the date specified by the appointing authority, though not earlier than the month of human resource management services approval. An earlier effective date may be applied with written approval from the director of human resource management services. The board's decision regarding a pay grade appeal is final.

8. The employee's agency shall reimburse the appealing employee for the required time, travel, meals, and lodging expenses to appear before the board. The reimbursement may not exceed the amounts allowed state employees.

History: Effective November 1, 1996; amended effective July 1, 2004; April 1, 2020.
General Authority: NDCC 54-44.3-07(1)
Law Implemented: NDCC 54-44.3-07(3), 54-44.3-12

TITLE 61

STATE BOARD OF PHARMACY

APRIL 2020

CHAPTER 61-02-07.1

61-02-07.1-07. Pharmacy technician registration requirements.

1. A pharmacy technician must register with the board of pharmacy on an annual basis.
2. The pharmacy technician will be assigned a registration number.
3. The board of pharmacy must provide the pharmacy technician with an annual registration card and pocket identification card.
4. The pharmacy technician certificate and annual registration card must be displayed and visible to the public in the pharmacy where the pharmacy technician is employed.
5. The pharmacy technician must wear a name badge while in the pharmacy which clearly identifies the person as a "pharmacy technician".
6. Pharmacy technicians shall identify themselves as pharmacy technicians on all telephone conversations while on duty in the pharmacy.
7. The northland association of pharmacy technicians shall appoint annually three of their members as an advisory committee to the board of pharmacy.
8. Every registered pharmacy technician, within fifteen days after changing address or place of employment, shall notify the board of the change. The board shall make the necessary changes in the board's records.
9. A pharmacy technician having passed the reciprocity examination of the national association of boards of pharmacy, or any other examination approved by the board, shall be granted reciprocity and shall be entitled to registration as a registered pharmacy technician in North Dakota.
10. A pharmacy technician registered by the board may use the designations "registered pharmacy technician" and "R. Ph. Tech.".
11. A pharmacy technician holding a certificate of registration as a pharmacy technician in North Dakota may go on inactive status, and continue to hold a certificate of registration in North Dakota, provided that the technician on inactive status may not practice within North Dakota. A pharmacy technician on inactive status will not be required to meet the continuing education requirements of the board under chapter 61-02-07.1. In order for a pharmacy technician to change an inactive status registration to an active status of registration, the pharmacy

technician must complete ten hours of approved pharmacy technician continuing education and thereafter comply with the continuing education requirements of the board.

12. In the case of loss or destruction of a certificate of registration, a duplicate can be obtained by forwarding the board an affidavit setting forth the facts.

13. Provisional registration for a military spouse as defined in North Dakota Century Code section 43-51-01.

    a. A provisional registration may be granted upon application for registration if the individual holds a registration or license as a pharmacy technician in another state and has worked under such license or registration for at least two of the last four years.

    b. This provisional registration must be without fee until one year after the first renewal period has passed. This allows a maximum of two years without payment of a registration or renewal fee.

    c. If the applicant does not meet all the criteria for registration under North Dakota laws or rules, the applicant must complete those qualifications before the applicant's provisional registration period expires to continue registration.

History: Effective October 1, 1993; amended effective July 1, 1996; April 1, 2020.
General Authority: NDCC 28-32-02, 43-15-10(12)(14)(19)
Law Implemented: NDCC 28-32-03, 43-51-11, 43-51-11.1

61-03-01-04. Licensure transfer.

1. An applicant seeking licensure by licensure transfer or reciprocity must secure and file an application blank from the national association of boards of pharmacy. This board will license applicants by reciprocity if they possess the requirements in effect in North Dakota at the time the candidates were licensed by examination in other states. The applicant must pass the North Dakota law examination and pay the appropriate fees to obtain licensure.

2. Provisional licensure for a military spouse as defined in North Dakota Century Code section 43-51-01.

   a. A provisional license may be granted upon application for license if the individual holds a license as a pharmacist in another state and has worked under such a license or registration for at least two of the last four years.

   b. This provisional license must be without fee until one year after the first renewal period has passed. This allows a maximum of two years without payment of a registration or renewal fee.

   c. The provisional licensee has three months to successfully pass the multistate pharmacy jurisprudence examination.

   d. The provisional licensee shall apply and complete all requirements of the electronic license transfer program of the national association of boards of pharmacy.

History: Amended effective April 1, 2016; April 1, 2020.
General Authority: NDCC 28-32-02, 43-15-22
Law Implemented: NDCC 43-15-22, 43-51-11, 43-51-11.1

ARTICLE 61-04
PROFESSIONAL PRACTICE

CHAPTER 61-04-08
LIMITED PRESCRIPTIVE PRACTICES

[Repealed effective April 1, 2020]

~~Section~~
~~61-04-08-01 Purpose~~
~~61-04-08-02 Definitions~~
~~61-04-08-03 Eligibility and Approval~~
~~61-04-08-04 Procedures~~
~~61-04-08-05 Initiation of Drug Therapy~~
~~61-04-08-06 Modification of Drug Therapy~~
~~61-04-08-07 Form~~

CHAPTER 61-04-11
ADMINISTRATION OF MEDICATIONS AND IMMUNIZATIONS

61-04-11-01. Definitions.

For purposes of this chapter:

1. "Authorized pharmacist" means a pharmacist who has successfully completed ~~a board-approved course of~~an appropriate study or training pertaining to the ~~injectable~~ administration of drugs and maintains continuing competency according to ~~rules adopted by the board~~the standard of care.

2. "~~Certificate of authority~~Authority" means ~~documentation provided by the board to an authorized pharmacist, which must be displayed in the pharmacy at which the pharmacist is practicing~~designation on an active pharmacist license that a pharmacist is providing administrations and has attested the pharmacist is knowledgeable about and meet the requirements in North Dakota Century Code section 43-15-31.5 and this chapter.

3. "Written protocol" means a standing medical order between a ~~physician or nurse~~duly licensed practitioner and an authorized pharmacist which contains information required by board rules.

History: Effective May 1, 2002; amended effective April 1, 2020.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

61-04-11-02. Qualifications established to obtain ~~certificate of~~ authority.

A pharmacist must ~~possess~~attest to possessing the following qualifications in order to obtain ~~a certificate of~~ authority from the board:

1. Obtain and maintain a license to practice pharmacy issued by the North Dakota state board of pharmacy;

2. Successfully complete ~~a board-approved twenty-hour course of study and examination pertaining to the administration of medications by injection, which includes the current guidelines and recommendations of the centers for disease control and prevention. The course of study must be administered by an approved provider and consist of study material and hands-on training in techniques for administering injections. The course must require testing and completion with a passing score. The provider of the course of study shall provide successful participants with a certificate of completion. A copy of said certificate must be mailed to the state board of pharmacy offices and placed in the pharmacist's permanent file. The course of study must include, at a minimum:~~

~~a. Basic immunology, including the human immune response;~~

~~b. The mechanism of immunity, adverse effects, dose, and administration schedule of available vaccines;~~

~~c. Vaccine-preventable diseases;~~

~~d. Current immunization guidelines and recommendations of the centers for disease control and prevention;~~

~~e. Vaccine storage and management;~~

~~f. Management of adverse events due to the administration of medications by injection, including identification, appropriate response, documentation, and reporting;~~

~~g. Patient education on the need for immunizations;~~

~~h. Informed consent;~~

~~i. Physiology and techniques for subcutaneous, intradermal, and intramuscular injection; and~~

~~j. Recordkeeping requirements established by law and rules or established standards of care~~the educational requirements set forth in North Dakota Century Code section 43-15-31.5 according to the administrations that a pharmacist intends to perform. The educational requirements may be obtained through the pharmacist's accreditation council for pharmacy education accredited doctor of pharmacy program in which the pharmacist is or will complete. Educational requirements also may be obtained through training received after graduation and should be sufficient to ensure any intended administrations can be provided competently to meet the standard of care;

3. Obtain and maintain current certification in cardiopulmonary resuscitation or basic cardiac life support;

4. Complete an ~~application~~attestation process adopted by the board and, upon any request, provide required documentation; and

5. Maintain continuing competency to retain the ~~certificate of~~ authority~~. A minimum of six hours of the thirty-hour requirement for continuing education, every two years, must be dedicated to this area of practice~~ according to the pharmacist's standard of care.

History: Effective May 1, 2002; amended effective April 1, 2020.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

61-04-11-03. Procedures to obtain certificate of authority.

Repealed effective April 1, 2020.

~~An authorized pharmacist shall provide the board with a copy of a certificate of completion from a board-approved course, a copy of current certification in cardiopulmonary resuscitation or basic cardiac life support, and other information required on a form supplied by the board. If requirements are met, the board shall issue a certificate of authority that shall be valid for two years. In order to renew the certificate, the pharmacist shall submit evidence of six hours of continuing education dedicated to this area of practice.~~

~~**History:** Effective May 1, 2002.~~
~~**General Authority:** NDCC 43-15-10~~
~~**Law Implemented:** NDCC 43-15-10, 43-15-31.5~~

61-04-11-04. Requirements of ~~physician or nurse~~ practitioner order for a pharmacist to administer injections.

The order must be written, received electronically or if received orally be reduced to writing, and must contain at a minimum the:

1. Identity of the ~~physician or nurse~~ practitioner issuing the order;
2. Identity of the patient to receive the injection;
3. Identity of the medication or vaccine, and dose, to be administered; and
4. Date of the original order and the dates or schedule, if any, of each subsequent administration.

History: Effective May 1, 2002; amended effective January 1, 2005; April 1, 2020.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

61-04-11-05. Requirements of written protocol.

A ~~physician or nurse~~ practitioner may prepare a written protocol governing the administration of medications ~~by injection~~ with an authorized pharmacist for a specific period of time or purpose. The written protocol may be valid for a time period not to exceed two years, subject to earlier withdrawal by the ~~physician or nurse~~ practitioner. The protocol must contain the:

1. Identity of the participating ~~physician or nurse~~ practitioner and the pharmacist;
2. Identity of the ~~immunization or vaccination~~drug which may be administered;
3. Identity of the patient or groups of patients to receive the authorized ~~immunization or vaccination~~drug;
4. Identity of the authorized routes and sites of administration allowed;
5. Identity of the course of action the pharmacist shall follow in the case of reactions following administration;
6. ~~Identity of the location at which the pharmacist may administer the authorized immunization or vaccination; and~~
7. ~~7.~~ Recordkeeping requirements and procedures for notification of administration.

History: Effective May 1, 2002; amended effective April 1, 2020.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

61-04-11-06. Requirements of records and notifications.

A pharmacist administering ~~by injection~~ shall meet the following recordkeeping and notification requirements:

1. Notification of administration must be made to the ordering physician or nurse practitioner and other authorities as required by law and rule. Notification may be through inclusion of the record in the patient's medical record or by submission to the immunization information system.
    a. When administration has occurred pursuant to an order, the pharmacist shall notify the ordering physician or nurse practitioner within forty-eight hours of the identity of the patient, identity of the medication or vaccine administered, route of administration site of

the administration, dose administered, and date of administration and the disposition of any adverse events or reactions experienced by the patient.

b. When administration has occurred pursuant to a written protocol, the pharmacist shall notify the participating physician or nurse practitioner within fourteen days of the identity of the patient, identity of the medication or vaccine administered, site of the administration, dose administered, and date of administration and the disposition of any adverse events or reactions experienced by the patient.

c. In the case of immunizations and vaccinations, the pharmacist shall also provide notification to the physician or nurse practitioner of the manufacturer and lot number of the product administered.

2. Every record, including notification, which is required to be made under this section, must be kept by the administering pharmacist and by the pharmacy when in legal possession of the drugs administered for at least two years from the date of administration. Records of administration must contain all information required in subsection 1, plus the name of the ordering physician or nurse practitioner. Records of administration by order must be by patient name and, in the case of administration by written protocol, records may be maintained in roster form.

History: Effective May 1, 2002; amended effective April 1, 2020.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

61-04-11-07. Location of administration by injection.

Pharmacists may administer medications ~~by injection within a licensed North Dakota pharmacy or~~ at ~~a~~any location within North Dakota or may be limited to those specifically identified in a written protocol. The location ~~in the pharmacy~~ must:

1. Ensure privacy;

2. Be maintained to promote an aseptic environment;

3. Have adequate telecommunications devices to summon aid and communicate emergency situations; and

4. Have adequate equipment and supplies to respond to adverse events and emergency situations.

History: Effective May 1, 2002; amended effective April 1, 2020.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

61-04-11-08. Policy and procedural manual.

The pharmacy shall maintain a policy and procedural manual, with a section related to the administration of medications ~~by injection~~, in compliance with section 61-02-01-18.

History: Effective May 1, 2002; amended effective October 1, 2014; April 1, 2020.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

TITLE 61.5

NORTH DAKOTA BOARD OF PHYSICAL THERAPY

APRIL 2020

CHAPTER 61.5-01-02

61.5-01-02-01. Definitions.

Unless specifically stated otherwise, the following definitions are applicable throughout this title:

1. "A school of physical therapy or a program of physical therapist assistant training" is a nationally accredited program approved by the board.

2. "Board" means the North Dakota board of physical therapy.

3. "Consultation by ~~means of telecommunications~~telehealth" means that a physical therapist renders professional or expert opinion or advice to another physical therapist or professional health care provider via ~~telecommunications~~electronic communications or computer technology from a distant location. ~~It includes the transfer of data or exchange of educational or related information by means of audio, video, or data communications. The physical therapist may use telehealth technology as a vehicle for providing only services that are legally or professionally authorized.~~ The patient's written or verbal consent will be obtained and documented prior to such consultation. All records used or resulting from a consultation by means of ~~telecommunications~~telehealth are part of a patient's record and are subject to applicable confidentiality requirements.

4. "Continuing competence" ~~means~~is the lifelong process of maintaining and documenting competence through ongoing self-assessment, development and implementation of a personal learning plan, and subsequent reassessment.

5. "Direct supervision" means the supervising physical therapist is physically present on the premises and immediately available for direction and supervision~~. The physical therapist will have~~, has direct contact with the patient during each visit~~. Telecommunications~~, and completes all components of care requiring skilled therapy services. Telehealth does not meet the requirement for direct supervision.

6. "Examination" means a national examination approved by the board for the licensure of a physical therapist or a physical therapist assistant.

7. "General supervision" means the supervising physical therapist is onsite and present where services are provided or is immediately available to the physical therapist assistant being supervised by means of electronic communications, maintains continual involvement in the appropriate aspects of patient care, and has primary responsibility for all patient care services rendered by a physical therapist assistant.

8. "Manual therapy" means the use of techniques such as mobilization or manipulation, manual lymphatic drainage, and manual traction on one or more regions of the body.

~~8.~~9. "Onsite supervision" means the supervising physical therapist is onsite and present in the department or facility where services are provided, is immediately available to the ~~person~~individual being supervised, and maintains continued involvement in appropriate aspects of each treatment session in which ~~supportive personnel~~a student physical therapist or a student physical therapist assistant are involved in components of care.

~~9.~~10. "Physical therapist" means ~~a person~~an individual licensed under North Dakota Century Code chapter 43-26.1 or holding a North Dakota compact privilege in accordance with North Dakota Century Code chapter 43-26.2 to practice physical therapy. The term "physiotherapist" is synonymous with "physical therapist" for purposes of these rules.

~~10.~~11. "Physical therapist assistant" means ~~a person~~an individual licensed under North Dakota Century Code chapter 43-26.1 or holding a North Dakota compact privilege in accordance with North Dakota Century Code chapter 43-26.2 who assists a physical therapist in selected components of physical therapy intervention. ~~The physical therapist assistant must be a graduate of a physical therapist assistant program approved by the board.~~

~~11.~~12. "Physical therapy" means the care and services by or under the direction of a physical therapist.

~~12.~~13. "Physical therapy aide" means ~~a person~~an individual trained under the direction of a physical therapist who performs designated and supervised routine tasks related to physical therapy.

~~13.~~14. "Practice of physical therapy" means:

a. Examining, evaluating, and testing individuals with mechanical, physiological, and developmental impairments, functional limitations in movement and mobility, and disabilities or other health-related and movement-related conditions ~~in order~~ to determine a diagnosis for physical therapy, prognosis, and plan of therapeutic intervention, and to assess the ongoing effects of intervention.

b. Alleviating impairments, functional limitations in movement and mobility, and disabilities by designing, implementing, and modifying therapeutic interventions that may include therapeutic exercise; neuromuscular education; functional training related to positioning, movement, and mobility in self-care and in-home, community, or work integration or reintegration; manual therapy; therapeutic massage; prescription, application and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic, protective, and supportive devices and equipment related to positioning, movement, and mobility; airway clearance techniques; integumentary protection and repair techniques; debridement and wound care; physiotherapy; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient-related instruction.

c. Engaging as a physical therapist in reducing the risk of injury, impairment, functional limitation, and disability, including the promotion and maintenance of fitness, health, and wellness in populations of all ages.

d. Engaging as a physical therapist in administration, consultation, education, and research.

~~14.~~15. "Restricted license" for a physical therapist or physical therapist assistant means a license on which the board places restrictions or conditions, or both, as to scope of practice, place of practice, supervision of practice, duration of licensed status, or type or condition of patient or client to whom the licensee may provide services.

~~15.~~16. "Student" is an individual who is currently engaged in the fulfillment of a physical therapy or physical therapist assistant educational program approved by the board.

~~16.~~17. "Supportive personnel" are ~~persons other than licensed physical therapists who function~~physical therapist assistants and physical therapy aides working in a physical therapy setting ~~and assist with physical therapy care~~.

~~17.~~18. "Telehealth" is the use of electronic communications to provide and deliver ~~a host of~~ health-related information and health care services, including~~, but not limited to~~ physical ~~therapy related~~therapy-related information and services, over ~~large and small~~any distance. Telehealth encompasses ~~a variety of~~ health care and health promotion activities, including~~, but not limited to,~~ education, advice, reminders, interventions, and the monitoring of interventions.

~~18.~~19. "Testing" means standard methods and techniques used to gather data about the patient.

History: Effective December 1, 1980; amended effective April 1, 1992; December 1, 1994; July 1, 2004; April 1, 2006; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-01, 43-26.1-04

61.5-02-01-03. Repeating examinations.

An applicant who fails an examination may repeat the examination, but must pay another examination fee to the federation of state boards of physical therapy each time the examination is repeated. ~~After the second failed attempt, an applicant must complete a remediation plan approved by the board. An applicant is limited to three examination attempts within any twelve month period.~~

History: Effective December 1, 1980; amended effective April 1, 1992; July 1, 2004; April 1, 2006; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-03, 43-26.1-05

61.5-02-01-04. Eligibility to take examination.

An applicant must have graduated from an approved program or demonstrate good standing in the final semester of an approved program prior to writing the examination. The earliest date the examination for licensure may be taken by the applicant is the examination nearest to and before the applicant's expected graduation date. An applicant who does not pass the examination on the first attempt may retake up to six times. There is a limit of two attempts for scores below four hundred.

History: Effective April 1, 1992; amended effective July 1, 2004; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-03, 43-26.1-05

CHAPTER 61.5-02-02

61.5-02-02-01. General licensure requirements for graduates of approved curricula.

The following requirements apply to all applicants for licensure who are graduates of physical therapy or physical therapist assistant curricula approved by the board:

1. United States-educated applicants:
   a. A completed application form.
   b. Payment of the fees set by the board.
   c. An official transcript or electronic confirmation giving evidence of graduation from a curricula approved by the board.
   d. Passing scores on the national examination approved by the board.
   e. Completion of the juris prudence examination.
   f. Completion of other educational requirements as set by the board.
   g. At the board's discretion, an interview with the board or its designees.
   h. Completion of a criminal history background check.
2. Foreign-educated applicants:
   a. A completed application form.
   b. Payment of the appropriate fees set by the board.
   c. Verification of documents by an agency recognized by the board.
   d. Satisfactory evidence that the applicant's education is substantially equivalent to the requirements of physical therapists or physical therapist assistants educated in ~~a~~ physical ~~therapy~~therapist or physical therapist assistant education ~~program~~programs approved by the board. Substantially equivalent means an applicant for licensure educated outside of the United States shall have:
      (1) Graduated from a physical therapist or physical therapist assistant education program that prepares the applicant to engage without restrictions in the practice of physical therapy.
      (2) Proof that the applicant's school of physical ~~therapy~~therapist or physical therapist assistant education is recognized by its own ministry of education.
      (3) Pass the board-approved English proficiency examination if the applicant's native language is not English.
      (4) For initial licensure, satisfactory completion of the federation of state boards of physical therapy coursework ~~tool~~tools in effect in ~~2015, and for~~2017.
      (5) For licensure by endorsement, satisfactory completion of the federation of state boards of physical therapy ~~2015~~2017 coursework ~~tool~~tools, or a prior version in effect at the time of graduation from the physical ~~therapy~~therapist or physical therapist assistant education program.
   e. Passing scores on the national examination approved by the board.

f. Completion of juris prudence examination.

g. At the board's discretion, an interview with the board or its designees.

h. At the board's discretion, successful completion of a supervised clinical practice, including one thousand hours of a preceptorship under the onsite supervision of a physical therapist licensed and actively practicing in North Dakota.

i. Completion of a criminal history background check.

History: Effective December 1, 1980; amended effective July 1, 2004; April 1, 2006; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-03, 43-26.1-04

61.5-02-02-02. Types of licensure.

1. For licensure by examination, all general licensure requirements must be met.

2. For licensure by endorsement from another United States jurisdiction:

   a. All general licensure requirements must be met.

   b. Verification of licensure ~~in good standing~~ from all jurisdictions in which the applicant ~~has been~~is currently licensed.

   c. Copy of scores on the examination transmitted by a score transfer service approved by the board.

   d. At the board's discretion, an interview with the board or its designees.

   e. If the applicant has not practiced physical therapy for three or more years, the applicant shall demonstrate to the board's satisfaction competence to practice physical therapy by one or more of the following as determined by the board:

      (1) Practice for a specified time under a restricted license.

      (2) Complete prescribed remedial courses.

      (3) Complete continuing ~~education~~competence or similar requirements for the period of the expired license.

      (4) Pass an examination approved by the board.

   ~~f. If the applicant is foreign trained, satisfactory completion of the 2015 federation of state boards of physical therapy coursework tool, or a prior version in effect at the time of graduation from the physical therapy education program.~~

3. For compact privileges, all general requirements set forth in the physical therapy licensure compact in North Dakota Century Code chapter 43-26.2.

History: Effective December 1, 1980; amended effective April 1, 1992; December 1, 1994; July 1, 2004; April 1, 2006; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-04, 43-26.1-05

61.5-02-02-05. Renewal of licensure.

1. Licenses not renewed annually by January thirty-first will expire.

2. If a licensee fails to receive the renewal notice, it is the licensee's responsibility to contact the board before the January thirty-first deadline.

3. A licensee who fails to renew the license on or before the expiration date shall not practice as a physical therapist or physical therapist assistant in this state, and may be subject to a late renewal fee.

4. Complete other ~~educational~~competence requirements as prescribed by the board.

5. Each licensee is responsible for reporting to the board ~~a name change and changes in business, email, and home addresses~~changes in contact information within thirty days of the change.

~~6. All licensed physical therapists may be required to file with the board a notarized statement indicating they have read these administrative rules.~~

History: Effective December 1, 1980; amended effective April 1, 1992; December 1, 1994; July 1, 2004; April 1, 2006; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-08, 43-26.1-09

61.5-02-02-05.1. Reinstatement of licenses.

1. The board may reinstate an expired license upon payment of a renewal fee and reinstatement fee.

2. If a license has expired for more than one year, the licensee is not eligible for renewal, but must submit application for licensure.

3. Licensees whose licenses have lapsed and who have been unlicensed for more than one year but less than three years from the last renewal must reapply for licensure and provide evidence that the cumulative continuing education requirements have been met for the unlicensed period.

4. Licensees whose licenses have lapsed for more than three consecutive years must reapply for licensure and shall demonstrate to the board's satisfaction competence to practice physical therapy, by one or more of the following as determined by the board:

   a. Practice for a specified time under a restricted license.

   b. Complete prescribed remedial courses.

   c. Complete continuing ~~education~~competency or similar requirements for the period of the expired license.

   d. Pass an examination approved by the board.

History: Effective April 1, 2006; amended effective January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-09

61.5-02-02-06. Exceptions to licensure.

~~1.~~ The following persons are exempt from North Dakota physical therapy licensure requirements when engaged in the following activities:

~~a.~~1. A person in a professional education program approved by the board who is pursuing a course of study leading to a degree as a physical therapist or a physical therapist assistant

and who is satisfying supervised clinical education requirements related to the person's physical therapy education while under onsite supervision of a licensed physical therapist.

~~b.~~2. A physical therapist or a physical therapist assistant who is practicing in the United States armed services, United States public health service, or veterans administration pursuant to federal regulation for state licensure of health care providers.

~~c.~~3. A physical therapist or a physical therapist assistant who is licensed in another United States jurisdiction or a foreign-educated physical therapist credentialed in another country if that person is performing physical therapy in connection with teaching or participating in an educational seminar of no more than sixty days in a calendar year.

~~d. A physical therapist who is licensed in another United States jurisdiction if that person is providing consultation by means of telecommunication to a physical therapist licensed in North Dakota.~~

~~2. If aides provide physical therapy services other than under direct supervision of a licensed physical therapist, or if students provide physical therapy services other than under onsite supervision of a licensed physical therapist, they are in violation of North Dakota Century Code chapter 43-26.1.~~

4. A military spouse, as defined in North Dakota Century Code section 43-51-01 is immediately eligible to work as a physical therapist or physical therapist assistant if the military spouse has an active unencumbered license to practice in another jurisdiction. This practice privilege is good for ninety days as long as progress is being made with the spouse's application process in North Dakota. If the spouse is unable to complete the application process within ninety days, the board may grant an extension on a case-by-case basis as provided under North Dakota Century Code section 43-51-11.1. The board shall provide for identification as a military spouse on any license application or renewal form.

History: Effective December 1, 1980; amended effective July 1, 2004; April 1, 2006; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-51
Law Implemented: NDCC 43-26.1-07, 43-51-01, 43-51-11.1, 43-51-11.2

61.5-02-02-07. Grounds for disciplinary actions.

The board may refuse to license any physical therapist or physical therapist assistant, may discipline, or may suspend or revoke the license of any physical therapist or physical therapist assistant for any of the following grounds:

1. Violating any provision of this chapter, board rules, or a written order of the board.
2. Practicing or offering to practice beyond the scope of the practice of physical therapy.
3. Failing to refer a patient or client to an appropriate practitioner if the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise.
4. Obtaining or attempting to obtain a license by fraud or misrepresentation.
5. Engaging in the performance of substandard physical therapy care due to a deliberate or negligent act or failure to act, regardless of whether actual injury to the patient is established.
6. Engaging in the performance of substandard care by a physical therapist assistant, including exceeding the authority to perform components of intervention selected by the supervising physical therapist regardless of whether actual injury to the patient is established.

7. Failing to supervise physical therapist assistants or physical therapy aides in accordance with this chapter and board rules.

8. A determination by the board that a licensee's conviction of an offense has a direct bearing on the licensee's ability to serve the public as a physical therapist or physical therapist assistant or that, following conviction of any offense, the holder is not sufficiently rehabilitated as provided under North Dakota Century Code section 12.1-33-02.1.

9. Practicing as a physical therapist or working as a physical therapist assistant when physical or mental abilities are impaired by the use of controlled substances or other habit-forming drugs, chemicals, alcohol, or by other causes.

10. Having had a license revoked or suspended, other disciplinary action taken, or an application for licensure refused, revoked, or suspended by the proper authorities of another state, territory, or country.

11. Engaging in sexual misconduct. For the purpose of this subsection, sexual misconduct includes:

    a. Engaging in or soliciting sexual relationships, whether consensual or nonconsensual, while a physical therapist or physical therapist assistant-patient relationship exists~~, except with a spouse~~.

    b. Making sexual advances, requesting sexual favors, or engaging in other verbal conduct or physical contact of a sexual nature with patients or clients.

    c. Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.

12. Failing to adhere to the standards of ethics ~~of the physical therapy profession~~adopted in 2010 by the American physical therapy association and adopted by rule by the board.

13. Charging unreasonable or fraudulent fees for services performed or not performed.

14. Making misleading, deceptive, untrue, or fraudulent representations in violation of this chapter or in the practice of the profession.

15. Having been adjudged mentally incompetent by a court.

16. Aiding and abetting a person who is not licensed in this state in the performance of activities requiring a license.

17. Failing to report to the board, when there is direct knowledge, any unprofessional, incompetent, or illegal acts that appear to be in violation of this chapter or any rules established by the board.

18. Interfering with an investigation or disciplinary proceeding by failure to cooperate, by willful misrepresentation of facts, or by the use of threats or harassment against any patient or witness to prevent that patient or witness from providing evidence in a disciplinary proceeding or any legal action.

19. Failing to maintain adequate patient records. For the purposes of this subsection, "adequate patient records" means legible records that contain at a minimum sufficient information to identify the patient, an evaluation of objective findings, a diagnosis, a plan of care, a treatment record, and a discharge plan.

20. Failing to maintain patient confidentiality without the written authorization of the patient or unless otherwise permitted by law. All records used or resulting from a consultation under North Dakota Century Code section 43-51-03 are part of a patient's records and are subject to applicable confidentiality requirements.

21. Promoting any unnecessary device, treatment intervention, or service resulting in the financial gain of the practitioner or of a third party.

22. Providing treatment intervention unwarranted by the condition of the patient or continuing treatment beyond the point of reasonable benefit.

23. Participating in underutilization or overutilization of physical therapy services for personal or institutional financial gain.

24. Attempting to engage in conduct that subverts or undermines the integrity of the examination or the examination process, including a violation of security and copyright provisions related to the national licensure examination, utilizing recalled or memorized examination questions from or with any individual, communicating or attempting to communicate with other examinees during the examination, or copying or sharing examination questions or portions of questions.

History: Effective December 1, 1980; amended effective July 1, 2004; April 1, 2006; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-13

CHAPTER 61.5-02-03

61.5-02-03-01. Fees.

1. Application fee - not refundable - $200.00.
2. Annual renewal fee - $100.00 for physical therapists and $60.00 for physical therapist assistants.
3. Late renewal fee - $50.00.
4. Compact fee - $40.00.

History: Effective December 1, 1980; amended effective July 1, 2004; April 1, 2006; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-10

CHAPTER 61.5-03-02
CONTINUING COMPETENCE ACTIVITIES AND UNIT STANDARDS

Section
61.5-03-02-01 ~~Activity Content~~Unit Standards
61.5-03-02-02 ~~Unit Standards~~Activity Content

61.5-03-02-01. ~~Activity content~~Unit standards.

~~Twenty-five units are required every two years. At least fifteen of the required units shall be clinically related and certified activities. Nonclinical and approved activities shall relate to a therapist's job responsibilities. Certified activities have completed a certification process to determine if the activity meets a minimal threshold of required criteria. Certified activities include all continuing competence activities related to physical therapy sponsored by the American physical therapy association, state physical therapy associations, medical institutions, educational institutions, or certified by the federation of state boards of physical therapy and are automatically certified activities. Any continuing competence activities planned, sponsored, or cosponsored by national or state health organizations, which meet the credit standards of section 61.5-03-02-02, are automatically approved as certified activities. Any postsecondary coursework taken at an accredited educational institution will be automatically approved as certified activities, provided the coursework meets the credit standards. Approved activities do not go through a formal certification process because these activities would be difficult to certify. Approved activities are assigned a set value as a group versus each individual activity being assigned a value.~~One unit equals one hour of participation in competence activities. The following unit standards apply to any continuing competence activity that is intended to meet the continuing competence requirements for physical therapists or physical therapist assistants:

1. The educational activities must have significant intellectual or practical content dealing primarily with matters directly related to the practice of physical therapy or to the professional responsibility or ethical obligations of the participants.

2. Each person making a presentation at a continuing competence activity must be qualified by practical or academic experience to teach the subject the person covers.

3. Credit may not be given for entertainment or recreational activities or programs, employment orientation sessions, holding an office or serving as an organizational delegate, meeting for the purpose of making policy, or noneducational association meetings.

4. Credit may not be given for meals, keynote speeches, introductory or preliminary sessions, postsession activities, and similar events associated with continuing competence programs.

History: Effective April 1, 1992; amended effective January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-03(7)

61.5-03-02-02. ~~Unit standards~~Activity content.

~~The following unit standards apply to any continuing competence activity that is intended to meet the continuing competence requirements for physical therapists or physical therapist assistants:~~

~~1. The educational activities shall have significant intellectual or practical content dealing primarily with matters directly related to the practice of physical therapy or to the professional responsibility or ethical obligations of the participants.~~

~~2. Each person making a presentation at a continuing competence activity shall be qualified by practical or academic experience to teach the subject the person covers.~~

~~3. Participants shall attend educational activities in a classroom or other setting suitable for the activity. Video, motion picture, or sound presentations may be used.~~

~~4. Credit may not be given for entertainment or recreational activities or programs, employment orientation sessions, holding an office or serving as an organizational delegate, meeting for the purpose of making policy, or noneducational association meetings.~~

~~5. Credit may not be given for meals, keynote speeches, introductory or preliminary sessions, postsession activities, and similar events associated with continuing competence programs.~~

~~6. A person teaching an approved continuing competence activity shall be awarded additional credit for preparation time not to exceed a ratio of five to one between preparation time and presentation time respectively. This credit may be taken for only one course annually.~~Twenty-five units are required every two years. The units may include:

1. Activities related to physical therapy approved by the American physical therapy association, state physical therapy associations, and state physical therapy boards.

2. Completion of an American physical therapy association specialty certification or recertification will equal fifteen units.

3. Completion of a physical therapy residency program equals twenty-five units.

4. One unit for every one hundred sixty-five hours of clinical instruction with a maximum of five units per reporting period.

5. A person teaching an approved continuing competence activity must be awarded additional credit for preparation time not to exceed a ratio of five to one between preparation time and presentation time respectively. This credit may be taken for only one course annually.

6. Teaching at an accredited physical therapy or physical therapist assistant program as long as teaching is not the licensee's primary occupation. One unit is allowed per direct contact hour in teaching a maximum of five units per recording period.

History: Effective April 1, 1992; amended effective July 1, 2004; January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-03(7)

CHAPTER 61.5-03-04

61.5-03-04-01. Evidence of competence.

1. Qualification for manual therapy as defined in subsection 3 of North Dakota Century Code section 43-26.1-01 and subsection 6 of North Dakota Administrative Code section 61.5-01-02-01, other than ~~high velocity, low amplitude~~high-velocity, low-amplitude thrust manual therapy, include:

   a. Graduate of a United States accredited, entry-level physical therapist or physical therapist assistant program.

   b. Foreign-educated licensees would have to show evidence of entry-level training in manual therapy techniques as part of their curriculum.

   c. Physical therapist assistants may perform soft tissue mobilization and peripheral joint mobilization when the physical therapist has determined that the physical therapist assistant has the necessary degree of education, training, and skill for safe patient care.

2. Qualification for ~~high velocity, low amplitude~~high-velocity, low-amplitude thrust manual therapy must include one or more of the following:

   a. Graduate from entry-level, commission on accreditation of physical therapy education accredited doctor of physical therapy programs within the state of North Dakota.

   b. Graduates from other physical therapy programs would have to submit evidence showing that ~~high velocity, low amplitude~~high-velocity, low-amplitude thrust techniques were included in their entry-level educational program.

   c. Hold the orthopedic clinical specialist (OCS) or sports clinical specialist (SCS) certification ~~from the American physical therapy association~~ with documentation that ~~high velocity, low amplitude~~high-velocity, low-amplitude thrust techniques were included in the study program.

   d. Complete a formal, credentialed manual therapy fellowship or other certification.

   e. Successful completion of post entry-level education in ~~high velocity, low amplitude~~high-velocity, low-amplitude thrust techniques.

3. In addition to the above criteria, licensees are also bound by the regulations listed in North Dakota Century Code section 43-26.1-13 regarding practicing beyond their scope of practice or performing substandard physical therapy care as being grounds for disciplinary actions and North Dakota Century Code section 43-26.1-11 concerning patient care management. Physical therapists are mandated by North Dakota Administrative Code section 61.5-03-01-02 to obtain twenty-five units of continuing competence every two years.

History: Effective April 1, 2006; amended effective January 1, 2016; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-03(7), 43-26.1-14(1)

CHAPTER 61.5-04-01

61.5-04-01-01. Violations.

Complaints and problems about alleged violations of North Dakota Century Code chapter 43-26.1 shall be forwarded to the board for its consideration. The board shall review and, if necessary, investigate all complaints and allegations that come before it. The board may seek the advice and assistance of legal counsel in this review and investigation process. The board may direct its executive officer, or other personnel, to act either directly, on its behalf, or to assist others, in filing complaints of North Dakota Century Code chapter 43-26.1 violations with state's attorneys, and to provide assistance and information as required by state's attorneys. The board may seek the advice of legal counsel concerning the use of injunctions as a means of preventing or stopping violations, and may direct legal counsel, on its behalf, to use such remedies. The board shall keep all information relating to the receipt and investigation of the complaint confidential until the information is disclosed in the course of the investigation or any subsequent proceeding, or until disclosure is required by law. However, patient records, including clinical records, files, any other report or oral statement relating to diagnostic findings of a patient or treatment of a patient, any information from which a patient or the patient's family might be identified, or information received and records or reports kept by the board as a result of an investigation made pursuant to North Dakota Century Code chapter 43-26.1, are confidential.

History: Effective December 1, 1980; amended effective July 1, 2004; April 1, 2006; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC 43-26.1-03(16), 43-26.1-16, 43-26.1-17

CHAPTER 61.5-05-01

61.5-05-01-01. Delegation of responsibility.

When a physical therapist delegates patient care responsibilities to physical therapist assistants ~~or other supportive personnel~~, the physical therapist holds responsibility for supervision of the physical therapy program. Physical therapists shall not delegate to a less qualified person any activity that requires the unique skills, knowledge, and judgment of the physical therapist. The primary responsibility for physical therapy care ~~rendered by supportive personnel~~ rests with the supervising physical therapist.

1. Adequate supervision requires, at a minimum, that the supervising physical therapist perform the following activities:

   ~~1.~~ a. Designate or establish channels of written and oral communication.

   ~~2.~~ b. Interpret available information concerning the individual under care.

   ~~3.~~ c. Provide initial evaluation.

   ~~4.~~ d. Develop plan of care, including short-term and long-term goals.

   ~~5.~~ e. Select and delegate appropriate tasks for plan of care.

2. When the supervising physical therapist is not available the supervising physical therapist shall transfer responsibility of all patient care to another qualified physical therapist who assumes responsibility for all patient care, including those being rendered by the physical therapist assistant under general supervision.

3. The supervising physical therapist maintains primary responsibility for all patient care services, including those rendered by a physical therapist assistant under general supervision.

~~6.~~4. Assess competence of supportive personnel to perform assigned tasks.

~~7.~~5. Direct and supervise supportive personnel in delegated tasks.

~~8.~~6. Identify and document precautions, goals, anticipated progress, and plans for reevaluation.

~~9.~~7. Reevaluate, adjust plan of care when necessary, perform final evaluation, and establish followup plan of care.

History: Effective December 1, 1994; amended effective April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC ~~43-26.1-01(7)~~43-26.1-01, 43-26.1-11, 43-26.1-13(7)

61.5-05-01-02. Physical therapist assistants.

The physical therapist assistant shall perform ~~specific physical therapy duties~~selected components of patient care under the supervision of a physical therapist who is properly credentialed in the jurisdiction in which the physical therapist assistant practices.

1. ~~Performance of service in general.~~

   ~~a.~~ The physical therapist assistant may initiate or alter a treatment program only with prior evaluation by, and approval of, the supervising physical therapist.

   ~~b.~~2. The physical therapist assistant, with prior approval by the supervising physical therapist, may adjust the specific treatment procedure in accordance with changes in the patient's status.

~~c.~~3. The physical therapist assistant may interpret data only within the scope of the physical therapist assistant's education.

~~d.~~4. The physical therapist assistant may respond to inquiries regarding a patient's status to appropriate parties within the protocol established by the supervising physical therapist.

~~e.~~5. The physical therapist assistant shall refer inquiries regarding patient prognosis to a supervising physical therapist.

~~f.~~6. Documentation other than the initial note and the discharge summary can be written by a physical therapist assistant.

~~2. Service in home health, long-term care, and school settings.~~

~~a.~~7. ~~A qualified~~The supervising physical therapist must be accessible by communication to the physical therapist assistant at all times while the physical therapist assistant is treating the patient.

~~b.~~8. An initial visit must be made by ~~a qualified~~the supervising physical therapist for evaluation of the patient and establishment of a plan of care.

~~c.~~9. A joint visit by the supervising physical therapist and physical therapist assistant or a conference between the supervising physical therapist and physical therapist assistant must be made prior to or on the first physical therapist assistant visit to the patient. ~~The physical therapist must complete the initial evaluation.~~ This visit must include:

a. A functional assessment;

b. Review of activities with appropriate revisions or termination of plan of care; and

c. Assessment of utilization of outside resources.

~~d.~~10. At least once ~~every~~after a sixth physical therapist assistant visit or at least once every thirty calendar days, whichever occurs first, ~~the~~a physical therapist must visit the patient. Following each ~~onsite~~ visit by a supervising physical therapist, the medical/education record must reflect a documented conference with the physical therapist assistant outlining treatment goals and program ~~modification. The physical therapist must make the final visit to terminate the plan of care~~modifications. The supervising physical therapist shall complete the documentation for this conference. If the physical therapist performing the sixth visit is not the patient's initial evaluator, the medical record must reflect a transfer of supervisory authority from the initial evaluator to that physical therapist.

~~e. A supervisory onsite visit must include:~~

~~(1) An onsite functional assessment.~~

~~(2) Review of activities with appropriate revisions or termination of plan of care.~~

~~(3) Assessment of utilization of outside resources.~~

~~3. Service in hospitals or other clinical settings require constant onsite supervision.~~

~~a. All duties must conform with section 61.5-05-01-01.~~

~~b. A joint treatment with the physical therapist and physical therapist assistant or after a direct treatment by the physical therapist with a conference between the physical therapist and physical therapist assistant must occur at least once per week.~~

History: Effective December 1, 1994; amended effective July 1, 2004; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC ~~43-26.1-01(6)~~43-26.1-01, 43-26.1-11, 43-26.1-13(7)

61.5-05-01-04. Physical therapy aides.

The physical therapy aide may assist the physical therapist in the following activities:

1. Carry out established procedures for the care of equipment and supplies.
2. Prepare, maintain, and clean up treatment areas and maintain a supportive area.
3. Transport patients, records, equipment, and supplies in accordance with established policies and procedures.
4. Assemble and disassemble equipment and accessories.
5. Under the direct supervision of a physical therapist, assist in preparation for and perform routine tasks as assigned. Routine tasks do not include components of patient care which require the unique skills, knowledge, and abilities of a physical therapist.

History: Effective December 1, 1994; amended effective July 1, 2004; April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC ~~43-26.1-01(8)~~43-26.1-01(13), 43-26.1-11, 43-26.1-13(7)

CHAPTER 61.5-06-01

61.5-06-01-01. Terms and titles.

A physical therapist shall use the letters "PT" in connection with the physical therapist's name or place of business to denote licensure under North Dakota Century Code chapter 43-26.1. Other letter designations such as "RPT", "LPT", or academic and professional degrees should not be substituted for the regulatory designation of "PT".

1. "PTA" is the preferred regulatory designation of a physical therapist assistant. A physical therapist assistant shall use the letters "PTA" in connection with that person's name to denote licensure under this chapter. A person shall not use the title "physical therapist assistant", the letters "PTA", or any other words, abbreviations, or insignia in connection with that person's name to indicate or imply, directly or indirectly, that the person is a physical therapist assistant unless that person is licensed under this chapter.

2. Except as otherwise provided by law, a person or business entity, and its employees, agents, or representatives, shall not use in connection with that person's or entity's name or activity the words "physical therapy", "physical therapist", "physiotherapist", "registered physical therapist", the letters "PT", "MPT", "DPT", "LPT", "RPT", or any other words, abbreviation, or insignia indicating or implying directly or indirectly that physical therapy is provided or supplied, unless such services are provided by or under the direction of a physical therapist licensed pursuant to this chapter. A person or business entity shall not advertise or otherwise promote another person as being a "physical therapist" or "physiotherapist" unless the individual so advertised or promoted is licensed as a physical therapist under this chapter. A person or business entity that offers, provides, or bills any other person for services shall not characterize those services as "physical therapy" unless the individual performing that service is licensed as a physical therapist under this chapter.

3. The designations "SPT" and "SPTA" should be used for physical therapist students and physical therapist assistant students, respectively, up to the time of graduation.

4. In order to promote consistent communication of the presentation of credentials and letter designations, the preferred order of credentials should be:

   a. PT/PTA.

   b. Highest earned physical therapy-related degree.

   c. Other earned academic degrees.

   d. Specialist certification credentials in alphabetical order (specific to the American board of physical therapy specialties).

   e. Physical therapists who have graduated from a DPT program may use the title "doctor of physical therapy". A physical therapist holding a DPT degree or another doctoral degree may not use the title "doctor" without clearly informing the public of the physical therapist's profession as a physical therapist.

History: Effective April 1, 2006; amended effective April 1, 2020.
General Authority: NDCC 43-26.1-03(5)
Law Implemented: NDCC ~~43-26.1-15~~43-26.1-15(5)

TITLE 62

PLUMBING, BOARD OF

APRIL 2020

CHAPTER 62-03.1-01
ADMINISTRATION

62-03.1-01-01. Conformance with ~~Uniform~~the North Dakota Plumbing Code~~ - Exceptions~~.

1. State plumbing code defined. The board adopts, as the state plumbing code, the ~~2009~~2018 edition of the Uniform Plumbing Code published by the international association of plumbing and mechanical officials (IAPMO), to be known as the 2018 North Dakota Plumbing Code, including chapters 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, and 17; appendices A, B, C, D, E, I, and ~~L,~~M; ~~published by the international association of plumbing and mechanical officials, with the exceptions and modifications described in section 62-03.1-02-02~~ and chapter 62-03.1-03.

2. All plumbing as defined in North Dakota Century Code section 43-18-01, including materials, must meet or exceed the minimum provisions of this article and the ~~Uniform~~North Dakota Plumbing Code.

History: Effective March 1, 2000; amended effective April 1, 2010; April 1, 2020.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03.1-01-04. Administrative powers and duties.

The secretary-chief inspector and other inspectors of the North Dakota state plumbing board, under the direction of the board, shall administer laws, rules, plumbing installation standards of this state, and the ~~Uniform~~North Dakota Plumbing Code. In all cases when any action is taken by the secretary-chief inspector or inspectors of the board to enforce the provisions of any sections contained in this article or the ~~Uniform~~North Dakota Plumbing Code, such acts must be done in the name of and on behalf of the state.

History: Effective March 1, 2000; amended effective April 1, 2020.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03.1-01-05. Application for plumbing installation certificate.

Any plumbing installation 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~~paper or electronic certificates for ~~distribution to~~ the person in charge of the installation.

1. Inspection fees for each certificate issued must be according to the schedule of fees shown on the plumbing installation certificate. If work has commenced prior to submittal of the 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 must be charged at fifty dollars per hour, plus travel expense.

2. ~~The certificate~~Paper certificates must be signed by the applicant and the original returned to the board along with the proper fees prior to commencement of work. The duplicate copy must be retained by the plumbing contractor and the triplicate copy must be submitted to the building owner. Electronic certificates are processed online. The issuing certificate fee must be charged for each certificate that must be reissued.

History: Effective March 1, 2000; amended effective April 1, 2010; April 1, 2020.
General Authority: NDCC 43-18-08
Law Implemented: NDCC 43-18-17.2, 43-18-17.3

CHAPTER 62-03.1-02
GENERAL REGULATIONS

62-03.1-02-02. Uniform Plumbing Code - Exceptions and modifications.

Repealed effective April 1, 2020.

~~The following chapters and appendices of the Uniform Plumbing Code are modified as follows:~~

1. ~~**Administration.** Add to 101.5.6 the words "or within" after the word "into". The following subsections do not apply: 103.1 through 103.4; 103.5.1.2, 103.5.3.1, 103.5.6, and table 1-1.~~

2. ~~**Definitions.** Add to 211.0: "Inspection report" means a notice, written by a plumbing inspector to the person responsible for the plumbing installation, describing work inspected and stating violations and noncompliance of rules and regulations as listed, which must be corrected within a designated time.~~

   ~~Add to 218.0: "Plumbing installation certificate" means a document consisting of one or more copies certifying that certain plumbing installations, plumbing fixtures, plumbing appliances, and other appurtenances were installed in conformity with the rules and regulations of the plumbing board. "Permit" as used in the Uniform Plumbing Code has the same meaning as plumbing installation certificate.~~

   ~~"Plumbing" add to definition: Maintenance does not include making repairs to faucets, valves, appliances, and fixtures, or removal of stoppages in waste or drainage pipes. See also North Dakota Century Code section 43-18-01.~~

   ~~"Plumbing system": Not included in this definition are medical gas and medical vacuum systems, liquid and fuel gas piping, and vents for water heaters.~~

3. ~~**General regulations.** Add to 313.2: When a water heater is located in an attic, attic-ceiling assembly, floor-ceiling assembly, or floor-subfloor assembly where damage results from a leaking water heater, a watertight pan of corrosion-resistant materials shall be installed beneath the water heater with not less than three-quarters of an inch [19.05 millimeters] diameter drain to an approved location. Add to 313.6: Water service piping must be installed with a minimum earth cover of seven feet [2.13 meters]. Minimum earth cover for building sewers must be four feet [1.22 meters].~~

   ~~Subsection 313.12.4 does not apply.~~

4. ~~**Plumbing fixtures and fixture fittings.** Add to 402.4: Mixing-type hand-closing faucets may be installed on lavatories for public use. Lavatories must have waste outlets not less than one and one-fourth inches [31.75 millimeters] in diameter, with open strainers.~~

   ~~Add to 405.2: Urinals with nonintegral traps shall be prohibited.~~

   ~~Add to 408.1: Water closets in private rooms of hotels, motels, dormitories, and boarding houses must be of the elongated bowl type.~~

   ~~Delete table 4-1 from 412.1 and add table 2902.1 of the most recently state-adopted International Building Code, with the following modifications: References on table 2902.1 to sections of the International Building Code and International Plumbing Code do not apply.~~

Add to Note a: Types of occupancies not shown on this table shall be considered individually by the administrative authority. The occupant load shall be composed of fifty percent of each sex.

Add the following notes:

Drinking fountains. There shall be a minimum of one drinking fountain per occupied floor in schools, theaters, auditoriums, dormitories, and businesses. Where food is consumed indoors, water stations may be substituted for drinking fountains. Where bottled water coolers are provided, drinking fountains shall not be required. Drinking fountains shall not be required in occupancies with less than thirty persons. Drinking fountains shall not be installed in toilet rooms.

Urinals. The provision of urinals may offset water closets otherwise required but the number of water closets required may not be reduced in this manner by more than fifty percent. Walls and floors within two feet [609.6 millimeters] of the sides and front of urinals must be finished with a smooth, hard, nonabsorbent finish.

Lavatories. Where circular or similar handwashing appliances are provided, twenty-four lineal inches [609.6 millimeters] of wash sink or eighteen inches [457.2 millimeters] of a circular basin, when provided with water outlets for such space, shall be considered equivalent to one lavatory.

Restaurant. For the purpose of this table, a restaurant is defined as a business that sells food to be consumed on premises. The number of occupants for a drive-in restaurant shall be considered as equal to the number of parking stalls. A hand sink is required to be available to employees in a restaurant or other food preparation occupancy.

Subsection 414.5 does not apply.

Toilet facilities. Every dwelling unit shall be provided with a water closet, lavatory, and a bathtub or shower.

Kitchen. Each dwelling unit shall be provided with a kitchen area and every kitchen area shall be provided with a sink.

Sewage disposal. All plumbing fixtures shall be connected to a sanitary sewer or to an approved private sewage disposal system.

Water supply to fixtures. All plumbing fixtures shall be connected to an approved water supply. Kitchen sinks, lavatories, bathtubs, showers, bidets, laundry tubs, and washing machine outlets shall be provided with hot and cold water.

5. **Water heaters.** Does not apply.

6. **Water supply and distribution.** Add to 602.4. Every building intended for human habitation, occupancy, or use, and located on premises where public water is available, must be connected to such public water. Public water is considered available if located within two hundred feet [60.96 meters] from any proposed building required to have potable water located on any lot or premises which abuts and is served by public water.

Delete from 604.2 exception: or underground outside of structures.

Delete from 604.8 exception: Plastic materials for water service piping outside underground shall have a blue insulated copper tracer wire or other approved conductor installed adjacent to the piping. Access shall be provided to the tracer wire or the tracer wire shall terminate

aboveground at each end of the nonmetallic piping. The tracer wire size shall be not less than eighteen AWG and the insulation type shall be suitable for direct burial.

Add to 604.10: new heading "Lead Content"; also add additional sentences to the end of the paragraph: Effective January 4, 2014, the maximum allowable lead content shall not exceed a weighted average of twenty-five hundredths percent with respect to wetted surfaces of pipes, pipe fittings, plumbing fittings, and fixtures used to convey or dispense water for human consumption.

Add to 605.2: Each building water supply shall be provided with a fullway valve installed on the inlet side of each water meter. Valves up to and including two inches [50.8 millimeters] in size must be a ball valve.

Add to 605.3: Wall hydrants must be separately controlled by an accessible valve inside the building.

7. **Sanitary drainage.** Add to 705.1.6. For aboveground installations an approved shielded coupling must be used to prevent outward expansion.

Delete from 712.1: Except that plastic pipe shall not be tested with air. Add to table 7-1, under reference standards column for PVC, SDR 35 ASTM 3034 or heavier. Note 1.

Delete from 723.0: Plastic drainage waste and vent (DWV) piping systems shall not be tested by the air test method.

8. **Indirect wastes.** Add to 807.4 or the discharge line from the dishwasher may be looped up and securely fastened to the underside of the counter.

9. **Vents.** Subsections 908.2.1, 908.2.2, and 908.2.3 do not apply: Replace 908.2.1 with an individually vented lavatory in a single bathroom or single toilet room shall be permitted to serve as the wet vent for one water closet and one bathtub or shower stall, or one water closet and one bathtub and shower combination if all of the following conditions are met:

a. The wet vent, and the dry vent extending from the wet vent, shall be two inches [50.8 millimeters] minimum pipe size.

b. The wet vent pipe opening shall not be below the weir of the trap that it serves. Vent sizing, grades, and connections shall comply with sections 904.0 and 905.0.

c. The horizontal branch drain serving both the lavatory and the bathtub or shower stall shall be two inches [50.8 millimeters] minimum pipe size.

d. The length of the trap arm from the bathtub or shower stall complies with the limits in table 10-1.

e. The distance from the outlet of the water closet to the connection of the wet vent complies with the limits in table 10-1.

f. The horizontal branch drain serving the lavatory and the bathtub or shower stall shall connect to the horizontal water closet branch above its centerline. When the bathroom or toilet room is the topmost load on a stack, the horizontal branch serving the lavatory and the bathtub or shower stall shall be permitted to connect to the stack below the water closet branch.

g. No fixture other than those listed in L 6.2.1 shall discharge through a single bathroom or single toilet room wet-vented system.

Replace 908.2.2 with: Double Bathtubs, Bathtub and Shower Combinations, Shower Stalls, and Lavatories.

Two lavatories, each rated at 1.0 drainage fixture unit, and two bathtubs, bathtub and shower combinations or shower stalls, installed in adjacent bathrooms, shall be permitted to drain to a horizontal drain branch that is two inches [50.8 millimeters] minimum pipe size, with a common vent for the lavatories and no individual vents for the bathtubs, bathtub and shower combinations or shower stalls, provided that the wet vent from the lavatories and their dry vent is two inches [50.8 millimeters] minimum pipe size and the length of all trap arms comply with the limits in table 10-1.

Add to 909.0. A combination waste and vent system may also be used for island sinks. The vertical waste pipe must be the same size as required for the combination waste and vent. The fixture trap size must be as required by chapter 7.

Subsection 910.2 does not apply.

10. **Traps and interceptors.** No change.

11. **Storm drainage.** No change.

12. **Fuel piping.** Does not apply.

13. **Health care facilities and medical gas and vacuum systems.** Does not apply.

14. **Referenced standards.** No change.

15. **Firestop protection.** Does not apply.

16. **Nonpotable water reuse systems.** No change.

17. **Appendix E, manufactured or mobile home parks and recreational vehicle parks.** Add to E1.0 water and sewer connections under the manufactured home may be made by individuals certified by the North Dakota department of commerce in accordance with the North Dakota manufactured home installation guidelines.

    Part D does not apply.

18. **Appendix L.** Delete from L8.1 circuit venting shall be designed by a registered professional engineer as an engineered design.

History: Effective March 1, 2000; amended effective March 1, 2002; April 1, 2010; January 1, 2014; July 1, 2015.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

TITLE 67

PUBLIC INSTRUCTION, SUPERINTENDENT OF

APRIL 2020

ARTICLE 67-11
EDUCATION PROFESSIONAL CREDENTIALS

CHAPTER 67-11-15
SCHOOL PSYCHOLOGY INTERN APPROVAL

[Repealed effective April 1, 2020]

~~Section~~
~~67-11-15-01 Licensure Required~~
~~67-11-15-02 Issuing Agency~~

~~67-11-15-03 Letter of Approval Standards~~
~~67-11-15-04 Application Process~~
~~67-11-15-05 Renewal Requirements~~
~~67-11-15-06 Effective Dates~~

CHAPTER 67-11-22
COMPUTER SCIENCE AND CYBERSECURITY CREDENTIALS

67-11-22-01. Definitions.

For the purpose of this chapter:

1. "Board" means the education standards and practices board.

2. "Computer science and cybersecurity credential" means the credential that allows an individual to teach the content of computer science and cybersecurity education in grades kindergarten through twelve.

3. "Department" means the department of public instruction.

4. "Superintendent" means the superintendent of public instruction.

History: Effective April 1, 2020.
General Authority: NDCC 15.1-02-04, 15.1-02-16, 28-32
Law Implemented: NDCC 15.1-02-16

67-11-22-02. Issuing agency.

The North Dakota principal's credential issuing agency address is:

Superintendent of Public Instruction
Department of Public Instruction
600 East Boulevard Avenue, Department 201
Bismarck, ND 58505-0440

History: Effective April 1, 2020.
General Authority: NDCC 15.1-02-04, 15.1-02-16, 28-32
Law Implemented: NDCC 15.1-02-16

67-11-22-03. Types of credentials.

1. A level I credential:

   a. Is issued upon satisfying the following requirements:

      (1) Hold a valid teaching license issued by the board; and

      (2) Complete one of the following:

         (a) Complete two hundred or more hours of documented computer science or cybersecurity training as approved by the department;

(b) Obtain fifteen or more credits in computer science or cybersecurity as approved by the department; or

(c) Demonstrate computer science or cybersecurity competencies through obtaining three stacks of department-approved microcredentials.

b. Allows the recipient to teach any computer science or cybersecurity-related course, including advanced courses, at any grade level corresponding with the recipient's teaching license.

2. A level II credential:

a. Is issued upon satisfying the following requirements:

(1) Hold a valid teaching license issued by the board; and

(2) Complete one of the following:

(a) Complete forty or more hours documented computer science or cybersecurity training as approved by the department;

(b) Obtain six or more credits in computer science or cybersecurity as approved by the department; or

(c) Demonstrate computer science or cybersecurity competencies through obtaining one stack of department-approved microcredentials.

b. Allows the recipient to teach introductory and intermediate-level computer science or cybersecurity-related courses, as determined by the department, at any grade level corresponding with the recipient's teaching license.

3. A level III credential:

a. Is issued upon satisfying the following requirements:

(1) Hold a valid teaching license issued by the board; and

(2) Complete one of the following:

(a) Complete fifteen or more hours documented computer science or cybersecurity training as approved by the department; or

(b) Demonstrate computer science or cybersecurity competencies through obtaining three or more stacks of department-approved microcredentials.

b. Allows the recipient to teach integrated computer science or cybersecurity-related instruction in other contents at any grade level corresponding with the recipient's teaching license. The recipient also may teach computer science or cybersecurity-related courses in grades kindergarten through grade eight as applicable to the recipient's teaching license.

History: Effective April 1, 2020.
General Authority: NDCC 15.1-02-04, 15.1-02-16, 28-32
Law Implemented: NDCC 15.1-02-16

67-11-22-04. Computer science and cybersecurity credential standards.

Trainings, credits, or microcredentials as approved by the department must align to content standards in the following areas:

1. Computational thinking, problem solving, and algorithms;

2. Digital citizenship and cybersecurity;

3. Technology systems hardware and software;

4. Information literacy and data use; and

5. Impacts of computing.

History: Effective April 1, 2020.
General Authority: NDCC 15.1-02-04, 15.1-02-16, 28-32
Law Implemented: NDCC 15.1-02-16

67-11-22-05. Application process.

The application process to obtain a credential under this chapter requires submission of:

1. A completed application including the applicant's name, social security number, date, address, telephone number, educator's professional license type and number, current employment information if applicable, academic preparation, and references; and

2. A copy of official transcripts or other documentation as needed.

History: Effective April 1, 2020.
General Authority: NDCC 15.1-02-04, 15.1-02-16, 28-32
Law Implemented: NDCC 15.1-02-16

67-11-22-06. Credential renewal.

Recipients of the level I, level II, and level III computer science and cybersecurity credentials must maintain a current teaching license for the credential to be valid. Documentation of thirty hours of applicable training, two credits, or two microcredentials or a combination of training, credits, or microcredentials is required every five years for renewal of the computer science and cybersecurity credential.

History: Effective April 1, 2020.
General Authority: NDCC 15.1-02-04, 15.1-02-16, 28-32
Law Implemented: NDCC 15.1-02-16

67-11-22-07. Reconsideration.

If issuance or renewal of any credential under this chapter is denied, the denial must be in writing and must state all reasons for denial and the applicant must be notified of the opportunity for reconsideration. If an application for issuance or renewal of any credential under this chapter is denied, the applicant may request a reconsideration of the decision. A request for reconsideration must be in writing and must be received by the superintendent of public instruction within three weeks of the date of mailing by the department of public instruction. Late requests will not be considered. The reconsideration request must state the following:

1. The facts, law, or rule the applicant believes was erroneously interpreted or applied; and

2. The applicant's arguments on how the facts, law, or rule should have been applied, giving specific reasons and thorough analysis. The superintendent of public instruction shall issue a final written response on the reconsideration request within three weeks after receiving a complete reconsideration request.

History: Effective April 1, 2020.

General Authority: NDCC 15.1-02-04, 15.1-02-16, 28-32
Law Implemented: NDCC 15.1-02-16

67-15-02-03. Application.

Application for a reconfigured calendar must be made on SFN 58170 which is available on the department of public instruction's web site. The application must include the school name, signatures of the administrator and board chairman, and the information that is responsive to the considerations to be made by the superintendent, including how the proposed reconfigured school calendar relates to the criteria listed in section 67-15-02-05. At a minimum, each applicant shall include the following in the application:

1. The goals and objectives of the reconfiguration program;
2. Documentation of community input into the proposed program, including written correspondence on the subject, summaries of oral contacts, and a summary of any discussions at public meetings or hearings;
3. A cost-benefit study, including potential for savings in transportation and energy costs;
4. The number of hours of instructional time for the most recent school year completed prior to the application;
5. A proposed school calendar that will assure middle and high school students will receive one thousand ~~thirty-eight~~fifty hours of instructional time and elementary students will receive nine hundred ~~fifty-one~~sixty-two and one-half hours of instructional time;
6. A class schedule for each grade level;
7. A contingency plan for makeup days and allowances for storms and other school closings;
8. A professional development plan; and
9. An evaluation plan, including specific plans to evaluate:
    a. Student performance;
    b. Student use of facilities;
    c. Community use of facilities;
    d. The success rate of any innovations;
    e. The change in educational opportunities for students;
    f. The change in academic opportunities for students; and
    g. Any costs savings attributable to the reconfiguration, including savings in staffing, energy, transportation, and maintenance costs.

History: Effective June 1, 2002; amended effective October 1, 2006; April 1, 2020.
General Authority: NDCC ~~15.1-06-05~~15.1-06-08.1(2), 15.1-06-08.1(5), 28-32-02
Law Implemented: NDCC ~~15.1-06-05~~15.1-06-08.1, 15.1-21-03, 15.1-21-04

67-15-02-05. Evaluation of applications.

Each application for a reconfigured school calendar must be evaluated by the superintendent using the following criteria:

1. The impact of the reconfiguration plan on the period of instructional time. Under this criterion the superintendent will consider:

   a. Whether the elementary students will receive at least nine hundred ~~fifty-one~~sixty-two and one-half hours each year under the plan; and

   b. Whether the middle and high school students will receive at least one thousand ~~thirty-eight~~fifty hours of instructional time.

2. The superintendent must also find one of the following to be a likely result of the reconfiguration:

   a. That the proposed plan encourages innovation. Under this criterion the superintendent will consider:

      (1) Educational trends relevant to the proposed reconfiguration;

      (2) Research relevant to the proposed reconfiguration; and

      (3) The likelihood that instructional staff will develop and use innovative means of instruction.

   b. That the proposed plan will improve educational opportunities for students. Under this criterion the superintendent will consider:

      (1) Educational opportunities available to students under the existing configuration; and

      (2) Educational opportunities available to students if the reconfiguration plan is adopted.

   c. That the proposed plan will enhance the academic opportunities of the students attending the school. Under this criterion the superintendent will consider:

      (1) Academic opportunities available to students under the existing configuration; and

      (2) Academic opportunities available to students if the reconfiguration plan is adopted.

   d. That the proposed plan will allow current students greater flexibility in the use of the school facilities. Under this criterion the superintendent will consider:

      (1) Existing facility use by current students;

      (2) The flexibility in use of school facilities available to current students under the existing configuration; and

      (3) The flexibility in use of school facilities available to current students if the reconfiguration plan is adopted.

   e. That individuals or groups other than current students will have greater flexibility in the use of the school facilities. Under this criterion the superintendent will consider:

      (1) Existing facility use by individuals and groups other than current students;

      (2) The flexibility in use of school facilities available to individuals or groups other than current students under the existing configuration; and

      (3) The flexibility in use of school facilities available to individuals or groups other than current students if the reconfiguration plan is adopted.

f. That the reconfiguration plan will result in significant cost-savings to the district applying. Under this criterion the superintendent will consider:

(1) Present costs of the district;

(2) Proposed reductions in the district's costs; and

(3) The difference between the present costs to the district and the proposed costs under the reconfigured plan will be considered significant if the present costs are anticipated to exceed the proposed costs by forty dollars per student.

History: Effective June 1, 2002; amended effective October 1, 2006; April 1, 2020.
General Authority: NDCC ~~15.1-06-05~~15.1-06-08.1(2), 15.1-06-08.1(5), 28-32-02
Law Implemented: NDCC ~~15.1-06-05~~15.1-06-08.1, 15.1-21-03, 15.1-21-04

ARTICLE 67-29
ARMED FIRST RESPONDER PROGRAM

CHAPTER 67-29-01
ARMED FIRST RESPONDER PROGRAM

67-29-01-01. Purpose.

The purpose of the armed first responder program is to give local school boards the ability to decide if an armed first responder will be a part of their school safety plan. The armed first responder program may include an individual carrying a concealed firearm or dangerous weapon as defined by North Dakota Century Code section 62.1-01-01 on school premises, but also requires the school to:

1. Work closely with local law enforcement and the department of emergency services' division of homeland security;

2. Identify school crisis and emergency threats and risks through a comprehensive emergency operations assessment; and

3. Participate in annual active shooter training.

History: Effective April 1, 2020.
General Authority: NDCC 62.1-02-14, 28-32
Law Implemented: NDCC 62.1-02

67-29-01-02. Participation.

Any public or nonpublic school wanting to participate, with permission and approval from their school board or governing body, shall submit a letter of intent to the superintendent of public instruction indicating its intent to participate in an armed first responder program.

History: Effective April 1, 2020.
General Authority: NDCC 62.1-02-14, 28-32
Law Implemented: NDCC 62.1-02

67-29-01-03. Intent.

The letter of intent must be comprised of a short statement that describes the school's intention to participate in the implementation of an armed first responder program and official approval of the school board or governing board. Meeting minutes that include discussion and approval of the armed first responder program and signed by the president of the school board and superintendent or chair of the governing board and the chief executive officer will suffice as official approval and must be included

with the letter of intent. The letter of intent may be mailed or submitted by electronic mail to the director of the office of school approval and opportunity. Once the letter of intent is received by the superintendent of public instruction, the submitting school, within ninety days, shall:

1. Identify the armed first responder;

2. Begin or complete a comprehensive emergency operations assessment, deemed approved by the department of emergency services, homeland security division, or have completed an assessment within three years prior to the submission of the letter of intent to the superintendent of public instruction. The purpose of the assessment is to identify school crisis and emergency threats and risks;

3. Submit the planning proposal as required for the armed first responder program in section 67-29-01-04.

History: Effective April 1, 2020.
General Authority: NDCC 62.1-02-14, 28-32
Law Implemented: NDCC 62.1-02

67-29-01-04. Proposed plan.

1. Within ninety days of submitting the letter of intent pursuant to section 67-29-01-03, the submitting school shall submit a proposed plan to the superintendent of public instruction. The proposed plan must be mailed or submitted by electronic mail to the director of the office of school approval and opportunity.

2. To be considered for approval, the proposed plan must include a description of the overall safety plan of the submitting school that is comprised of, at a minimum, the following required criteria:

   a. The training for the armed first responder defined in subsection 7 of North Dakota Century Code section 62.1-02-14;

   b. A comprehensive emergency operations assessment deemed approved by the department of emergency services, homeland security division for the purpose of identifying school crisis and emergency threats and risk;

   c. Informing local law enforcement, in writing, of the name of the armed first responder;

   d. Response time from local law enforcement;

   e. Training with armed first responder and local law enforcement to provide a coordinated response, in the event of a school emergency, to building lockdown and active assailant events;

   f. Annual active shooter trainings for the district and annual armed first responder recertification;

   g. Developing a strategy for lockbox if one is going to be used;

   h. Approving a posttraumatic stress disorder treatment program for armed first responder;

   i. Approval of proposed plan by local law enforcement; and

   j. Armed first responder eligibility requirements are all met.

3. The proposed plan must include a narrative of the status of completion of each required criteria. Estimated dates of completion must be included for the required criteria that are not completed.

4. The superintendent of public instruction may approve the proposal, reject the proposal, or work with the submitting school to modify the proposal to conform to the requirements herein.

History: Effective April 1, 2020.
General Authority: NDCC 62.1-02-14, 28-32
Law Implemented: NDCC 62.1-02

67-29-01-05. Eligibility requirements for armed first responder.

An individual selected to become an armed first responder for a school participating in the program:

1. Must be a law enforcement officer who has retired within the previous three years or completed the training, education, and firearm qualifications necessary to return to employment as law enforcement or an individual who meets the training criteria set forth in subsection 7 of North Dakota Century Code section 62.1-02-14;

2. Must be a United States citizen;

3. Must be at least twenty-one years of age;

4. Must be a high school graduate or state recognized equivalent;

5. Shall complete a criminal background check and be approved by local law enforcement agencies with jurisdiction over the school premises where the individual will be an armed first responder;

6. Shall successfully complete a physical and mental evaluation provided by individuals mentioned in subdivision f of subsection 8 of North Dakota Century Code section 62.1-02-14;

7. Shall complete a faculty and administrator safety training and emergency response program that includes training in:

   a. Armed response;

   b. Crisis management; and

   c. Automated external defibrillator, cardiopulmonary resuscitation, and stop bleeding during an emergency;

8. Must have approval from the school board or governing body to carry a firearm concealed on school property;

9. Must possess a valid class 1 firearm license from the state of North Dakota; and

10. May not be directly responsible for the supervision of children while serving as an armed first responder. An individual directly responsible for the supervision of children is an adult with primary responsibility, as assigned by the school board or school board designee, for observing and directing the actions of children.

History: Effective April 1, 2020.
General Authority: NDCC 62.1-02-14, 28-32
Law Implemented: NDCC 62.1-02

67-29-01-06. Final plan approval.

1. Prior to submission for final approval, the plan must be approved by local law enforcement. Upon completion of all required criteria and receipt of approval from local law enforcement, the plan must be submitted to the superintendent of public instruction for final approval. The plan may be submitted, via mail or electronic mail to the director of the office of school approval and opportunity. The plan must attest to the completion of the required criteria and indicate the date each such criteria was completed. The plan must include the signature of an individual authorized by local law enforcement confirming approval of the plan.

2. Once the plan is submitted and approved by the department of emergency services' division of homeland security, and the superintendent of public instruction, the submitting school or district may implement the armed first responder program in accordance with the plan.

3. The superintendent of public instruction may revoke any plan approved under North Dakota Century Code section 62.1-02-14 if the superintendent of public instruction, in consultation with the department of emergency services and the attorney general, determines the school has failed to perform in accordance with the agreed upon terms of the approved plan or failed to meet the requirements of this section.

History: Effective April 1, 2020.
General Authority: NDCC 62.1-02-14, 28-32
Law Implemented: NDCC 62.1-02

67-29-01-07. Plan changes after approval.

1. Any change to an approved plan relating to the individual designated by the school to serve as an armed first responder under the plan or to the location of a lockbox on school property must be reported by the school to local law enforcement no later than the next business day following the change. The school's armed first responder program will be suspended temporarily until the school receives approval of the change from local law enforcement.

2. If a school modifies any of the required criteria of an approved plan, including a change to the individual designated as an armed first responder under the plan or the location of a lockbox on school property, the school shall submit the modified plan to the superintendent of public instruction within thirty days of modification.

3. The modified plan must be approved by the superintendent of public instruction and the department of emergency services' division of homeland security. The school may continue to implement the armed first responder program as set forth in the modified plan while awaiting approval from the superintendent of public instruction and the department of emergency services' division of homeland security provided the school has received any approval by local law enforcement required by this section.

History: Effective April 1, 2020.
General Authority: NDCC 62.1-02-14, 28-32
Law Implemented: NDCC 62.1-02

67-29-01-08. Program evaluation data.

1. Any public or nonpublic school with an approved armed first responder program shall submit program evaluation data to the superintendent of public instruction upon request.

2. Each year, within thirty days prior to the anniversary of the effective date of an approved plan, the school shall submit to the superintendent of public instruction confirmation of armed first responder recertification and completion of active shooter training. Failure to provide this data may result in program suspension or termination.

3. The occurrence of any of the following events requires automatic data submission, within five business days, to the superintendent of public instruction:

   a. The school or district terminates the armed first responder program;

   b. An incident that causes a firearm to not be under direct control of the armed first responder or in the lockbox as required by the school's plan; or

   c. If a firearm is discharged on school property.

History: Effective April 1, 2020.
General Authority: NDCC 62.1-02-14, 28-32
Law Implemented: NDCC 62.1-02

TITLE 71

RETIREMENT BOARD

APRIL 2020

CHAPTER 71-01-02

71-01-02-04. Election notification.

1. The director of the North Dakota public employees retirement system shall ensure that notification of an active member vacancy and the election is given to all employees through publication of a notice in the North Dakota public employees retirement system newsletter ~~and~~or any other method of communication as deemed appropriate by the director at least three weeks in advance of a filing date for nomination petitions. The director shall ensure that notification of the vacancy of a retiree member and the election is given to all persons who have accepted a retirement allowance through publication of a notice in the North Dakota public employees retirement system newsletter ~~and~~or any other method of communication as deemed appropriate by the director at least three weeks in advance of a filing date for nomination petitions.

2. The notice must include a statement of voter and candidate eligibility, the candidate nomination requirements, the date of election, and where to obtain the nomination petitions for filing.

History: Effective April 1, 1992; amended effective July 1, 2000; April 1, 2008; April 1, 2014; April 1, 2020.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-03

71-01-02-06. Procedure for completing and filing petitions.

1. No period of time, on which an employee is entitled to receive wages or salary from the state of North Dakota or a political subdivision, may be used by the candidates to promote their election except as permitted by the employing agency. In addition, no public funds may be used for the purpose of promoting an election unless permitted by the employing agency.

2. Nomination petitions must be filed with the North Dakota public employees retirement system no later than four p.m. on the ~~first Friday of May~~date provided in the election notice and must be validated by the election committee or their representatives following the filing deadline and prior to ballots being distributed.

3. Nomination petitions not furnished by the North Dakota public employees retirement system will be accepted provided they are submitted in the prescribed form.

4. A candidate may withdraw that candidate's nomination petition up until one week ~~prior to the date the ballots are printed~~after the date the nomination petition is filed with the North Dakota public employees retirement system. The notice must be in writing and duly witnessed.

5. Nomination petitions may be accompanied by a three-inch [76.20-millimeter] by five-inch [127.00-millimeter] photograph of the candidate and a narrative not to exceed two hundred words. The absence of a photo or narrative will not invalidate the candidate's eligibility, but only the candidate's name will then appear with the other candidates' information that accompanies the ballots.

6. The retirement board or its representative reserves the right to edit lengthy narratives to the two hundred word limit.

7. The board or its representative shall inform all candidates of the validation of their candidacy.

History: Effective April 1, 1992; amended effective July 1, 2000; April 1, 2008; April 1, 2020.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-03

71-01-02-08. Election.

1. Ballots must be mailed by first-class United States mail to the ~~home~~ address of all eligible active voters for an election of an active board member, or all eligible retired voters for an election of a retired board member, as determined by the North Dakota public employees retirement system's membership roles as of April fifteenth in the year of the election. Each eligible voter gets one ballot. Lost ballots may not be replaced.

2. North Dakota public employees retirement system members who become eligible to vote after April fifteenth, but before the deadline for the receipt of ballots, may be issued a special election ballot by making their request for such ballot in writing to the North Dakota public employees retirement system office no later than the ~~second Monday in June~~two weeks before the deadline for receipt of ballots.

3. Ballots must be returned to the North Dakota public employees retirement system office no later than ~~the close of business on the Friday immediately preceding the third Monday in June~~four p.m. on the date provided on the election ballots.

4. The candidate receiving the highest number of votes must be considered elected. When there is more than one active member board vacancy to be filled, the candidate with the second highest number of votes must be considered elected. If there are three active member board vacancies to be filled, the person with the third highest number of votes must be considered elected.

History: Effective April 1, 1992; amended effective April 1, 2008; April 1, 2020.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-03

71-01-02-09. Canvassing rules.

1. Ballot counting by election committee members or their authorized representatives will commence ~~at nine a.m.~~ on the ~~third Monday of June~~date set for the election committee to do so and will continue until complete.

2. Each candidate may have one overseer present at the canvassing who may examine each ballot as to its sufficiency after the canvassers have completed the canvassing of all ballots. No overseer may possess a pen, pencil, or other device which could be considered capable of altering a ballot in any manner.

3. A candidate may act as his or her overseer. If a candidate wishes to designate a representative to act as his or her overseer, that candidate must provide a written authorization, duly witnessed, to the election committee at the canvassing. An overseer may

act on behalf of more than one candidate; however, each person must show the required authorization from each candidate represented.

4. The overseer may question the decision of the canvassers regarding a ballot after completion of the canvassing. If questioned, the comments of an overseer will be heard. The canvassers will then vote regarding the acceptability of the ballot with the majority vote ruling.

5. A ballot is not valid where the number of votes on the ballot exceeds the number of vacancies in the election. A ballot that does not, in the opinion of a majority of the canvassers, show a clear indication of the voter's intention, may not be counted.

6. If the percentage of votes received by the candidate receiving the highest number of votes is less than one percent more than the votes received by the candidate receiving the next highest number of votes, the board shall order a recount.

7. Tie votes will be determined by a coin toss. If this procedure is necessary, the election committee will establish and notify the tied candidates of the procedure and location for resolving the tie.

8. If the committee should determine that the outcome of the election has been compromised for any reason, the committee may determine the election to be invalid. If the election is determined to be invalid, the committee shall call for a new election with a new election schedule.

History: Effective April 1, 1992; amended effective April 1, 2008; July 1, 2010; April 1, 2020.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-03

71-01-02-10. Notification of election results.

1. Election results must be presented to the retirement board following the canvassing of votes. Such report must include an itemization of the number of ballots returned, votes cast for each candidate, votes invalidated, and votes not counted due to late receipt.

2. All candidates will be notified of the election results no later than the business day following the June meeting of the retirement board.

3. ~~Departments and agencies~~Employers and the membership participating in the North Dakota public employees retirement system will be notified of the election results. ~~In addition, a report of the election results will be included in the North Dakota public employees retirement system newsletter.~~

History: Effective April 1, 1992; amended effective April 1, 2008; April 1, 2020.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-03

CHAPTER 71-02-01

71-02-01-01. Definitions.

As used in North Dakota Century Code chapter 54-52 and this article:

1. "Accumulated contributions" means the total of all of the following:

   a. The employee account fund balance accumulated under the prior plan as of June 30, 1977.

   b. The vested portion of the employee's "vesting fund" accumulated under the prior plan as of June 30, 1977.

   c. The member's mandatory contributions made after July 1, 1977.

   d. The member's vested employer contributions made after January 1, 2000, pursuant to North Dakota Century Code section 54-52-11.1.

   e. The interest on the sums determined under subdivisions a, b, c, and d, compounded annually at the rate of five percent from July 1, 1977, to June 30, 1981, six percent from July 1, 1981, through June 30, 1986, and one-half of one percent less than the actuarial interest assumption from July 1, 1986, to the member's withdrawal from the plan or retirement.

   f. The sum of any employee purchase or repurchase payments.

2. "Actuarial equivalent" means a benefit calculated to be of equal value to the benefit otherwise payable when computed on the basis of assumptions and methods adopted for this purpose by the board in a way that precludes employer discretion pursuant to Internal Revenue Code section 401(a)(25). Such assumptions and methods adopted by the board, and any table of adjustment factors established in accordance with the assumptions and methods, shall be incorporated herein by reference.

3. "Alternative retirement system" means the teachers' fund for retirement, the highway patrolmen's retirement system, and the teachers' insurance and annuity association of America.

4. "Beneficiary" means any person in receipt of a benefit provided by this plan or any person designated by a participating member to receive benefits.

5. "Board" means the board of trustees for the public employees retirement system.

6. "Bonus" means cash compensation for services performed in addition to base salary excluding commission and shift differentials. Bonus does not include lump sum payments of sick leave provided under North Dakota Century Code section 54-06-14 or lump sum payments of annual leave or vacation pay.

7. "Claim" means the right to receive a monthly retirement allowance, the receiving of a retirement allowance, or the receiving of a disability benefit.

8. "Continuously employed" means any period of employment uninterrupted by voluntary or involuntary termination or discharge. A member who has taken a leave of absence approved by the member's employer, not to exceed a year unless approved by the executive director, and returns to employment shall be regarded as continuously employed for the period.

9. "Contribution" means the payment into the fund as a percentage of the salary of a member.

10. "Correctional officer" means a person who has completed a correctional officer course approved or certified by the North Dakota department of corrections and rehabilitation and is employed by a correctional facility as defined in North Dakota Century Code chapter 12-44.1.

11. "County judge" means a judge who was elected pursuant to North Dakota Century Code section 27-07.1-01 or an individual holding the position of county judge, county justice, or judge of county court prior to the general election in 1982, who meets all the eligibility requirements established under North Dakota Century Code chapter 54-52.

12. "Interruption of employment" is when an individual is inducted (enlists or is ordered or called to active duty into the armed forces of the United States) and leaves an employment position with a state agency or political subdivision, other than a temporary position. The individual must have left employment to enter active duty and must make application in accordance with the Uniformed Services Employment and Reemployment Rights Act.

13. "Leave of absence" means the period of time up to one year for which an individual may be absent from covered employment without being terminated. At the executive director's discretion, the leave of absence may be extended not to exceed two years, or indefinitely if the leave of absence is due to interruption of employment.

14. "Medical consultant" means a person or committee appointed by the board of the North Dakota public employees retirement system to evaluate medical information submitted in relation to disability applications, recertifications, and rehabilitation programs or other such duties as assigned by the board.

15. "Normal retirement age", except for members of the national guard and law enforcement, means age sixty-five unless otherwise provided. For members of the national guard and law enforcement, normal retirement age means age fifty-five, unless otherwise provided.

16. "Office" means the administrative office of the public employees retirement system.

17. "Overtime" as used in subsection 23 of North Dakota Century Code section 54-52-01 means, for employees other than firefighters and peace officers, any hours worked over the regularly scheduled work week and not to exceed forty hours in a week which are paid either at the regular hourly rate or time and one-half. For firefighters and peace officers, overtime means hours worked over the regularly scheduled work period which are paid either at the regular hourly rate or time and one-half.

18. "Participating employer" means an employer who contributes to the North Dakota public employees retirement system. For confidentiality purposes, "participating employer" means the person or group of persons with the ultimate authority over personnel decisions within the agency or political subdivision with which the member is employed or the person's or group's official designee.

~~18.~~19. "Pay status" means a member is receiving a retirement allowance from the fund.

~~19.~~20. "Permanent and total disability" for members of the main retirement system and the national guard/law enforcement retirement plan means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months. For members of the judge's retirement plan, "permanent and total disability" is determined pursuant to subdivision e of subsection 3 of section 54-52-17 of the North Dakota Century Code.

~~20.~~21. "Plan administrator" means the executive director of the North Dakota public employees retirement system or such other person or committee as may be appointed by the board of the North Dakota public employees retirement system from time to time.

~~21.~~22. "Plan year" means the twelve consecutive months commencing July first of the calendar year and ending June thirtieth of the subsequent calendar year.

~~22.~~23. "Prior plan" means the state employees' retirement system which existed from July 1, 1966, to June 30, 1977.

~~23.~~24. "Regularly funded" means a legislatively authorized full-time equivalent (FTE) position for state agencies. For all governmental units other than state agencies, regularly funded means a similar designation by the unit's governing board which is created through the regular budgeting process and receives traditional employee benefits such as sick leave and annual leave.

~~24.~~25. "Retiree" means an individual receiving a monthly retirement allowance pursuant to chapter 54-52.

~~25.~~26. "Retirement allowance" means a reoccurring, periodic benefit from an eligible employer-sponsored retirement plan as approved by the board.

~~26.~~27. "Service credit" means increments of time to be used in the calculation of retirement benefits. Service credit may be earned as stated in section 71-02-03-01 or may be purchased or repurchased according to section 71-02-03-02.1.

~~27.~~28. "Substantial gainful activity" is to be based upon the totality of the circumstances including consideration of an individual's training, education, and experience; an individual's potential for earning at least seventy percent of the individual's predisability earnings; and other items deemed significant on a case-by-case basis. Eligibility is based on an individual's employability and not actual employment status.

~~28.~~29. "Termination of employment" for the purposes of determination for eligibility for benefit payments means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence or if reemployed by any covered employer prior to receiving a lump sum distribution of the member's account balance does not constitute termination of employment.

~~29.~~30. "Termination of participation" means termination of eligibility to participate in the retirement plan.

History: Amended effective September 1, 1982; November 1, 1990; September 1, 1991; January 1, 1992; September 1, 1992; June 1, 1993; July 1, 1994; June 1, 1996; July 1, 2000; April 1, 2002; May 1, 2004; July 1, 2006; July 1, 2010; April 1, 2014; April 1, 2016; July 1, 2018; April 1, 2020.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52

71-02-03-02.4. Crediting purchased or repurchased service.

Service purchased or repurchased will be credited in the following manner:

1. For each month the system receives a payment toward a purchase contract, the member will earn a proportion of service credit.

2. Member acceptance of a service purchase contract extinguishes all pending service purchase cost estimates, excluding purchase of unused sick leave.

3. Service purchase contracts set up on a payment plan and only partially paid will have the remaining unpaid portion of service credit included when preparing the new service purchase cost calculation.

4. For members converting service under the public employees retirement system to service under the judge's retirement system, each month of county judge service under the public employees retirement system will be converted to one month of judicial service credit. The account balance from the public employees retirement system will be transferred to the judges' retirement system account once the contract is paid in full or closed.

History: Effective November 1, 1990; amended effective July 1, 1994; June 1, 1996; May 1, 2004; July 1, 2010; April 1, 2020.
General Authority: NDCC 54-52-02.6, 54-52-04, 54-52-17, 54-52-17.2, 54-52-17.4
Law Implemented: NDCC 54-52-02.6, 54-52-17, 54-52-17.2, 54-52-17.4

71-02-03-05. Coordination of multiple plan membership.

Upon providing proper documentation of retirement plan participation, a member who meets the following criteria may use service credit in the teachers' insurance retirement fund for the purpose of meeting the ~~rule of eighty-five or~~normal retirement date for vesting purposes under North Dakota Century Code chapter 54-52. The member:

1. Must have participated in both the teachers' fund for retirement and the teachers' insurance and annuity association of America-college retirement equities fund.

2. Must have elected to transfer the member's teachers' insurance retirement fund account balance to teachers' insurance and annuity association of America-college retirement equities fund in connection with the administrative coordination of the various state retirement plans as provided under chapter 133 of the 1973 North Dakota Session Laws.

3. Did not have a cash out since the time of the transfer of funds.

4. Did not relinquish such service credit in writing.

History: Effective June 1, 1996; amended effective July 1, 1998; April 1, 2020.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-01(11)(12)(16), 54-52-17

71-02-04-13. Reduced benefit option.

A participating member may enter into an agreement with the retirement board to receive an actuarially adjusted monthly retirement benefit to accommodate the less than full payment for years of service credit necessary to meet the ~~rule of eighty-five~~normal retirement date, if the following criteria are met:

1. The participating member is within seventy-two months of obtaining the ~~rule of eighty-five~~normal retirement date.

2. The service cannot be purchased prior to the participating member drawing a retirement benefit because it would be in violation of 26 U.S.C. 415 or limits of purchasing additional service credit found under subsection 10 of North Dakota Century Code section 54-52-17.4.

3. The participating member must have completed all other types of purchases the participating member is eligible for prior to entering into the reduced benefit agreement.

4. The participating member's reduced benefit agreement must indicate a benefit option election. If a benefit election is an optional benefit under subsection 1 or 2 of section 71-02-04-04, the reduced benefit is payable over the lifetime of both the member and surviving spouse.

History: Effective June 1, 1996; amended effective July 1, 1998; April 1, 2002; May 1, 2004; April 1, 2020.
General Authority: NDCC 54-52-04
Law Implemented: NDCC ~~39-03.1-11.1~~39-03.1-11, 54-52-17

71-02-07-03. Return to service - Disabled member.

If the recipient of a disability benefit under North Dakota Century Code chapter 54-52 returns to work, that member is responsible for reporting employment to the public employees retirement system.

1. If a member is working in a permanent full-time position and is eligible to participate in the public employees retirement system, monthly benefits from the public employees retirement system must be suspended. If the individual is not able to continue employment for a consecutive period of time resulting in nine months of service credit as a result of the disability and continues to meet eligibility requirements under the plan, that member may resume disability status with the public employees retirement system.

2. If a member returns to substantial gainful activity in employment not covered under the public employees retirement system, the disability benefit may continue for up to nine consecutive months. If the individual is not able to continue employment for at least nine months as a result of the disability and continues to meet eligibility requirements under the plan, the member may continue disability status with the public employees retirement system.

3. Upon subsequent termination and retirement, the member is required to select the same benefit option as the option selected at initial retirement.

4. If a member dies during subsequent employment, the member's initial retirement benefit option election applies and the date of death is considered the subsequent retirement date.

5. If a member's spouse dies during the subsequent employment of the member, section 71-02-04-04 applies to the member's initial and subsequent retirement benefit calculation.

History: Effective November 1, 1990; amended effective September 1, 1992; July 1, 1994; July 1, 2000; April 1, 2002; April 1, 2020.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-17

CHAPTER 71-04-01

71-04-01-01. Definitions.

The terms used throughout this title have the same meaning as in North Dakota Century Code section 54-52.2-04, except:

1. "Beneficiary" means an individual designated by the participant to receive benefits under the plan in the event the participant dies.

2. "Compensation" means the total annual remuneration for employment or contracted services received by the participant from the employer.

3. "Deferred compensation" means the amount of compensation not yet earned which the participant and the employer shall mutually agree shall be deferred from current monthly salary in accordance with the provisions of the plan.

4. "Eligible state deferred compensation plan" means a plan established and maintained by this state that complies with the Internal Revenue Code (IRC) 457(b).

5. "Employer" means the state of North Dakota or any of its political subdivisions, institutions, departments, or agencies.

6. "Participant" is any employee of a participating employer who executes a participant agreement.

7. "Participant agreement" means an agreement between the employer and a participant setting forth certain provisions and elections relative to the plan, incorporating the terms of the plan and establishing the ~~participant's~~ deferral and participation in the plan.

8. "Provider" means any insurance company, federally insured financial institutions, Bank of North Dakota, or registered dealer under North Dakota Century Code chapter 10-04 authorized by the retirement board to provide investment vehicles to employees.

9. "Retirement" means separation from service with the employer on a date coincidental with the normal, postponed, early, or disability retirement dates as described in North Dakota Century Code chapter 54-52-17.3.

10. "Retirement board" or "board" means the ~~seven~~nine persons described in North Dakota Century Code chapter 54-52-03.

11. "Separation from service" means that term as defined under Internal Revenue Code section 402(d)(4)(A)(3i) and includes termination of employment with the employer by reason of death, disability, retirement, resignation, or discharge.

12. "State" means the state of North Dakota, or any department, institution, or separate agency thereof acting as an employer of the participant.

13. "Unforeseeable emergency" means a severe financial hardship to the participant resulting from a sudden and unexpected illness or accident of the participant, the participant's spouse or dependent of the participant, loss of the participant's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the participant.

History: Effective April 1, 1989; amended effective July 1, 1994; April 1, 2002; May 1, 2004; July 1, 2010; April 1, 2016; April 1, 2020.
General Authority: NDCC 28-32-02, 54-52.2-03.2
Law Implemented: NDCC 54-52.2-03, 54-52.2-03.2, 54-52.2-04

CHAPTER 71-05-01

71-05-01-01. Definitions.

As used in North Dakota Century Code chapter 39-03.1:

1. "Actuarial equivalent" means a benefit calculated to be of equal value to the benefit otherwise payable when computed on the basis of assumptions and methods adopted for this purpose by the board in a way that precludes employer discretion pursuant to Internal Revenue Code section 401(a)(25). Such assumptions and methods adopted by the board, and any table of adjustment factors established in accordance with the assumptions and methods, shall be incorporated herein by reference.

2. "Covered employment" means employment with the North Dakota highway patrol.

3. "Medical examination" means an examination conducted by a doctor licensed to practice in North Dakota that includes a diagnosis of the disability, the treatment being provided for the disability, the prognosis and classification of the disability, and a statement indicating how the disability prevents the individual from performing the duties of a highway patrolman.

4. "Normal retirement age" means age fifty-five except as otherwise provided.

5. "Office" means the administrative office of the public employees retirement system.

6. "Overtime" as used in subsection 23 of North Dakota Century Code section 39-03.1-01 means any hours worked over an employee's regularly scheduled work period. Whether paid at the regular hourly rate or one and one-half times the regular rate, overtime is to be excluded as reportable retirement contributions.

7. "Permanent and total disability" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months.

~~7.~~8. "Plan administrator" means the executive director of the North Dakota public employees retirement system.

~~8.~~9. "Substantial gainful activity" is to be based upon the totality of the circumstances, including consideration of an individual's training, education, and experience; an individual's potential for earning at least seventy percent of the individual's predisability earnings; and other items deemed significant on a case-by-case basis. Eligibility is based on an individual's employability and not actual employment status.

History: Effective November 1, 1990; amended effective October 1, 1991; June 1, 1992; July 1, 2006; April 1, 2016; April 1, 2020.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1

CHAPTER 71-05-07

71-05-07-01. Return to service - Retired member.

The benefits of a retired member who returns to permanent employment must be suspended without interest accruing on the suspended account. Upon ~~final~~subsequent termination and retirement, the ~~member's benefit must be recalculated~~member is required to select the same benefit option as the option selected at initial retirement. The member's total benefit upon subsequent retirement must equal the original benefit plus the calculated benefit for the return-to-work period. The member's benefit attributable to any return-to-work period shall be based upon service and earnings attributable to the return-to-work period only and be calculated as follows:

1. The member's benefit must be based on the benefit provisions in effect at ~~final~~subsequent retirement and shall include the member's and spouse's ages, salary earned during the period of reemployment, ~~and~~ total service earned ~~before and~~ after reemployment, ~~adjusted to take account of benefit payments received prior to reemployment. If a different option is selected at the second retirement date, the member and office will submit information as required to make an actuarial determination of the elected benefit and the related payment of such~~and actuarial factors in effect at subsequent retirement.

2. If a member dies during subsequent employment, the member's initial retirement benefit option election will apply~~. The member's benefit shall be based on the benefit provisions in effect at final retirement and shall include the member's and spouse's ages, salary earned during the period of reemployment, and total service credits earned before and after reemployment, adjusted to take account of benefit payments received prior to reemployment~~ and the date of death will be considered the subsequent retirement date.

3. If a member's spouse dies during the subsequent employment of the member, section 71-05-05-04 applies to the member's initial and subsequent retirement benefit calculation.

History: Effective October 1, 1991; amended effective May 1, 2004; July 1, 2010; April 1, 2020.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-07-02. Return to service - Disabled member.

If the recipient of a disability benefit returns to work, said member is responsible for reporting employment to the public employees retirement system.

1. If a member is working in a permanent full-time position and is eligible to participate in the North Dakota highway patrolmen's retirement system, monthly benefits from the North Dakota highway patrolmen's retirement system must be suspended. If an individual is not able to continue employment for ~~at least~~a consecutive period of time resulting in nine months~~, said~~ of service credit as a result of the disability and continues to meet eligibility requirements under the plan, that member may resume disability status with the North Dakota highway patrolmen's retirement system.

2. If a member is receiving disability benefits from the North Dakota highway patrolmen's retirement system, and returns to substantial gainful activity in employment not covered under the highway patrolmen's retirement system, the disability ~~benefits~~benefit may continue for up to nine consecutive months. If the individual is not able to continue employment for a consecutive period of time resulting in nine months of service credit as a result of the disability and continues to meet eligibility requirements under the plan, that member may continue disability status with the North Dakota highway patrolmen's retirement system.

3. If a member becomes ineligible for a disability benefit from the North Dakota highway patrolmen's retirement system, the disability benefit will be discontinued on the date the member becomes ineligible for disability status.

History: Effective October 1, 1991; amended effective April 1, 2020.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

CHAPTER 71-06-01

71-06-01-02. Calculation of retiree health insurance credit.

Retiree health insurance credit will be calculated on actual years and months of service, identical to retirement benefits under North Dakota Century Code chapter 54-52.

1. Retiree health insurance credit will be subject to reduction factors in the event of early retirement.

For annuitants of the public employees retirement system defined benefit plan and North Dakota public employees retirement system judges, and for members of the defined contribution retirement plan, excluding national guard/law enforcement and highway patrol retirees, who take a periodic distribution:

Age at Retirement	Reduction Factor	Age at Retirement	Reduction Factor
64 to 65	3%	59 to 60	33%
63 to 64	9%	58 to 59	39%
62 to 63	15%	57 to 58	45%
61 to 62	21%	56 to 57	51%
60 to 61	27%	55 to 56	57%

For annuitants of the job service retirement program: This includes those who retired under a discontinued service annuity but does not include those who retired at a normal or optional date.

Age at Retirement	Reduction Factor	Age at Retirement	Reduction Factor	Age at Retirement	Reduction Factor
64 to 65	3%	59 to 60	33%	54 to 55	63%
63 to 64	9%	58 to 59	39%	53 to 54	69%
62 to 63	15%	57 to 58	45%	52 to 53	75%
61 to 62	21%	56 to 57	51%	51 to 52	81%
60 to 61	27%	55 to 56	57%	50 to 51	87%

For annuitants of the highway patrol fund and national guard/law enforcement retirees and national guard/law enforcement retirees who transferred to the defined contribution retirement plan:

Age at Retirement	Reduction Factor
54 to 55	3%
53 to 54	9%
52 to 53	15%
51 to 52	21%
50 to 51	27%

2. Disabled annuitants receiving benefits under subdivision g of subsection 3 of North Dakota Century Code section 54-52-17, subdivision d of subsection 3 of North Dakota Century Code section 39-03.1-11, North Dakota Century Code section 52-11-01, or section 71-02-05-05 will be eligible for full retiree health insurance credit benefits. No age reduction factor will be applied.

3. A surviving spouse eligible to receive benefits under paragraph 2 of subdivision a and paragraphs 2 and 3 of subdivision b of subsection 6 of North Dakota Century Code section 54-52-17, ~~subdivisions~~subdivision b ~~and c~~ of subsection 6 of North Dakota Century Code section 39-03.1-11, or North Dakota Century Code section 52-11-01 will receive retiree health insurance credit based on the deceased member's years of service without any age reduction applied.

4. A surviving spouse receiving benefits under the provisions of subdivision b ~~or~~, c, d, or e of subsection 9 of North Dakota Century Code section 54-52-17; subdivisions a, b, and c of subsection 5 of North Dakota Century Code section 27-17-01; subsection 9 of North Dakota Century Code section 39-03.1-11; or North Dakota Century Code section 52-11-01 will receive retiree health insurance credit for the duration benefits are paid, based upon the original annuitant's retirement age.

History: Effective April 1, 1992; amended effective June 1, 1996; July 1, 2000; July 1, 2010; April 1, 2016; April 1, 2020.
General Authority: NDCC 54-52.1-03.2(b)
Law Implemented: NDCC 54-52.1-03.3

CHAPTER 71-08-02
MEMBERSHIP IN DEFINED CONTRIBUTION RETIREMENT PLAN

Section

71-08-02-01. Membership of individuals who become employees covered under the judges' retirement plan, the highway patrol retirement plan, ~~the law enforcement plan,~~ the teachers' fund for retirement plan, or the alternate retirement plan of the state board of higher education.

If a member of the defined contribution retirement plan begins employment in a position covered under the judges' retirement plan, the highway patrol retirement plan, ~~the law enforcement plan,~~ the teachers' fund for retirement plan, or the alternate retirement plan of the state board of higher education, the member's status as a member of the defined contribution retirement plan is suspended and the member becomes a new member of the retirement plan for which that member's new position is eligible. The member's account balance remains in the defined contribution retirement plan, but no new contributions may be made to that account. The member's service credit and salary history that were forfeited as a result of the member's transfer to the defined contribution retirement plan remain forfeited, and service credit accumulation in the new retirement plan begins from the first day of employment in the new position. If the member later returns to employment that is eligible for the defined contribution plan, the member's suspension is terminated, the member again becomes a member of the defined contribution plan, and the member's account shall resume accepting contributions. The contributions to the alternate retirement plan shall remain with that plan unless at the member's option, the member elects to transfer any available balance as determined by the provisions of the alternate retirement plan into the member's account in the defined contribution retirement plan.

History: Effective July 1, 2000; amended effective April 1, 2002; July 1, 2006; April 1, 2020.
General Authority: NDCC 28-32-02(1)
Law Implemented: NDCC 54-52.6-01(3)

TITLE 75

DEPARTMENT OF HUMAN SERVICES

APRIL 2020

CHAPTER 75-02-02
MEDICAL SERVICES

75-02-02-24 Contractual Rights to Receive Money Payments [Repealed]
75-02-02-25 Disqualifying Transfers [Repealed]
75-02-02-26 Eligibility Under 1972 State Plan [Repealed]
75-02-02-27 Scope of Drug Benefits - Prior Authorization
75-02-02-28 Drug Use Review Board and Appeals
75-02-02-29 Primary Care Provider

75-02-02-02. Authority and objective.

Under authority of North Dakota Century Code ~~chapter~~chapters 50-24.1 and 50-29, the department ~~of human services~~ is empowered to promulgate such rules and regulations as are necessary to qualify for federal funds under section 1901 specifically and ~~title~~titles XIX and XXI generally of the Social Security Act. These regulations are subject to the ~~medical assistance~~Medicaid and children's health insurance program state plan and to applicable federal and state law and regulations.

History: Effective October 1, 1979; amended effective February 1, 1981; April 1, 2020.
General Authority: NDCC 50-06-05.1, 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 USC 1396a

75-02-02-03. State organization.

1. **Single state agency.** The department of human services is the single state agency with authority to supervise the administration of the ~~medical assistance~~Medicaid and children's health insurance program state plan and program.

2. **Statewide operation.**

   a. The state plan will be in operation, through a system of local offices on a statewide basis, in accordance with equitable standards for assistance and administration that are mandatory throughout the state.

   b. The state plan will be administered by the political subdivisions of the state and will be mandatory on such political subdivisions.

   c. The department of human services, hereinafter referred to as the state agency, will assure that the plan is continuously in operation in all local offices or local agencies through:

      (1) Methods for informing staff of state policies, standards, procedures, and instructions.

      (2) Regular planned examination and evaluation of operations in local offices by regularly assigned state staff, including regular visits by such staff; and through reports, controls, or other necessary methods.

History: ~~Amended~~Effective October 1, 1979; amended effective May 1, 1986; April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-06-05.1, 50-24.1-04; 42 CFR 431.10; 42 CFR 431.20

75-02-02-03.2. Definitions.

For purposes of this chapter:

1. "Behavioral health service" means an evaluation, therapy, or testing service rendered by one of the following practitioners within their scope of practice: physician, licensed ~~independent~~ clinical social worker, psychologist, licensed ~~addition~~addiction counselor, licensed clinical addiction counselor, master addiction counselor, licensed associate professional counselor,

licensed professional counselor, licensed professional clinical counselor, clinical nurse specialist, physician assistant, nurse practitioner, licensed baccalaureate social worker, licensed marriage and family therapist, or licensed ~~certified~~master social worker.

2. "Certification of need" means a regulatory review process that requires specific health care providers to obtain prior authorization for provision of services for Medicaid applicants or eligible recipients under age twenty-one. Certification of need is a determination of the medical necessity of the proposed services as required for all applicants or recipients under the age of twenty-one prior to admission to a psychiatric hospital, an inpatient psychiatric program in a hospital, or a psychiatric facility, including a psychiatric residential treatment facility. The certification of need evaluates the individual's capacity to benefit from proposed services, the efficacy of proposed services, and consideration of the availability of less restrictive services to meet the individual's needs.

3. ~~"County agency" means the county social service board.~~

~~4.~~ "Department" means the North Dakota department of human services.

~~5.~~4. "Drug use review board" means the board established pursuant to North Dakota Century Code chapter 50-24.6.

~~6.~~5. "Exercise program" includes regimens to achieve various improvements in physical fitness and health.

~~7.~~6. "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 participation.

~~8.~~7. "Indian health services or tribal health facility or clinic" means either a health services facility or clinic operated by the United States department of health and human services Indian health services division or a federally recognized tribal nation that has opted to contract with Indian health services to plan, conduct, and administer one or more individual programs, functions, services, or activities, resulting in tribal health facilities or clinics operated by tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act [Pub. L. 93-638].

~~9.~~8. "Licensed practitioner" means an individual other than a physician who is licensed or otherwise authorized by the state to provide health care services within the practitioner's scope of practice.

~~10.~~9. "Medical emergency" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

~~11.~~10. "Medically necessary" includes only medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the recipient's diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the recipient or provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective.

~~12.~~11. "Provider" means an individual, entity, or facility furnishing medical or remedial services or supplies pursuant to a provider agreement with the department.

~~13.~~12. "Psychiatric residential treatment facility" is as defined in subsection 13 of section 75-03-17-01.

~~14.~~13. "Recipient" means an individual approved as eligible for ~~medical assistance~~Medicaid or children's health insurance program.

~~15.~~14. "Rehabilitative services" means any medical or remedial items or services prescribed for a recipient by the recipient'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 recipient to the recipient's best possible functional level.

~~16.~~15. "Remedial services" includes those services, including rehabilitative services, which produce the maximum reduction in physical or mental disability and restoration of a recipient to the recipient's best possible functional level.

~~17.~~16. "Weight loss program" includes programs designed for reduction in weight, but does not include weight loss surgery.

~~18. "Section 1931 group" includes individuals whose eligibility is based on the provisions of section 1931 of the Social Security Act [42 U.S.C. 1396u-1].~~

History: Effective May 1, 2000; amended effective August 29, 2000; November 1, 2001; September 1, 2003; October 1, 2012; April 1, 2016; January 1, 2017; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02-08. Amount, duration, and scope of ~~medical assistance~~Medicaid and children's health insurance program.

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 medically necessary medical and remedial care and services which are described in the approved Medicaid and children's health insurance program state plan in effect at the time the service is rendered by providers. Services may include:

   a. (1) Inpatient hospital services. "Inpatient hospital services" means 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~~Medicaid or children's health insurance program.

   (2) Inpatient prospective payment system hospitals that are reimbursed by a diagnostic-related group will follow Medicare guidelines for supplies and services included and excluded as outlined in 42 CFR 409.10.

   b. Outpatient hospital services. "Outpatient hospital services" means 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 and 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 that 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.

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 recipient 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 recipient 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. Nursing facility services. "Nursing facility services" does not include services in an institution for mental diseases and means those items and services furnished by a licensed and otherwise eligible nursing facility or swing-bed hospital maintained primarily for the care and treatment 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 for individuals who need or needed on a daily basis nursing care, provided directly or requiring the supervision of nursing personnel, or other rehabilitation services which, as a practical matter, may only be provided in a nursing facility on an inpatient basis.

e. Intermediate care facility for individuals with intellectual disabilities services. "Intermediate care" means those items and services 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. "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as provided in chapter 75-04-01.

f. Early and periodic screening, diagnosis, and treatment of individuals. "Early and periodic screening, diagnosis, and treatment" means the services provided to ensure that individuals under age twenty-one who are eligible under the plan receive appropriate, preventative, mental health developmental, and specialty services to correct or ameliorate medical conditions.

g. Physician's services. "Physician's services" whether furnished in the office, the recipient's home, a hospital, nursing facility, or elsewhere means 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 other than physician's services recognized under state law and furnished by licensed practitioners within the scope of their practice as defined by state law.

i. Home health care services. "Home health care services", is in addition to the services of physicians, dentists, physical therapists, and other services and items available to recipients in their homes and described elsewhere in this section, means any of the following items and services when they are provided, based on physician order, medical

necessity, and a written plan of care, to a recipient in the recipient's place of residence, excluding a residence that is a hospital or a skilled nursing facility:

(1) Intermittent or part-time skilled nursing services furnished by a home health agency;

(2) Intermittent or part-time nursing services of a registered nurse, or a licensed practical nurse, or which are provided under the direction of a physician and under the supervision of a registered nurse, when a home health agency is not available to provide nursing services;

(3) Medical supplies, equipment, and appliances ordered or prescribed by the physician as required in the care of the patient and suitable for use in the home; and

(4) Services of a home health aide provided to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and in collaboration with the home health agency.

j. Hospice care. "Hospice care" means the care described in 42 CFR 418 furnished to a terminally ill individual who has voluntarily elected to have hospice care. Hospice care may be provided to an individual while the individual is a resident of a nursing facility, but only the hospice care payment may be made. An individual's voluntary election must be made in accordance with procedures established by the department.

k. Private duty nursing services. "Private duty nursing services" means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or is routinely provided by the nursing staff of a medical facility. Services are provided by a registered nurse or a licensed practical nurse under the direction of and ordered by a physician.

l. Dental services. "Dental services" means 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. Dental 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. Dental services reimbursed under 42 C.F.R. 440.90 may only be reimbursed if provided through a public or private nonprofit entity that provides dental services.

m. Physical therapy. "Physical therapy" means those services prescribed by a physician or other licensed practitioner of the healing arts within the scope of that person's practice under state law and provided to a recipient by or under the supervision of a qualified physical therapist.

n. Occupational therapy. "Occupational therapy" means those services prescribed by a physician or other licensed practitioner of the healing arts within the scope of that person's practice under state law and provided to a recipient and given by or under the supervision of a qualified occupational therapist.

o. Services for individuals with speech, hearing, and language disorders. "Services for individuals with speech, hearing, and language disorders" means those diagnostic, screening, preventive, or corrective services provided by or under the supervision of a speech pathologist or audiologist in the scope of practice of the speech pathologist's or audiologist's profession for which a recipient is referred by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

p. Prescribed drugs. "Prescribed drugs" means 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.

q. Durable medical equipment and supplies. "Durable medical equipment and supplies" means those medically necessary items that are primarily and customarily used to serve a medical purpose and are suitable for use in the home and used to treat disease, to promote healing, to restore bodily functioning to as near normal as possible, or to prevent further deterioration, debilitation, or injury 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. Durable medical equipment includes prosthetic and orthotic devices, eyeglasses, and hearing aids. For purposes of this subdivision:

(1) "Eyeglasses" means 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 recipient may select, to aid or improve vision;

(2) "Hearing aid" means a specialized orthotic device individually prescribed and fitted to correct or ameliorate a hearing disorder; and

(3) "Prosthetic and orthotic devices" means replacement, corrective, or supportive devices prescribed for a recipient 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.

r. Other diagnostic, screening, preventive, and rehabilitative services.

(1) "Diagnostic services", other than those for which provision is made elsewhere in these definitions, includes any medical procedures or supplies recommended for a recipient by the recipient'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 recipient.

(2) "Preventive services" means 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.

(3) "Rehabilitative services", in addition to those for which provision is made elsewhere in these definitions, includes any medical or remedial items or services prescribed for a recipient by the recipient'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 recipient to the recipient's best possible functional level.

(4) "Screening services" consists 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, to identify suspects for more definitive studies, or identify individuals suspected of having certain diseases.

s. Inpatient psychiatric services for individuals under age twenty-one, as defined in 42 CFR 440.160, provided consistent with the requirements of 42 CFR part 441 and section 75-02-02-10.

t. Services provided to persons age sixty-five and older in an institution for mental diseases, as defined in 42 U.S.C. 1396d(i).

u. Personal care services. "Personal care services" means those services that assist an individual with activities of daily living and instrumental activities of daily living in order to maintain independence and self-reliance to the greatest degree possible.

v. Any other medical care and any other type of remedial care recognized under state law and specified by the secretary of the United States' department of health and human services, including:

(1) Nonemergency medical transportation, including expenses for transportation and other related travel expenses, necessary to securing medical examinations or treatment when determined by the department to be medically necessary.

(2) Family planning services, including drugs, supplies, and devices, when such services are under the medical direction of a physician or licensed practitioner of the healing arts within the scope of their practices as defined by state law. There must be freedom from coercion or pressure of mind and conscience and freedom of choice of method, so that individuals may 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 or licensed practitioner and when it is not available to the recipient from other sources.

w. A community paramedic service. "Community paramedic service" means a Medicaid-covered service rendered by a community paramedic, advanced emergency medical technician, or emergency medical technician. The care must be provided under the supervision of a physician or advanced practice registered nurse.

2. The following limitations apply to medical and remedial care and services covered or provided under the ~~medical assistance~~Medicaid program and children's health insurance program:

a. Coverage may not be extended and payment may not be made for an exercise program or a weight loss program prescribed for eligible recipients.

b. Coverage may not be extended and payment may not be made for alcoholic beverages prescribed for eligible recipients.

c. Coverage may not be extended and payment may not be made for orthodontia prescribed for eligible recipients, except for orthodontia necessary to correct serious functional problems.

d. Coverage may not be extended and payment may not be made for any service provided to increase fertility or to evaluate or treat fertility.

e. Coverage and payment for eye examinations and eyeglasses for eligible recipients are limited to, and payment will only be made for, examinations and eyeglass replacements necessitated because of visual impairment.

f. (1) Coverage may not be extended to and payment may not be made for any physician-administered drugs in an outpatient setting if the drug does not meet the

requirements for a covered outpatient drug as outlined in section 1927 of the Social Security Act [42 U.S.C. 1396r-8].

(2) Payment for any physician-administered drugs in an outpatient setting will be the lesser of the provider's submitted charge, the Medicare allowed amount, or the pharmacy services allowed amount described in subdivision n.

g. Coverage and payment for home health care services and private duty nursing services are limited to no more, on an average monthly basis, to the equivalent of one hundred seventy-five visits. The limit for private duty nursing is in combination with the limit for home health services.

(1) This limit may be exceeded in cases where it is determined there is a medical necessity for exceeding the limit and the department has approved a prior treatment authorization request.

(2) The prior authorization request must describe the medical necessity of the home health care services or private duty nursing services, and explain why less costly alternative treatment does not afford necessary medical care.

(3) At the time of initial ordering of home health services, a physician or other licensed practitioner shall document that a face-to-face encounter related to the primary reason the recipient requires home health services occurred no more than ninety days before or thirty days after the start of home health services.

h. Coverage may not be extended and payment may not be made for transportation services except as provided in sections 75-02-02-13.1 and 75-02-02-13.2.

i. Coverage may not be extended and payment may not be made for any abortion except when necessary to save the life of the mother or when the pregnancy is the result of an act of rape or incest.

j. After consideration of North Dakota Century Code section ~~50-241-15~~50-24.1-15, coverage for ambulance services must be in response to a medical emergency and may not be extended and payment may not be made for ambulance services that are not medically necessary, as determined by the department.

k. Coverage for an emergency room must be made in response to a medical emergency and may not be extended and payment may not be made for emergency room services that are not medically necessary, as determined by the department under section 75-02-02-12.

l. Coverage may not be extended and payment may not be made for medically necessary chiropractic services exceeding twelve treatments for spinal manipulation services and two radiologic examinations per year, per recipient, unless the provider requests and receives prior authorization from the department.

m. Coverage and payment for personal care services:

(1) May not be made unless prior authorization is granted, and the recipient meets the criteria established in subsection 1 of section 75-02-02-09.5; and

(2) May be approved for:

(a) Up to one hundred twenty hours per month, or at a daily rate;

(b) Up to two hundred forty hours per month if the recipient meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for individuals with intellectual disabilities level of care; or

(c) Up to three hundred hours per month if the recipient is determined to be impaired in at least five of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring; meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for individuals with intellectual disabilities level of care; and none of the three hundred hours approved for personal care services are allocated to the tasks of laundry, shopping, or housekeeping.

n. Coverage and payment for pharmacy services are limited to the coverage and methodology approved by the centers for Medicare and Medicaid services in the current North Dakota Medicaid state plan.

3. a. Except as provided in subdivision b, remedial services are covered services.

b. Remedial services provided by residential facilities such as licensed basic care facilities, licensed foster care homes or ~~facilities~~qualified residential treatment programs, and specialized facilities are not covered services, but expenses incurred in securing such services must be deducted from countable income in determining financial eligibility.

4. a. The department may refuse payment for any covered service or procedure for which a prior treatment authorization request is required but not secured.

b. The department may consider making payment if the provider demonstrates good cause for the failure to secure the required prior treatment authorization request. Provider requests for good cause consideration must be received within twelve months of the date the services or procedures were furnished and any related claims must be filed within timely claims submission requirements.

c. The department may refuse payment for any covered service or procedure provided to an individual eligible for both Medicaid and third-party coverage if the third-party coverage denies payment because of the failure of the provider or recipient to comply with the requirements of the third-party coverage.

5. A provider who renders a covered service except for personal care, but fails to receive payment due to the requirements of subsection 4, may not bill the recipient. A provider who 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 requirements of subsection 4, has by so doing breached the terms of their Medicaid provider agreement.

6. Community paramedic services are limited to vaccinations, immunizations, and immunization administration.

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; January 1, 1994; January 1, 1996; July 1, 1996; January 1, 1997; May 1, 2000; amendments partially voided by the Administrative Rules Committee effective June 5, 2000; November 8, 2002; September 1, 2003; July 1, 2006; January 1, 2010; July 1, 2012; October 1, 2012; July 1, 2014; April 1, 2016; January 1, 2017; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04; 42 USC 1396n(b)(1); 42 CFR 431.53; 42 CFR 431.110; 42 CFR 435.1009; 42 CFR Part 440; 42 CFR Part 441, subparts A, B, D

75-02-02-09. Nursing facility level of care.

1. "Nursing facility level of care" means, for purposes of ~~medical assistance~~Medicaid and children's health insurance program, services provided by a facility that meets the standards for nursing facility licensing established by the state department of health, and in addition, meets all requirements for nursing facilities imposed under federal law and regulations governing the ~~medical assistance~~Medicaid program and the children's health insurance program.

2. 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, seven days a week.

   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 when 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.

4. If no criteria of subsection 2 or 3 is met, an individual who applies to or resides in a nursing facility designated as a facility for nongeriatric individuals with physical disabilities may demonstrate that a nursing facility level of care is medically necessary if the individual is determined to have restorative potential.

5. If no criteria of subsection 2, 3, or 4 is met, an individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if:

a. The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; and

b. As a result of the brain injury, the individual requires direct supervision at least ~~eight~~four hours a day, ~~seven~~five days a week.

6. 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~~Medicaid or children's health insurance program 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~~Medicaid or children's health insurance program 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~~Medicaid or children's health insurance program 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~~Medicaid or children's health insurance program, may be made only after a nursing facility level of care determination is made.

7. A nursing facility shall ensure that appropriate medical, social, and psychological services are provided to each resident of the facility who is dependent in whole or in part on the ~~medical assistance~~Medicaid program or children's health insurance program~~ under title XIX of the Social Security Act~~. The appropriateness of such services must be based on the need of each

resident 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; November 1, 2001; October 1, 2012; April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 442

75-02-02-09.1. Cost sharing.

Repealed effective April 1, 2020.

~~1. Copayments provided for in this section may be imposed unless:~~

~~a. The recipient receiving the service:~~

~~(1) Is in a nursing facility, intermediate care facility for individuals with intellectual disabilities, or any medical institution and is required to spend all income except for the recipient's personal needs allowance for the recipient's cost of care;~~

~~(2) Receives swing-bed services in a hospital;~~

~~(3) Has not reached the age of twenty-one years;~~

~~(4) Is pregnant;~~

~~(5) Is an Indian who is eligible to receive, is currently receiving, or who has ever received an item or service furnished by Indian health service providers or through referral under contract health services;~~

~~(6) Is terminally ill and is receiving hospice care;~~

~~(7) Is receiving medical assistance because of the state's election to extend coverage to eligible individuals receiving treatment for breast or cervical cancer; and~~

~~(8) Is an inmate, otherwise eligible for medical assistance, and is receiving qualifying inpatient services.~~

~~b. The service is:~~

~~(1) Emergency room services; or~~

~~(2) Family planning services.~~

~~2. Copayments are:~~

~~a. Seventy-five dollars for each inpatient hospital admission, including admissions to distinct part psychiatric and rehabilitation units of hospitals and excluding long-term hospitals;~~

~~b. Two dollars for each office or consultation visit;~~

~~c. Three dollars for each office visit to a rural health clinic or federally qualified health center;~~

~~d. One dollar for each chiropractic manipulation of the spine;~~

~~e. Two dollars for each dental visit that includes an oral examination;~~

~~f. Three dollars for each brand name prescription filled;~~

~~g. Two dollars for each optometric visit that includes a vision examination;~~

~~h. Three dollars for each podiatric office visit;~~

~~i. Two dollars for each occupational therapy visit;~~

~~j. Two dollars for each physical therapy visit;~~

~~k. One dollar for each speech therapy visit;~~

~~l. Three dollars for each hearing aid dispensing service;~~

~~m. Two dollars for each audiology testing visit;~~

~~n. Two dollars for each behavioral health service visit; and~~

~~o. Two dollars for each licensed independent clinical social worker visit.~~

~~**History:** Effective January 1, 1997; amended effective November 8, 2002; September 1, 2003; July 1, 2006; July 1, 2012; October 1, 2012; April 1, 2016; January 1, 2017; April 1, 2018.~~
~~**General Authority:** NDCC 50-24.1-04~~
~~**Law Implemented:** NDCC 50-24.1-04~~

75-02-02-10. Limitations on inpatient psychiatric services for individuals under age twenty-one.

1. Inpatient psychiatric services for individuals under age twenty-one must be provided:

   a. Under the direction of a physician;

   b. By a psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the joint commission on accreditation of health care organizations, or by a psychiatric facility that is not a hospital and which is accredited by the joint commission on accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the council on accreditation of services for families and children, or by any other accrediting organization with comparable standards; and

   c. Before the recipient reaches age twenty-one, or, if the individual was under age twenty-one at the time of admission, before the earlier of:

      (1) The date the recipient no longer requires inpatient psychiatric services; or

      (2) The date the recipient reaches age twenty-two.

2. A psychiatric facility or program providing inpatient psychiatric services to individuals under age twenty-one shall:

   a. Except as provided in subdivision c, obtain a certification of need from an independent review team qualified under subsection 3 prior to admitting a recipient;

   b. Obtain a certification of need from an independent review team qualified under subsection 3 for an individual who applies for ~~medical assistance~~Medicaid while in the facility or program covering any period for which claims are made; or

   c. Obtain a certification of need from an independent review team qualified under subsection 3 for an emergency admission of an individual, within fourteen days after the admission, covering any period prior to the certification for which claims are made.

3. a. An independent review team must:

(1) Be composed of individuals who have no business or personal relationship with the inpatient psychiatric facility or program requesting a certification of need;

(2) Include a physician;

(3) Have competence in diagnosis and treatment of mental illness; and

(4) Have knowledge of the recipient's situation for which the certification of need is requested.

b. Before issuing a certification of need, an independent review team must use professional judgment and standards approved by the department and consistent with the requirements of 42 CFR part 441, subpart D, to demonstrate:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;

(2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) The requested services can reasonably be expected to improve the recipient's condition or prevent further regression so services may no longer be needed.

4. Payment may not be made for services provided to a recipient under age twenty-one in a psychiatric residential treatment facility without a certification of need.

5. Prior to the dates of services of January 1, 2019, payment may not be made for any other medical services not provided by a psychiatric residential treatment facility if the facility is an institution for mental diseases.

History: ~~Amended~~Effective October 1, 1979; amended effective February 1, 1981; January 1, 1997; November 1, 2001; November 8, 2002; July 1, 2006; October 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 441, subpart D

75-02-02-10.2. Limitations on services for treatment of addiction.

1. For purposes of this section:

a. "~~Services for treatment of addiction" means ambulatory services provided to an individual with an impairment resulting from an addictive disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual. Services for treatment of addiction may be hospital-based or nonhospital-based~~American Society of Addiction Medicine I" means services for treatment of addiction as prescribed in article 75-09.1.

b. "American Society of Addiction Medicine ~~II.5~~II.1" means ~~an intense level of~~ services for treatment of addiction as prescribed in article 75-09.1.

c. "American Society of Addiction Medicine ~~II.1~~II.5" means ~~an intermediate level of~~ services for treatment of addiction as prescribed in article 75-09.1.

d. "American Society of Addiction Medicine ~~I~~III.1" means ~~a low level of ambulatory behavioral health care that provides chemical dependency treatment for~~ services for treatment of addiction as prescribed in article 75-09.1.

e. "American Society of Addiction Medicine III.5" means services for treatment of addiction as prescribed in article 75-09.1.

f. "Services for treatment of addiction" means ambulatory services provided to an individual with an impairment resulting from an addictive disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual. Services for treatment of addiction may be hospital-based or nonhospital-based.

2. ~~No payment for services for treatment of addiction will be made unless the provider requests authorization from the department within five business days of providing such services and the department approves such request. A provider must submit a written request for authorization to the department on forms prescribed by the department.~~

~~3.~~ Limitations.

a. Payment may not be made for American Society of Addiction Medicine ~~II.5~~II.1 services exceeding ~~forty-five~~thirty days per calendar year per recipient.

b. Payment may not be made for American Society of Addiction Medicine ~~II.1~~II.5 services exceeding ~~thirty~~forty-five days per calendar year per recipient.

c. Payment may not be made for American Society of Addiction Medicine ~~I~~III.5 services exceeding ~~twenty~~forty-five days per calendar year per recipient.

d. The department may ~~approve~~authorize additional days per calendar year per recipient ~~on a case-by-case basis~~if determined to be medically necessary.

e. Payment may not be made for American Society of Addiction Medicine III.1 services, unless the recipient is concurrently receiving American Society of Addiction Medicine II.1 or II.5 services.

~~4.~~3. Licensed addiction counselors, operating within their scope of practice, performing American Society of Addiction Medicine I, and practicing within a recognized Indian reservation in North Dakota are not required to also have licensure prescribed in article 75-09.1, for Medicaid American Society of Addiction Medicine I billed services provided within a recognized Indian reservation in North Dakota.

4. Licensed addiction counselor includes licensed clinical addiction counselors, licensed master addiction counselors, and practitioners possessing a similar license in a border state and operating within their scope of practice in that state.

5. Licensed addiction programs operating in a border state must provide documentation to the department of their state's approval for the operation of the addiction program.

History: Effective November 8, 2002; amended effective November 19, 2003; October 1, 2012; July 1, 2014; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 431.54

75-02-02-10.3. Limitations on partial hospitalization psychiatric services.

1. For purposes of this section:

a. ~~"Partial hospitalization psychiatric services" means services provided to an individual with an impairment resulting from a psychiatric, emotional, or behavior disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual with the intent to avert inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization psychiatric services must be hospital based.~~

~~b.~~ "Level A" means an intense level of partial hospitalization psychiatric services which provide treatment for an individual by at least three licensed health care professionals under the supervision of a licensed physician for at least four hours and no more than eleven hours per day for at least three days per week.

~~c.~~b. "Level B" means an intermediate level of partial hospitalization psychiatric services which provide treatment for an individual by at least three licensed health care professionals under the supervision of a licensed physician for three hours per day for at least two days per week.

c. "Partial hospitalization psychiatric services" means services provided to an individual with an impairment resulting from a psychiatric, emotional, or behavior disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual with the intent to avert inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization psychiatric services must be hospital based.

2. ~~No payment for partial hospitalization psychiatric services may be made unless the provider requests authorization from the department within five business days of providing such services and the department approves such request. A provider shall submit a written request for authorization to the department on forms prescribed by the department.~~

~~3.~~ Limitations.

a. Payment may not be made for level A services exceeding forty-five days per calendar year per recipient.

b. Payment may not be made for level B services exceeding thirty days per calendar year per recipient.

c. The department may ~~approve~~authorize additional days per calendar year per recipient ~~on a case-by-case basis~~if determined to be medically necessary.

History: Effective April 1, 2018; amended effective April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 431.54

75-02-02-11. Coordinated services.

1. For purposes of this section:

a. "Coordinated services" means the process used to limit a recipient's medical care and treatment to a single physician or other provider to prevent the continued misutilization of services.

b. "Coordinated services provider" means a physician, nurse practitioner, physician assistant, or Indian health services or tribal health facility or clinic selected by the coordinated services recipient to provide care and treatment to the recipient. The selected coordinated services provider is subject to approval by the department.

c. "Misutilization" means the incorrect, improper, or excessive utilization of medical services which may increase the possibility of adverse effects to a recipient's health or may result in a decrease in the overall quality of care.

2. Coordinated services may be required by the department of a past, current, or future recipient who has misutilized services, including:

a. Securing excessive services from more than one provider when there is little or no evidence of a medical need for those services;

b. Drug acquisition in excess of medical need resulting from securing prescriptions or drugs from more than one provider;

c. Excessive utilization of emergency services when no medical emergency is present; or

d. Causing services to be misutilized due to fraud, deception, or direct action, without regard to payer source.

3. The determination to require coordinated services of a recipient is made by the department upon recommendation of medical professionals who have reviewed and identified the services the recipient appears to be misutilizing.

4. The following factors must be considered in determining if coordinated services is to be required:

a. The seriousness of the misutilization;

b. The historical utilization of the recipient; and

c. The availability of a coordinated services physician or provider.

5. If a coordinated services recipient does not select a coordinated services provider within thirty days after qualifying for the program, the department will limit the recipient to only medically necessary medical and pharmacy services. If a coordinated services recipient selects a coordinated services provider after the initial thirty days, the selection will be reviewed by the department to determine if the selected provider is appropriate and to ensure the provider accepts the assignment. A coordinated services recipient may have a coordinated services provider in more than one specialty, such as medical, dental, or pharmacy.

6. Upon a determination to require coordinated services:

a. The department shall provide the recipient with written notice of:

(1) The decision to require coordinated services;

(2) The recipient's right to choose a coordinated services provider, subject to approval by the department and acceptance by the provider;

(3) The recipient's responsibility to pay for medical care or services rendered by any provider other than the coordinated services provider; and

(4) The recipient's right to appeal the requirement of enrollment into the coordinated services program.

b. The appropriate ~~county agency~~human service zone shall:

(1) Obtain the recipient's selection of a coordinated services provider; and

(2) Document that selection in the case record.

7. Coordinated services may be required of an individual recipient and may not be imposed on an entire ~~medical assistance~~Medicaid or children's health insurance program case. If more than one recipient within a case is misutilizing medical care, each individual recipient must be treated separately.

8. Coordinated services may be required without regard to breaks in eligibility until the department determines coordinated services is discontinued.

9. No ~~medical assistance~~Medicaid or children's health insurance program payment may be made for misutilized medical care or services furnished to the coordinated services recipient by any provider other than the recipient's coordinated services physician or provider, except for:

   a. Medical care rendered in a medical emergency; or

   b. Medical care rendered by a provider upon referral by the coordinated services physician or provider and approved by the department.

10. A recipient may appeal the decision to require coordinated services in the manner provided by chapter 75-01-03.

History: Effective May 1, 1981; amended effective May 1, 2000; July 1, 2006; October 1, 2012; April 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-02
Law Implemented: NDCC 50-24.1-01; 42 CFR Part 455

75-02-02-13. Limitations on out-of-state care.

1. For purposes of this section:

   a. "Out-of-state care" means care or services furnished by any individual, entity, or facility, pursuant to a provider agreement with the department, at a site located more than fifty statute miles [80.45 kilometers] from the nearest North Dakota border.

   b. "Out-of-state provider" means a provider of care or services that is located more than fifty statute miles [80.45 kilometers] outside of North Dakota. An out-of-state provider may be an individual or a facility but may not be located outside of the United States.

   c. "Primary care provider" means the enrolled medical provider who has assumed responsibility for the advice and care of the recipient.

   d. "Specialist" means a physician board certified in the required medical specialty who regularly practices within North Dakota or at a site within fifty statute miles [80.45 kilometers] from the nearest North Dakota border.

2. Except as provided in subsection 3, no payment for out-of-state care, including related travel expenses, will be made unless:

   a. The recipient was first seen by that recipient's primary care provider, unless the recipient is not required to have a primary care provider;

   b. The primary care provider determines, unless the recipient is not required to have a primary care provider, that it is advisable to refer the recipient for care or services which the primary care provider is unable to render and a referral is made to an in-state, board-certified physician specialist, if available;

   c. Recipient is evaluated by a board-certified physician specialist;

   d. The physician specialist concludes that the recipient should be referred to an appropriate out-of-state provider because necessary care or services are unavailable in the state;

   e. The primary care provider or in-state, board-certified physician specialist submits, to the department, a written request that includes medical and other pertinent information,

including the report of the specialist that documents the specialist's conclusion that the out-of-state referral is medically necessary;

f. The department determines that the medically necessary care and services are unavailable in the state and approves the referral on that basis; and

g. The claim for payment is otherwise allowable and verifies that the department approved the referral for out-of-state care.

3. a. A referral for emergency care, including related travel expenses, to an out-of-state provider can be made by the in-state primary care provider. A determination that the emergency requires out-of-state care may be made at the primary care provider's discretion, but is subject to review by the department. Claims for payment for such emergency services must identify the referring primary care provider and document the emergency.

b. Claims for payment for care for a medical emergency or surgical emergency, as those terms are defined in section 75-02-02-12, which occurs when the affected recipient is traveling outside of North Dakota, will be paid unless payment is denied pursuant to limitations contained in section 75-02-02-12.

c. Claims for payment for any covered service rendered to a recipient who is a resident of North Dakota for ~~medical assistance~~Medicaid and children's health insurance program purposes, but whose current place of abode is outside of North Dakota, will not be governed by this section.

d. Claims for payment for any covered service rendered to a recipient during a verified retroactive eligibility period will not be governed by this section.

e. If a recipient is referred for out-of-state care without first securing approval under subsection 2, and the care is not otherwise allowable under this subsection, the department may approve payment upon receipt of a written request, from the primary care provider or specialist, that:

(1) Demonstrates good cause for not first securing approval under subsection 2;

(2) Clearly establishes that the care and services were unavailable in the state; and

(3) Documents that the care and services were medically necessary.

4. An out-of-state provider who does not maintain a physical, in-state location or a location within fifty statute miles [80.45 kilometers] of North Dakota will not be enrolled as a Medicaid provider unless the department determines the provider's enrollment is necessary to ensure access to covered services.

History: Effective November 1, 1983; amended effective October 1, 1995; October 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02-13.1. Travel expenses for medical purposes - Limitations.

1. For purposes of this section:

a. "Family member" means spouse, sibling, parent, stepparent, child, stepchild, grandparent, stepgrandparent, grandchild, stepgrandchild, aunt, uncle, niece, or nephew, whether by half or whole blood, and whether by birth, marriage, or adoption; and

b. "Travel expenses" means fares, mileage, meals, lodging, and driver and attendant care.

2. General requirements.

a. A transportation service provider shall be enrolled as a provider in the ~~medical assistance~~Medicaid program and children's health insurance program and may be an individual, a taxi, a bus, a food service provider, a lodging provider, an airline service provider, a travel agency, or another commercial form of transportation.

b. The ~~county agency~~human service zone may determine and authorize the most efficient, economical, and appropriate means of travel to meet the medical needs of the recipient.

c. The cost of travel provided by a parent, spouse, or any other member of the recipient's ~~medical assistance~~Medicaid unit may be allowed as an expense of necessary medical or remedial care for recipient liability purposes. No parent, spouse, friend, household member, or family member of the recipient may be paid as an enrolled provider for transportation for that recipient. An individual who provides foster care, kinship, or guardianship may enroll as a transportation provider and is eligible for reimbursement to transport a Medicaid-eligible child to and from Medicaid-eligible medical appointments in situations in which the Medicaid-eligible child's medical needs exceed ordinary, typical, and routine levels. A guardian of a vulnerable adult may enroll as a transportation provider and is eligible for reimbursement to transport a Medicaid-eligible adult, for whom the guardian has been court-ordered to provide guardianship services, to and from Medicaid-covered medical appointments.

d. Emergency transport by ambulance is a covered service when provided in response to a medical emergency.

e. Nonemergency transportation by ambulance is a covered service only when medically necessary and ordered by the attending licensed provider.

f. A recipient may choose to obtain medical services outside the recipient's community. If similar medical services are available within the community and the recipient chooses to seek medical services elsewhere, travel expenses are not covered services and are the responsibility of the recipient.

g. If a provider refers a recipient to a facility or provider that is not located at the closest medical center, travel expenses are not covered services and are the responsibility of the recipient, unless special circumstances apply and prior authorization is secured.

3. Out-of-state travel expenses. Travel expenses for nonemergency out-of-state medical services, including follow-up visits, may be authorized if the out-of-state medical services are first approved by the department under section 75-02-02-13 or if prior approval is not required under that section.

4. Limitations.

a. Private or noncommercial vehicle mileage compensation is limited to the amount on the department fee schedule. This limit applies even if more than one recipient is transported at the same time. Mileage is determined by map miles from the residence or community of the recipient to the medical facility. When necessary to ensure volunteer drivers continue to provide transportation services to a recipient, the ~~county agency~~human service zone may request authorization from the department to make payment for additional mileage. Transportation services may be billed to ~~medical assistance~~the Medicaid program or children's health insurance program only upon completion of the service. Transportation services may be allowed if the recipient or a household member does not have a vehicle that is in operable condition or if the health of the recipient or

household member does not permit safe operation of the vehicle. If free or low-cost transportation services are available, including transportation that could be provided by a friend, family member, or household member, the department will not pay transportation costs.

b. Meals compensation is allowed only when medical services or travel arrangements require a recipient to stay overnight. Compensation is limited to the amount on the department fee schedule. The entity providing meals must be an enrolled Medicaid provider and must submit the proper requests for payment.

c. Lodging expense is allowed only when medical services or travel arrangements require a recipient to stay overnight. Lodging compensation is limited to the amount on the department fee schedule. Lodging providers must be enrolled in Medicaid and shall submit the proper requests for payment.

d. Travel expenses may not be authorized for both a driver and an attendant unless the referring licensed practitioner determines that one individual cannot function both as driver and attendant. Travel expenses may not be allowed for a noncommercial driver or an attendant while the recipient is a patient in a medical facility unless it is more economical for the driver or attendant to remain in the service area, as determined by the department.

e. Travel expenses may be authorized for one parent to travel with a child who is under eighteen years of age. No additional travel expenses may be authorized for another driver, attendant, or parent unless the referring licensed practitioner determines that person's presence is necessary for the physical, psychological, or medical needs of the child.

f. Compensation for attendant services, provided by an attendant who is not a family member, may be allowed at a rate determined by the department if the department determines attendant services are medically necessary. Attendant services must be approved by the ~~county agency~~human service zone.

History: Effective July 1, 1996; amended effective May 1, 2000; September 1, 2003; October 1, 2012; July 1, 2014; April 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

75-02-02-13.2. Travel expenses for medical purposes - Institutionalized individuals - Limitations.

1. For purposes of this section:

   a. "Long-term care facility" means a nursing facility, intermediate care facility for individuals with intellectual disabilities, or swing-bed facility; and

   b. "Medical center city" means Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, and Williston, and includes any city that shares a common boundary with any of those cities.

2. A long-term care facility may not charge a resident for the cost of travel provided by the facility. Except as provided in subsection 4, a long-term care facility shall provide transportation to and from any provider of necessary medical services located within, or at no greater distance than the distance to, the nearest medical center city. Distance must be calculated by road miles.

3. If the resident has to travel farther than the nearest medical center city, the costs of travel may be reimbursed by Medicaid according to the appropriate fee schedule. Distance must be calculated by map miles.

4. A long-term care facility is not required to pay for transportation by ambulance for emergency or nonemergency situations for residents.

5. A service provider that is paid a rate, determined by the department on a cost basis that includes transportation service expenses, however denominated, may not be compensated as a transportation service provider for transportation services provided to an individual residing in the provider's facility. The following service providers may not be so compensated:

   a. Basic care facilities;

   b. Residential habilitation services for individuals with intellectual or developmental disabilities;

   c. ~~Group homes serving children in foster care;~~

   ~~d.~~ Intermediate care facilities for individuals with intellectual disabilities;

   ~~e.~~d. Independent habilitation services for individuals with intellectual or developmental disabilities;

   ~~f.~~e. Nursing facilities;

   ~~g.~~f. Psychiatric residential treatment facilities;

   ~~h.~~g. ~~Residential child care facilities~~Qualified residential treatment programs; and

   ~~i.~~h. Swing-bed facilities.

6. If, under the circumstances, a long-term care facility is not required to transport a resident, and the facility does not actually transport the resident, the availability of transportation services and payment of travel expenses is governed by section 75-02-02-13.1.

History: Effective July 1, 1996; amended effective July 1, 2012; October 1, 2012; April 1, 2016; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

75-02-02-14. County administration.

Repealed effective April 1, 2020.

~~1. Except as provided in subsection 2, the county where the medical assistance unit is physically present is responsible for the administration of the program with respect to that unit.~~

~~2. When a unit receiving assistance moves from one county to another, the outgoing county continues to be responsible for the administration of the program with respect to that unit until the last day of the month after the month in which the unit assumes physical residence in an incoming county.~~

~~**History:** Effective November 1, 1983; amended effective July 1, 1984; May 1, 1986; May 1, 2000; October 1, 2012.~~
~~**General Authority:** NDCC 50-24.1-04~~
~~**Law Implemented:** NDCC 50-01.2-03~~

75-02-02-27. Scope of drug benefits - Prior authorization.

1. Prior authorization means a process requiring the prescriber or the dispenser to verify with the department or the department's contractor that proposed medical use of a particular drug for a ~~medical assistance~~Medicaid program or children's health insurance program recipient meets predetermined criteria for coverage by the ~~medical assistance~~Medicaid program or children's health insurance program.

2. A prescriber or a dispenser must secure prior authorization from the department or its designee as a condition of payment for those drugs subject to prior authorization.

3. A prescriber or a dispenser must provide to the department or its designee in the format required by the department the data necessary for the department or its designee to make a decision regarding prior authorization. The department shall deny a claim for coverage of a drug requiring prior authorization if the prescription was dispensed prior to authorization or if the required information regarding the prior authorization is not provided by the prescriber or the dispenser.

4. A prescriber or dispenser must submit a request for prior authorization to the department or its designee by telephone, facsimile, electronic mail, or in any other format designated by the department. The department or its designee must respond to a prior authorization request within twenty-four hours of receipt of a complete request that contains all of the data necessary for the department to make a determination.

5. Emergency supply.

   a. If a recipient needs a drug before a prescriber or dispenser can secure prior authorization from the department, the department shall provide coverage of the lesser of a five-day supply of a drug or the amount prescribed if it is not feasible to dispense a five-day supply because the drug is packaged in such a way that it is not intended to be further divided.

   b. The department will not provide further coverage of the drug beyond the five-day supply unless the prescriber or dispenser first secures prior authorization from the department.

6. The department must authorize the provision of a drug subject to prior authorization if:

   a. Other drugs not requiring prior authorization have not been effective or with reasonable certainty are not expected to be effective in treating the recipient's condition;

   b. Other drugs not requiring prior authorization cause or are reasonably expected to cause adverse or harmful reactions to the health of the recipient; or

   c. The drug is prescribed for a medically accepted use supported by a compendium or by approved product labeling unless there is a therapeutically equivalent drug that is available without prior authorization.

7. If a recipient is receiving coverage of a drug that is later subject to prior authorization requirements, the department shall continue to provide coverage of that drug until the prescriber must reevaluate the recipient. The department will provide a form by which a prescriber may inform the department of a drug that a recipient must continue to receive beyond the prescription reevaluation period regardless of whether such drug requires prior authorization. The form shall contain the following information:

   a. The requested drug and its indication;

   b. An explanation as to why the drug is medically necessary; and

c. The signature of the prescriber confirming that the prescriber has considered generic or other alternatives and has determined that continuing current therapy is in the best interest for successful medical management of the recipient.

8. If a recipient under age twenty-one is prescribed five or more concurrent prescriptions for antipsychotics, antidepressants, anticonvulsants, benzodiazepines, mood stabilizers, sedative, hypnotics, or medications used for the treatment of attention deficit hyperactivity disorder, the department shall require prior authorization of the fifth or more concurrent drug. Once the prescriber of the fifth or more concurrent drug consults with a board-certified pediatric psychiatrist regarding the overall care of the recipient, and if that prescriber wishes to still prescribe the fifth or more concurrent drug, the department will grant authorization for the drug.

9. The department may require prior authorization if a recipient age twenty-one or over is prescribed a stimulant medication used in the treatment of attention deficit disorder and attention deficit hyperactivity disorder by an individual who prescribes this medication at a rate two times higher than the rate of the top ten prescribers excluding the top prescriber based on data representing claims processed for a time period of no less than the previous quarter and no greater than the previous twelve months.

History: Effective September 1, 2003; amended effective July 26, 2004; July 1, 2006; October 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.6-04, 50-24.6-10
Law Implemented: NDCC 50-24.6; 42 USC 1396r-8

75-02-02-28. Drug use review board and appeals.

1. The department shall implement a prospective and retrospective drug use review program for outpatient prescription drugs and determine which drugs shall be subject to prior authorization before payment will be approved. The department shall consider the advice and recommendations of the drug use review board before requiring prior authorization of any drug.

2. The drug use review board shall:

   a. Cooperate with the department to implement a drug use review program;

   b. Receive and consider information regarding the drug use review process which is provided by the department and interested parties, including prescribers who treat significant numbers of recipients;

   c. Review and make recommendations to the department regarding drugs to be included on prior authorization status;

   d. Review no less than once each year the status of the drugs that have been deemed to require prior authorization and make recommendations to the department regarding any suggested changes;

   e. Review and approve the prior authorization program process used by the department, including the process to accommodate the provision of a drug benefit in an emergency situation;

   f. Advise and make recommendations to the department regarding any rule proposed for adoption by the department to implement the provisions of state and federal law related to drug use review; and

g. Propose remedial strategies to improve the quality of care and to promote effective use of ~~medical assistance~~Medicaid program and children's health insurance program funds or recipient expenditures.

3. The drug use review board may establish a panel of physicians and pharmacists to provide guidance and recommendations to the board in considering specific drugs or therapeutic classes of drugs to be included in the prior authorization program.

4. The drug use review board shall make a recommendation to the department regarding prior authorization of a drug based on:

   a. Consideration of medically and clinically significant adverse side effects, drug interactions and contraindications, assessment of the likelihood of significant abuse of the drug, and any other medically and clinically acceptable analysis or criteria requested by the drug use review board; and

   b. An assessment of the cost-effectiveness of the drug compared to other drugs used for the same therapeutic indication and whether the drug offers a clinically meaningful advantage in terms of safety, effectiveness, or clinical outcome over other available drugs used for the same therapeutic indication.

5. Drug use review board meeting procedures.

   a. Any interested party may address the drug use review board at its regular meetings if the presentation is directly related to an agenda item.

   b. The drug use review board may establish time limits for presentations.

   c. The department shall post on its web site the proposed date, time, location, and agenda of any meeting of the drug use review board at least thirty days before the meeting.

6. Within thirty days of the date the drug use review board's recommendation is received by the department, the department shall review the recommendations and make the final determination as to whether a drug requires prior authorization and, if so, when the requirement for prior authorization will begin. If the department's final determination is different from the recommendation of the drug use review board, the department shall present, in writing, to the drug use review board at its next meeting the basis for the final determination.

7. The department shall post on its web site the list of drugs subject to prior authorization and the date on which each drug became subject to prior authorization.

8. A recipient may appeal the department's denial, suspension, reduction, or termination of a covered drug based upon application of this section as authorized under North Dakota Century Code chapter 28-32.

History: Effective September 1, 2003; amended effective October 1, 2012; April 1, 2020.
General Authority: NDCC 50-24.6-10
Law Implemented: NDCC 50-24.6; 42 USC 1396r-8

75-02-02-29. Primary care provider.

1. Payment may not be made for services that require a referral from a recipient's primary care provider for recipients, with the exception of recipients who are notified by the department and are required within fourteen days from the date of that notice, but who have not yet selected, or have not yet been auto-assigned a primary care provider.

2. A primary care provider must be selected by or on behalf of the members in the following ~~medical assistance~~Medicaid units:

   a. The parents or caretaker relatives and their spouses of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, up to fifty-four percent of the federal poverty level.

   b. For up to twelve months, the parents or caretaker relatives, along with their spouses and dependent children, of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, who were eligible under the parents and caretaker relatives and their spouses category in at least three of the six months immediately preceding the month in which the parents or caretakers lose coverage under the parents and caretaker relatives and their spouses category due to increased earned income or hours of employment.

   c. For up to four months, the parents or caretaker relatives, along with their spouses and dependent children, of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, who were eligible under the parents and caretaker relative and their spouses category in at least three of the six months immediately preceding the month in which the parents or caretaker relatives lose coverage under the parents and caretaker relatives and their spouses category due to increased alimony or spousal support.

   d. A pregnant woman up to one hundred ~~forty-seven~~fifty-seven percent of the federal poverty level.

   e. An eligible woman who applied for and was eligible for Medicaid during pregnancy continues to be eligible for sixty days, beginning on the last day of pregnancy, and for the remaining days of the month in which the sixtieth day falls.

   f. A child born to an eligible pregnant woman who applied for and was found eligible for Medicaid on or before the day of the child's birth, for twelve months, beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls.

   g. A child, not including a child in foster care, from birth through five years of age up to one hundred forty-seven percent of the federal poverty level.

   h. A child, not including a child in foster care, from six through eighteen years of age, up to one hundred thirty-three percent of the federal poverty level.

   i. A child, not including a child in foster care, from six through eighteen years of age who becomes Medicaid eligible due to an increase in the Medicaid income levels used to determine eligibility.

   j. An individual who is not otherwise eligible for Medicaid and who was in title IV-E funded, state-funded, or tribal foster care in this state under in the month the individual reaches eighteen years of age, through the month in which the individual reaches twenty-six years of age.

   k. A pregnant woman who requires medical services and qualifies for Medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred ~~forty-seven~~sixty-two percent of the federal poverty level.

   l. A child less than nineteen years of age who requires medical services and qualifies for Medicaid on the basis of financial eligibility resulting in a recipient liability under section

75-02-02.1- 41.1 and whose income is above one hundred seventy percent of the federal poverty level.

m. The parents and caretaker relatives and their spouses of a deprived child who require medical services and qualify for Medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred thirty-three percent of the federal poverty level.

n. A child, not including a child in foster care, less than nineteen years of age with income up to one hundred seventy percent of the federal poverty level.

3. A physician, nurse practitioner, or physician assistant practicing in the following specialties or the following entities may be selected as a primary care provider:

a. Family practice;

b. Internal medicine;

c. Obstetrics;

d. Pediatrics;

e. General practice;

f. Adult health;

g. A rural health clinic;

~~g.~~h. A federally qualified health center; or

~~h.~~i. An Indian health services clinic or tribal health facility clinic.

4. A recipient need not select, or have selected on the recipient's behalf, a primary care provider if:

a. The recipient is aged, blind, or disabled;

b. The period for which benefits are sought is prior to the date of application;

c. The recipient is receiving foster care or subsidized adoption benefits;

d. The recipient is receiving home and community-based services; or

e. The recipient has been determined medically frail under section 75-02-02.1-14.1.

5. Payment may be made for the following medically necessary covered services whether or not provided by, or upon referral from, a primary care provider:

a. Early and periodic screening, diagnosis, and treatment of recipients under age twenty-one;

b. Family planning services;

c. Certified nurse midwife services;

d. Optometric services;

e. Chiropractic services;

f. Dental services;

g. Orthodontic services provided as the result of a referral through the early and periodic screening, diagnosis, and treatment program;

h. Services provided by an intermediate care facility for individuals with intellectual disabilities;

i. Emergency services;

j. Transportation services;

k. Targeted case management services;

l. Home and community-based services;

m. Nursing facility services;

n. Prescribed drugs except as otherwise specified in section 75-02-02-27;

o. Psychiatric services;

p. Ophthalmic services;

q. Obstetrical services;

r. Behavioral health services;

s. Services for treatment of addiction;

t. Partial hospitalization for psychiatric services;

u. Ambulance services;

v. Immunizations;

w. Independent laboratory and radiology services;

x. Public health unit services; and

y. Personal care services.

6. Except as provided in subsection 4, or unless the department exempts the recipient, a primary care provider must be selected for each recipient.

7. A primary care provider may be changed during the ninety days after the recipient's initial enrollment with the primary care provider or the date the state sends the recipient notice of the enrollment, at redetermination of eligibility, once every twelve months during the sixty-day open enrollment period, or with good cause. Good cause for changing a primary care provider less than twelve months after the previous selection of a primary care provider exists if:

   a. The recipient relocates;

   b. Significant changes in the recipient's health require the selection of a primary care provider with a different specialty;

   c. The primary care provider relocates or is reassigned;

   d. The selected provider refuses to act as a primary care provider or refuses to continue to act as a primary care provider; or

e. The department, or its agents, determines that a change of primary care provider is necessary.

History: Effective October 1, 2012; amended effective July 1, 2014; April 1, 2016; January 1, 2017; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.1-41
Law Implemented: NDCC 50-24.1-32, 50-24.1-41; 42 USC 1396u-2

75-02-02.1-24.1. Breast and cervical cancer early detection program.

The breast and cervical cancer early detection group consists of ~~women~~individuals under age sixty-five who:

1. Are uninsured and not otherwise eligible for Medicaid;

2. Have been screened for breast and cervical cancer ~~through women's way~~ under the centers for disease control and prevention's national breast and cervical cancer early detection program and have been found to require treatment for breast cancer, cervical cancer, or a precancerous condition relating to breast cancer or cervical cancer;

3. Meet the requirements of section 75-02-02.1-16, relating to residence, section 75-02-02.1-18, relating to citizenship, and section 75-02-02.1-19, relating to inmates of public institutions; and

4. Become eligible on the first day of the later of the month of diagnosis or the first month of retroactive eligibility, as provided in section 75-02-02.1-10, and continue to be eligible until they no longer require treatment for breast or cervical cancer or a precancerous condition or no longer meet the requirements of this subsection.

History: Effective July 1, 2003; amended effective April 1, 2020.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-17

CHAPTER 75-02-05
PROVIDER INTEGRITY

75-02-05-03. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Abuse" means practices that:

   a. Are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid and children's health insurance program;

   b. Elicit reimbursement for services that are not medically necessary;

   c. Are in violation of an agreement or certificate of coverage; or

   d. Fail to meet professionally recognized standards for health care.

2. "Administrative or fiscal agent" means an organization which processes and pays provider claims on behalf of the department.

3. "Affiliates" means persons having an overt or covert relationship each with the other such that any one of them directly or indirectly controls or has the power to control another.

4. "Business integrity agreement" means an agreement between the department and the provider that addresses the concerns of the department and recognizes essential elements of required compliance for the provider to preempt further sanction, exclusion from participation, or termination.

5. "Children's health insurance program" means a program to provide health assistance to low-income children funded through title XXI of the Social Security Act [42 U.S.C. 1397 aa et seq.].

6. "Client share" means the amount of monthly net income remaining after all appropriate deductions, disregards, and Medicaid income levels have been allowed. This is also referred to as recipient liability.

7. "Credible allegation of fraud" means an allegation which has been verified by the department.

8. "Department" means the department of human services' medical services, aging services, and developmental disabilities divisions.

9. "Direct owner" means someone with an active ownership interest in the disclosing entity.

10. "Disclosing entity" means a Medicaid or children's health insurance program provider, excluding an individual practitioner or group of practitioners, or a fiscal agent, that is required to provide ownership and enrollment information.

11. "Exclusion from participation" means permanent removal from provider participation in the North Dakota medical assistance or children's health insurance program.

12. "Fraud" means deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another and includes an act that constitutes fraud under applicable federal or state law.

13. "Group of practitioners" means two or more health care practitioners who practice their profession at a common location.

14. "High-risk providers" means a provider or a provider type or specialty deemed by the department as high risk, based on federal regulations, policy, and guidance.

15. "Indirect ownership interest" means disclosing ownership interest in a disclosing entity, including an ownership interest in any entity that has an indirect ownership in the disclosing entity.

16. "Institutional provider" for purposes of assessing an application fee means those defined by centers for Medicare and Medicaid services or as deemed by the department based on federal regulations, policy, and guidance.

17. "Licensed practitioner" means an individual, other than a physician who is licensed or otherwise authorized by the state to provide health care services within the practitioner's scope of practice.

18. "Loss of contact" means postal mail sent to an enrolled provider at the last known address is returned to the department.

19. "Managed care organization" means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 C.F.R. part 438, and that is:

    a. A federally qualified health management organization that meets the advance directives requirements of 42 C.F.R. 489.102; or

    b. Any public or private entity that meets the advance directives requirements and is determined by the secretary of the federal department of health and human services, or designee, to also make the services it provides to program enrollees as accessible as those services are to other Medicaid and children's health insurance program recipients within the area served by the entity and meets the solvency standards of 42 C.F.R. 438.116.

~~19.~~20. "Medicaid" means "medical assistance" and is a term precisely equivalent thereto.

~~20.~~21. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

~~21.~~22. "Person" means any natural person, company, firm, association, corporation, or other legal entity.

~~22.~~23. "Provider" means any individual or entity furnishing Medicaid or children's health insurance program services under a provider agreement with the department or managed care organization.

~~23.~~24. "Provider specialty" means the area that a provider specializes in.

~~24.~~25. "Provider type" means a general type of service or provider.

~~25.~~26. "Sanction" means an action taken by the department against a provider for noncompliance with a federal or state law, rule, or policy, or with the provisions of the Medicaid and children's health insurance program provider agreement.

~~26. "Suspension from participation" means temporary suspension of provider participation in the Medicaid program for a specified period of time.~~

27. "Suspend ~~Medicaid~~ payments" means the withholding of payments due a provider until the matter in dispute between the provider and the department is resolved.

28. "Suspension from participation" means temporary suspension of provider participation in the Medicaid program for a specified period of time.

29. "Termination" means determining a provider to be indefinitely ineligible to be a Medicaid and children's health insurance program provider.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: 42 CFR 431.107

75-02-05-04. Provider responsibility.

To assure quality medical care and services, Medicaid and children's health insurance program payments may be made only to providers meeting established standards. Providers who are certified for participation in Medicare are eligible for participation, providing no sanction has been imposed as provided for in section ~~75-02-05-08~~75-02-05-07. Comparable standards for providers who do not participate in Medicare are established by state law and appropriate licensing and standard-setting authorities in the health and mental health fields.

1. Payment for ~~covered~~ services under Medicaid and children's health insurance program is limited to those covered services that are medically necessary for the proper management, control, or treatment of an individual's medical problem and provided under the physician's or licensed practitioner's direction and supervision.

2. Each provider agrees to retain documentation to support medical services rendered for a minimum of seven years and, upon request, to make the documentation available to persons acting on behalf of the department and the United States department of health and human services. A provider shall provide the records at no charge.

3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established by the department. A provider performing a procedure or service may not request or receive any payment, in addition to the amounts established by the department, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a client share has been properly determined by a ~~county social service board~~human service zone, the provider may hold the recipient responsible for the client share.

4. A provider may not bill a recipient for services that are allowable under Medicaid or children's health insurance program, but not paid due to the provider's lack of adherence to Medicaid or children's health insurance program requirements.

5. If an enrolled Medicaid or children's health insurance program provider does not bill Medicaid for certain services, the enrolled Medicaid or children's health insurance program provider must notify all recipients of any limitation and secure acknowledgment, in writing. If the provider expressly informs the recipient, or in the case of a child, the recipient's parent or guardian, that provider would not accept Medicaid or children's health insurance program payment for certain services, the provider may bill the recipient as a private-pay client for the services.

6. No Medicaid or children's health insurance program payment will be made for claims received by the department later than twelve months following the date the service was provided. Claim adjustments submitted within twelve months of the most recent processed claim shall be considered timely.

7. The department will process claims six months past the Medicare explanation of benefits date if the provider followed Medicare's timely filing policy.

8. In all joint Medicare/Medicaid cases, a provider must accept assignment of Medicare payment to receive payment from Medicaid for amounts not covered by Medicaid and children's health insurance program.

9. When the recipient has other medical insurance, all benefits available due from that other insurance must be applied prior to the provider accepting payment by Medicaid.

10. A provider may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a Medicaid or children's health insurance program patient referral.

11. Claims for payment and documentation must be submitted as required by the department or its designee.

12. A provider shall comply with all accepted standards of professional conduct and practice in dealing with recipients and the department.

13. Each provider shall comply with all applicable centers for Medicare and Medicaid services regulations.

14. Each provider shall comply with requests for documentation from the provider's practice, that may include patient information for non-Medicaid or non-children's health insurance program recipients, which allows department staff or its authorized agent to evaluate overall scheduling, patient-to-provider ratios, billing practices, or evaluating the feasibility of services provided per day.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: 42 CFR 431.107

75-02-05-04.2. Termination of provider enrollment.

The department may terminate the enrollment of a Medicaid or children's health insurance program provider under the following circumstances:

1. The individual is enrolled to provide transportation, but does not possess a current driver's license or has a driver's license that has been suspended or revoked;

2. The enrolled provider fails to revalidate its enrollment per federal requirements and according to the re-enrollment schedule established by the department;

3. The enrolled provider or practitioner does not submit a Medicaid or children's health insurance program claim to the department for twenty-four months or more;

4. There is a loss of contact with the enrolled provider; or

5. As a result of sanction imposed in accordance with section 75-02-05-07 or North Dakota Century Code chapter 50-24.8.

History: Effective April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-24.1-36, 50-29-02
Law Implemented: NDCC 50-24.1-36; 42 CFR 431.107

75-02-05-07. Activities leading to and including sanction.

1. a. When the department determines that a provider has been rendering care or services in a form or manner inconsistent with program requirements or rules, or has received payment for which the provider may not be properly entitled, the department shall notify the provider in writing of the discrepancy noted. The notice to the provider may set forth:

(1) The nature of the discrepancy or inconsistency.

(2) The dollar value, if any, of such discrepancy or inconsistency.

(3) The method of computing such dollar values.

(4) Further actions which the department may take.

(5) Any action which may be required of the provider.

b. When the department has notified the provider in writing of a discrepancy or inconsistency, it may withhold payments on pending and future claims awaiting a response from the provider.

2. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the department may require the provider to participate in and complete an educational program.

a. If the department decides that a provider should participate in an educational program, the department shall provide written notice to the provider, by certified mail, setting forth the following:

(1) The reason the provider is being directed to attend the educational program;

(2) The educational program determined by the department; and

(3) That continued participation as a provider in Medicaid and children's health insurance program is contingent upon completion of the educational program identified by the department.

b. An educational program may be presented by the department. The educational program may include:

(1) Instruction on the correct submission of claims;

(2) Instruction on the appropriate utilization of services;

(3) Instruction on the correct use of provider manuals;

(4) Instruction on the proper use of procedure codes;

(5) Education on statutes, rules, and regulations governing the Medicaid and children's health insurance program;

(6) Education on reimbursement rates and payment methodologies;

(7) Instructions on billing or submitting claims; and

(8) Other educational tools identified by the department.

3. If a provider who is required to participate in an educational program refuses to participate in that program, the department shall suspend the provider from participation in Medicaid and children's health insurance program until the provider successfully completes the required program. The time frame to successfully complete the educational program may be extended upon provider request and with department approval.

4. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the department may require the provider to implement a business integrity agreement. If the department requires a provider to enter a business integrity agreement and the provider refuses, the department shall ensure the provider is suspended from participation in Medicaid and children's health insurance program until the provider implements the required agreement.

5. The department shall suspend ~~Medicaid~~ payments to a provider after the department determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid and children's health insurance program unless the provider has demonstrated good cause why the department should not suspend ~~Medicaid~~ payments or should suspend ~~Medicaid~~ payment only in part. If the provider also is enrolled in a managed care organization under contract with the department, the managed care organization must suspend all Medicaid payments to the provider.

6. The department may not make payments to a provider that is not complying with a department-directed repayment plan. Recoveries may be taken across any Medicaid program payment and delivery system.

7. The director of the medical services division, or the director's designee, shall determine the appropriate sanction for a provider under this chapter. The following may be considered in determining the sanction to be imposed:

a. Seriousness of the provider's offense.

b. Extent of the provider's violations.

c. Provider's history of prior violations.

d. Prior imposition of sanctions against the provider.

e. Prior provision of information and training to the provider.

f. Provider's agreement to make restitution to the department.

g. Actions taken or recommended by peer groups or licensing boards.

h. Access to care for recipients.

i. Provider's self-disclosure or self-audit discoveries.

j. Provider's willingness to enter a business integrity agreement.

~~7.~~8. When a provider has been excluded from the Medicare program, the provider will also be terminated or excluded from participation in the Medicaid and children's health insurance program.

~~8.~~9. If the division determines there is a credible allegation of fraud, the division may impose any one or a combination of the following temporary sanctions:

a. Prepayment review of claims;

b. Postpayment review of claims;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Notification and referral to the appropriate state regulatory agency or licensing agency;

f. Suspension from participation in the Medicaid or children's health insurance program, including providers operating under an arrangement with a managed care organization;

g. Suspend ~~Medicaid~~ payments to a provider;

h. Prior authorization of all services; and

i. Peer review at the provider's expense.

~~9.~~10. After the completion of a further investigation, the department shall document its findings in writing and provide a copy of that documentation to the provider. Following a determination by the department that the provider has engaged in fraud or abuse; the department may terminate, exclude or impose sanctions with conditions, including the following:

a. Recovery of overpayments;

b. Recovery of excess payments;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Prepayment review of claims;

f. Postpayment review of claims;

g. Notification and referral to the appropriate state regulatory agency or licensing agency;

h. Prior authorization of all services;

i. Penalties as established by the department; and

j. Peer review at the provider's expense.

~~10.~~11. A sanction may be applied to all known affiliates of a provider, provided that each sanctioned affiliate knew or should have known of the violation.

~~11.~~12. A provider subject to termination or exclusion from participation may not submit claims for payment, either personally or through claims submitted by any clinic, group, corporation, or

other association to the department, its fiscal agent or managed care organization for any services or supplies provided under the Medicaid or children's health insurance program except for any services or supplies provided prior to the effective date of the termination or exclusion.

~~12.~~13. A clinic, group, corporation, or other organization which is a provider may not submit claims for payment to the department or its fiscal agent for any services or supplies provided by a person within the clinic, group, corporation, or organization who has been terminated or is under exclusion from participation in this state or any other state or who has been excluded from Medicare except for those services or supplies provided prior to the effective date of the termination or exclusion.

~~13.~~14. When the department determines there is a need to sanction a provider, the director of the medical services division, or the director's designee, shall notify the provider in writing of the sanction imposed. The notice must advise the provider of the right to a review, when applicable.

~~14.~~15. After the department sanctions a provider, the director of the medical services division may notify the applicable professional society, board of registration or licensure, and any appropriate federal, state, human service zone, or county agency of the reasons for the sanctions and the sanctions imposed.

~~15.~~16. If the department sanctions a provider who also serves as a billing agent for other providers, the department may also impose sanctions against the other providers upon a finding that the actions performed as the billing agent fails to meet department standards.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2014; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-24.1-36, 50-29-02
Law Implemented: NDCC 50-24.1-04, 50-24.1-36; 42 CFR 455.13, 42 CFR 455.14, 42 CFR 455.15, 42 CFR 455.16, 42 CFR 455.17, 42 CFR 455.23

75-02-05-09. Review and appeal.

1. A provider may not request a review of a temporary sanction until further investigation has been completed and the department has made a final decision.

2. After completion of further investigation, if there is an imposition of a subsequent sanction, the provider may request a review of the sanction pursuant to subsection 6 of North Dakota Century Code section 50-24.1-36.

3. A provider who is aggrieved by the decision the department issues in response to a request for review may appeal as set forth in subsection 6 of North Dakota Century Code section 50-24.1-36.

4. An applicant may appeal a decision to deny enrollment or terminate provider enrollment by filing a written appeal with the department within fifteen days of the date of the written notice of the denial or termination. Upon receipt of a timely appeal, an administrative hearing may be conducted in the manner provided in chapter 75-01-03. An applicant who receives notice of denial and requests a timely review of that decision is not eligible to provide services until a final decision has been made by the department that reverses the decision to deny the application.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2014; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-09-02, 50-24.1-04

Law Implemented: NDCC 23-01-03, 23-16-01, 23-17.1-01, 23-20.1-04, 23-27-01, 25-16-02, 26.1-18-02, 43-05-09, 43-06-08, 43-12.1-03, 43-13-15, 43-15-15, 43-17-34, 43-26-13, 43-28-10, 43-32-17, 43-33-02, 43-37-03, 50-11.1-03, 50-24.1-36; NDAC 75-01-03; 42 USC 1396a(a)(39); 42 CFR 431.151; 42 CFR 455.13

ARTICLE 75-03
COMMUNITY SERVICES

CHAPTER 75-03-38
AUTISM SPECTRUM DISORDER VOUCHER PROGRAM

75-03-38-02. Eligibility.

1. A parent, custodian, or legal guardian may apply to the division to participate in the voucher program if all the following conditions are met:

   a. The child has an autism spectrum disorder diagnosis;

   b. The child's age is from three years through seventeen years;

   c. The household has an income below two hundred percent of the federal poverty level;

   d. The child is not currently served under any of the department's waivers;

   e. ~~The child has been recommended for voucher support by a qualified professional;~~

   ~~f.~~ The child's support need cannot be obtained through insurance or through other service systems, including educational and behavioral health systems;

   ~~g. The item or support requested is cost-effective in meeting the child's needs;~~

   ~~h.~~f. The child's needs cannot be met by a generic service or support;

   ~~i.~~g. The child lives with the child's parent, custodian, or legal guardian; and

   ~~j.~~h. The child is currently a North Dakota resident for at least six months.

2. ~~Voucher support approved for a child with an autism spectrum diagnosis under this chapter may not exceed twelve thousand five hundred dollars per state fiscal year.~~

~~3.~~ The department shall review complete voucher applications in the order received, and shall only approve voucher applications ~~based on the voucher slots available and~~ within the limits of legislative appropriations.

History: Effective July 1, 2014; amended effective April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-32.1
Law Implemented: NDCC 23-01-41, 50-06-32.1

75-03-38-04. Voucher ~~services~~administration.

1. ~~The division may approve an application for one state fiscal year.~~

2. ~~The division shall review the application for completeness and will determine the child's eligibility for voucher supports.~~ Voucher support approved for a child with an autism spectrum

diagnosis under this chapter may not exceed twelve thousand five hundred dollars per state fiscal year.

~~3.~~2. Upon approval of the application, the division shall issue a voucher request form to be completed by the parent, custodian, or legal guardian of the eligible child indicating the specific item or service being requested. A description of each item or service requested, from a provider working with the eligible child, must accompany the voucher request form, stating how the item or service will compensate for a deficit created by an autism spectrum disorder.

~~4.~~3. The division may approve a voucher request for a one-time purchase or for ~~multiple purchases~~a recurring purchase not to exceed the maximum amount in subsection 1. The difference between the maximum amount of funding permitted in subsection 1 and the amount approved may be used to fund additional voucher requests.

~~5.~~4. If a voucher is approved for ~~multiple~~recurring purchases, the division will monitor the voucher for activity.

~~6.~~5. If the voucher is not used for ~~one hundred eighty~~sixty consecutive calendar days, the division shall inform the parent, custodian, or legal guardian that, if an additional thirty calendar days pass without a voucher purchase or request for item or service, the voucher will be terminated. ~~Any~~Unspent funds from a terminated voucher ~~that are unspent~~ must be returned to the voucher program and the division may distribute the funds to another applicant.

~~7.~~6. A voucher application may be denied if approving the application, item, or service would exceed the limits of legislative appropriations. A voucher may be terminated if the funding awarded under the voucher is exhausted.

~~8.~~7. The voucher funds may not be used for:

a. Items or services that are parental responsibilities, including daily clothing, upkeep of residence, fences, internet, or utilities.

b. Duplicate items or services that address identical deficit goals, except for disposable items;

c. Items or services that are not age appropriate;

d. Items or services that are not connected to the child;

e. Items or services covered by insurance;

f. Items or services if the voucher is terminated;

g. Items or services that put the health and safety of the child at risk;

h. Replacement items, except for disposable products, such as sensory or tactile stimulation items; ~~and~~

i. Items that are restricted within property rental agreements or are the responsibility of landlords, tenants, or the homeowner;

j. Items that would cause a parent, custodian, or legal guardian to have additional or recurring costs; and

k. Service animals or emotional support animals and related items.

8. Items or supports requested through the voucher program must be cost-effective in meeting the child's needs.

9. Voucher funds are not available until the division approves the purchase request form.

History: Effective July 1, 2014; amended effective April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-32.1
Law Implemented: NDCC 50-06-32.1

CHAPTER 75-03-42
AUTHORIZED ELECTRONIC MONITORING

75-03-42-01. Definitions.

The terms used in this chapter have the same meanings as in North Dakota Century Code section 50-10.2-01. In addition, as used in this chapter, unless the context or subject matter otherwise requires, "roommate" means a resident occupying the same room as the resident requesting to install and use an authorized electronic monitoring device.

History: Effective April 1, 2020.
General Authority: NDCC 50-10.1-03, 50-10.2-02.1, 50-10.2-03
Law Implemented: NDCC 50-10.2-02.1, 50-10.2-03

75-03-42-02. Determination of capacity to consent.

1. A resident is presumed to have the capacity to consent to authorized electronic monitoring if the resident understands and appreciates the nature and consequences of the decision to consent to authorized electronic monitoring, including the benefits and risks of the decision. If a resident has capacity to consent, only the resident may consent to authorized electronic monitoring in the resident's room.

2. A resident's lack of capacity to consent to authorized electronic monitoring must be documented in writing by the resident's attending physician or by a court order pursuant to North Dakota Century Code chapter 30.1-28. If the resident is not under a guardianship, the attending physician also shall document in writing if the resident regains the capacity to consent to authorized electronic monitoring.

3. If a resident is determined to lack capacity to consent to authorized electronic monitoring, the resident representative may consent to authorized electronic monitoring and complete the required forms.

4. The resident representative shall make the decision of whether to consent to authorized electronic monitoring in the resident's room in accordance with the resident's wishes, values, preferences, and directions.

5. If a facility has reason to believe a resident representative is making decisions or taking actions that are not in the best interests of a resident regarding the use of authorized electronic monitoring, the facility shall report this concern in the manner required to the department or the department's designee.

History: Effective April 1, 2020.
General Authority: NDCC 50-10.1-03, 50-10.2-02.1, 50-10.2-03
Law Implemented: NDCC 50-10.2-02.1, 50-10.2-03

75-03-42-03. Documentation.

1. The forms and information relating to authorized electronic monitoring must be provided by the facility upon request in a language, form, and manner residents, resident representatives, and visitors can access and understand.

2. At the request of the resident or the resident representative, the facility shall provide a copy of the facility's standards and regulations regarding the installation, use, maintenance, disabling, and removal of the authorized electronic monitoring device to the resident or resident representative.

3. Before the use of authorized electronic monitoring or the installation of an authorized electronic monitoring device, the resident or resident representative shall submit the following documentation to the facility:

   a. A written notice to the facility of the intent to place and use an authorized electronic monitoring device, including an installation plan that complies with the facility's standards and regulations.

   b. A statement that the facility is not civilly or criminally liable for a violation of any resident's right to privacy arising from authorized electronic monitoring.

   c. A written consent form for placement and use of an authorized electronic monitoring device signed by the existing or proposed roommate or roommate's resident representative. The form must:

      (1) Allow the roommate or roommate's resident representative to specify any conditions or restrictions the roommate or roommate's resident representative may elect to place on the device's time of operation, direction, and focus, including verifying the viewing area captured by the camera, prohibiting audio, and turning off the authorized electronic monitoring device during certain times when total privacy is wanted.

      (2) State the roommate or roommate's resident representative has the right to withdraw consent at any time in writing and have the device disabled in compliance with the facility's standards and regulations after receipt of the written withdrawal.

      (3) State the facility may not be held civilly or criminally liable for a violation of the roommate's right to privacy arising out of authorized electronic monitoring conducted by the resident or the resident representative.

   d. An authorization signed by the existing or proposed roommate or roommate's resident representative for the disclosure of protected health information in compliance with title 45, Code of Federal Regulation, parts 160 and 164.

4. The facility shall maintain a copy of the applicable consent and authorization forms submitted pursuant to this section.

History: Effective April 1, 2020.
General Authority: NDCC 50-10.1-03, 50-10.2-02.1, 50-10.2-03
Law Implemented: NDCC 50-10.2-02.1, 50-10.2-03

75-03-42-04. Signs.

A facility shall clearly and conspicuously post a sign where authorized electronic monitoring is being conducted to alert and inform other residents, staff, and visitors to the facility. The sign must be provided in a language, form, and manner residents, staff, and visitors can access and understand.

History: Effective April 1, 2020.
General Authority: NDCC 50-10.1-03, 50-10.2-02.1, 50-10.2-03
Law Implemented: NDCC 50-10.2-02.1, 50-10.2-03

75-03-42-05. Use of internet and responsibilities.

1. The resident or resident representative shall select the type of monitoring device that will be used in the resident's room, accounting for any restrictions imposed by the roommate or roommate's resident representative. If the resident or resident representative chooses to install a monitoring device that uses internet technology, the monitoring device must have at least one hundred twenty-eight-bit encryption and enable a secure socket layer.

2. The resident or resident representative is responsible to contract with an internet provider if that is needed to operate the authorized electronic monitoring device and shall comply with facility's standards and regulations. The facility is not required to allow internet access through facility or corporate networks that maintain confidential patient, medical, financial, or personnel records.

History: Effective April 1, 2020.
General Authority: NDCC 50-10.1-03, 50-10.2-02.1, 50-10.2-03
Law Implemented: NDCC 50-10.2-02.1, 50-10.2-03

CHAPTER 75-04-01

75-04-01-01. Definitions.

In this chapter, unless the context or subject matter requires otherwise:

1. "Accreditation" means recognition by a national organization of a licensee's compliance with a set of specified standards.

2. "Applicant" means an entity which has requested licensure from the North Dakota department of human services pursuant to North Dakota Century Code chapter 25-16.

3. "Basic services" means those services required to be provided by an entity in order to obtain and maintain a license.

4. "Client" means an individual found eligible as determined through the application of North Dakota Administrative Code chapter 75-04-06 for services coordinated through intellectual disabilities - developmental disabilities program management, on whose behalf services are provided or purchased.

5. "Client-authorized representative" means a person who has legal authority, either designated or granted, to make decisions on behalf of the client.

6. "Day habilitation" means a day program of scheduled activities, formalized training, and staff supports to promote skill development for the acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities should focus on improving a client's sensory, motor, cognitive, communication, and social interaction skills.

7. "Department" means the North Dakota department of human services.

8. "Developmental disability" means a severe, chronic disability of an individual which:

    a. Is attributable to a mental or physical impairment or combination of mental and physical impairments, including Down syndrome;

    b. Is manifested before the individual 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 individual'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.

9. "Employment support" means ongoing supports to assist clients in obtaining and maintaining paid employment in an integrated setting. Services are designed for clients who need intensive ongoing support to perform in a work setting. Service includes on-the-job or off-the-job employment-related support for clients needing intervention to assist them in maintaining employment, including job development. Employment support includes individual employment support and small group employment support.

10. "Family member" means relatives of a client to the second degree of kinship.

11. "Family support services" means a family-centered support service contracted based on the client's or primary caregiver's need for support in meeting the health, developmental, and safety needs to remain in an appropriate home environment. Family support services ~~may include~~includes parenting support, extended home health care, in-home supports, and family care option.

12. "Generic service" means a service that is available to any member of the population and is not specific to meeting specialized needs of individuals with intellectual disabilities or developmental disabilities.

13. "Governing body" means the individual or individuals designated in the articles of incorporation of a corporation or constitution of a legal entity as being authorized to act on behalf of the entity.

14. "Group home" means any community residential service facility, licensed by the department pursuant to North Dakota Century Code chapter 25-16, housing more than three individuals with developmental disabilities. "Group home" does not include a community complex with self-contained rental units.

15. ~~"Independent habilitation" means formalized training and staff supports provided to clients on less than a daily basis. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the client's ability to independently reside and participate in an integrated community.~~

~~16.~~ "Infant development" means a systematic application of an individualized family service plan designed to alleviate or mediate developmental delay of the client from birth through age two.

~~17.~~16. "Intellectual disability" means a diagnosis of the condition of intellectual disability, based on an individually administered standardized intelligence test and standardized measure of adaptive behavior as accepted by the American psychiatric association, and made by an appropriately licensed professional.

~~18.~~17. "Intermediate care facility for individuals with intellectual disabilities" means a residential health facility operated pursuant to title 42, Code of Federal Regulations, parts 442 and 483, et seq.

~~19.~~18. "License" means authorization by the department to provide a service to individuals with developmental disabilities, pursuant to North Dakota Century Code chapter 25-16.

~~20.~~19. "Licensee" means that entity which has received authorization by the department, pursuant to North Dakota Century Code chapter 25-16, to provide a service or services to individuals with developmental disabilities.

~~21.~~20. "Prevocational services" means formalized training, experiences, and staff supports designed to prepare clients for paid employment in integrated community settings. Services are structured to develop general abilities and skills that support employability in a work setting. Services are not directed at teaching job-specific skills, but at specific habilitative goals outlined in the client's person-centered service plan.

~~22.~~21. "Primary caregiver" means a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization in meeting the needs of the client and who is not employed by or working under contract of a provider agency licensed pursuant to this chapter.

~~23.~~22. "Principal officer" means the presiding member of a governing body, a chairperson, or president of a board of directors.

~~24.~~23. "Program management" means a process of interconnected steps which will assist a client in gaining access to needed services, including medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

~~25.~~24. "Provider agency" means the organization or individual who has executed a Medicaid agreement with the department to provide services to individuals with developmental disabilities.

~~26.~~25. "Resident" means an individual receiving services provided through any licensed residential facility or service.

~~27.~~26. "Residential ~~habilitation~~services" means formalized training and supports provided to clients ~~who require some level of ongoing daily support. This service is designed~~ to assist with and develop self-help, socialization, and adaptive skills that improve the client's ability to independently reside and participate in an integrated community. Residential services include residential rehabilitation and independent habilitation.

~~28.~~27. "Standards" means requirements which result in accreditation by the council on quality and leadership in supports for people with disabilities, certification as an intermediate care facility for individuals with intellectual disabilities, or for employment supports results in accreditation by the commission on accreditation of rehabilitation facilities.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; April 1, 2000; July 1, 2001; July 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-18, 25-16-06

75-04-01-17. Identification of basic services subject to licensure.

Services provided to eligible clients must be identified and licensed by the following titles:

1. Residential ~~habilitation~~ services:
   a. Residential habilitation; or
   b. Independent habilitation;
2. Day habilitation;
3. ~~Independent habilitation services;~~
~~4.~~ Intermediate care facility for individuals with intellectual disabilities;
~~5.~~4. Employment supports:
   a. Individual employment supports; or
   b. Small group employment supports;
~~6.~~5. Prevocational services;

~~7.~~6. Family support services:

a. Parenting supports;

b. In-home supports;

c. Extended home health care; or

d. Family care option; or

~~8.~~7. Infant development services.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; July 1, 1996; July 1, 2001; July 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-06

75-04-01-23. Safety codes.

1. Applicant's intermediate care facilities for individuals with intellectual disabilities shall meet the provisions of either the health care occupancies chapters or the residential board and care occupancies chapter of the Life Safety Code of the national fire protection association, 2000 edition, as determined by the department.

2. Applicant's ~~residential service~~group home facilities which are not intermediate care facilities for individuals with intellectual disabilities shall meet the applicable life safety standards established by the local governing municipality's ordinances. If the local governing municipality has no ordinances establishing life safety standards, the ~~residential service~~group home facilities shall meet the one-family and two-family dwellings chapter of the Life Safety Code of the national fire protection association, 2000 edition, as determined by the department.

3. Upon written application, and good cause shown to the satisfaction of the department, the department may grant a variance from any specific requirement of the Life Safety Code, upon terms the department may prescribe, except no variance may permit or authorize a danger to the health or safety of the residents of the facility.

4. Applicant's facilities housing individuals with multiple physical disabilities or impairments of mobility shall conform to American National Standards Institute Standard No. A117.1 (1980), or, if remodeled or newly constructed after July 1, 1995, with appropriate standards as required by the Americans with Disabilities Act of 1990, Public Law 101-336.

5. Applicant's and licensee's buildings used to provide day services must conform to the appropriate occupancy chapters of the Life Safety Code of the national fire protection association, 2000 edition, as determined by the department and must meet applicable accessibility standards as required by the Americans with Disabilities Act of 1990, Public Law 101-336. The selection of an appropriate Life Safety Code chapter shall be determined considering:

a. Primary activities in the facility;

b. The ability of clients occupying the facility to take action for self-preservation in an emergency; and

c. Assistance available to clients occupying the facility for evacuation in an emergency.

6. All licensed day service facilities must be surveyed for Life Safety Code compliance at least annually. The department must be notified and a resurvey may be required if any of the following conditions are present between annual inspections:

a. Occupancy increases of ten percent or more;

b. Primary usage of the facility changes;

c. Hazardous materials or processes are introduced into the facility;

d. Building alterations or modifications take place;

e. Clients requiring substantial assistance to evacuate in an emergency are enrolled;

f. There are public or client concerns about safety conditions; or

g. Other changes occur in physical facilities, activities, materials and contents, or numbers and capabilities of clients enrolled which may affect safety in an emergency.

History: Effective April 1, 1982; amended effective June 1, 1986; August 1, 1987; December 1, 1995; April 1, 2000; May 1, 2004; July 1, 2012; April 1, 2020.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-06

CHAPTER 75-04-05

75-04-05-01. Definitions.

In this chapter, unless the context or subject matter requires otherwise:

1. ~~"Absence factor" means a cost component of the residential habilitation direct care rate intended to cover costs when a client is not in the residence.~~

~~2.~~ "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of costs in the period when incurred, regardless of when they are paid.

~~3.~~2. "Administrative costs" means those costs that are necessary to operate the business but are not client related.

~~4.~~3. "Allowable cost" means the program's actual and reasonable cost after appropriate adjustments for nonallowable costs, income, offsets, and limitations.

~~5.~~4. "Assessment score" means the client's score from the standard assessment tool administered by the department or its designee.

~~6.~~5. "Bad debts" means those amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing covered services that are eligible for payment through Medicaid federal financial participation.

~~7.~~6. "Basic services" means all of the services that provider agencies deliver to clients, including nondevelopmental disabilities services.

~~8.~~7. "Board" means all food and dietary supply costs.

~~9.~~8. "Capital asset" means a facility's buildings, land improvements, fixed equipment, movable equipment, leasehold improvements, and all additions to or replacements of those assets used for client care.

~~10.~~9. "Client" means an individual found eligible as determined through the application of chapter 75-04-06 for services coordinated through developmental disabilities program management on whose behalf services are provided or purchased.

~~11.~~10. "Client-authorized representative" means a person who has legal authority, either designated or granted, to make decisions on behalf of the client.

~~12.~~11. "Client representative" means a client-authorized representative or relative who has maintained significant contacts with the client.

~~13.~~12. "Community contribution" means a contribution to a civic organization or sponsorship of community activities. Community contribution does not include a donation to a charity.

~~14.~~13. "Cost center" means a division, department, or subdivision thereof, group of services or employees or both, or any unit or type of activity into which functions of a provider agency are divided for purposes of cost assignment and allocations.

~~15.~~14. "Day habilitation" means a day program of scheduled activities, formalized training, and staff supports to promote skill development for the acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities must focus on improving a client's sensory motor, cognitive, communication, and social interaction skills.

~~16.~~15. "Department" means the North Dakota department of human services.

~~17.~~16. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

~~18.~~17. "Depreciable asset" means a capital asset or other asset for which the cost must be capitalized for statement of costs purposes.

~~19.~~18. "Depreciation guidelines" means the American hospital association's guidelines as published by American hospital publishing, inc., in the most recently published "Estimated Useful Lives of Depreciable Hospital Assets".

~~20.~~19. "Direct care staff" means employees who are actively providing support to clients receiving a service from a provider agency.

~~21.~~20. "Direct care wage" means the wage level that is used as the basis of the payment system.

~~22.~~21. "Direct program support costs" means costs that are specific to the service provision of a client, including medical and program supplies.

~~23.~~22. "Documentation" means the furnishing of written or electronic records, including original invoices, contracts, timecards, and workpapers prepared to complete reports or for filing with the department.

~~24.~~23. "Employment-related expenses" means employee benefits, including federal Insurance Contributions Act, unemployment insurance, medical insurance, workers' compensation, retirement, disability, long-term care insurance, dental, vision, life, accrued paid time off, and unrecovered medical costs furnished at the provider agency's cost.

~~25.~~24. "Employment support" means ongoing supports to assist clients in obtaining and maintaining paid employment in an integrated setting. Services are designed for clients who need intensive ongoing support to perform in a work setting. Service includes on-the-job or off-the-job employment-related support for clients needing intervention to assist them in maintaining employment, including job development. Employment support includes individual employment support and small group employment support.

~~26.~~25. "Facility-based" means a facility for individuals with developmental disabilities licensed by the department to provide day services. This definition is not to be construed to include areas of the building determined by the department to exist primarily for nontraining.

~~27.~~26. "Fair market value" means value at which an asset could be sold in the open market in an arm's-length transaction between unrelated parties.

~~28.~~27. "Fixed equipment" means equipment used for client care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

~~29.~~28. "Generally accepted accounting principles" means the accounting principles approved by the American institute of certified public accountants.

~~30.~~29. "Group home" means any community residential service facility, licensed by the department pursuant to North Dakota Century Code chapter 25-16, housing more than three individuals with developmental disabilities. "Group home" does not include a community complex with self-contained rental units.

~~31.~~30. "Historical cost" means those costs incurred and recorded on the facility's accounting records as a result of an arm's-length transaction between unrelated parties.

~~32.~~31. "Hospital leave day" means any day that a client is not in the facility, but is in an acute care setting as an inpatient and is expected to return to the facility. A hospital leave day is only

available to clients residing in an intermediate care facility for ~~the intellectually disabled~~individuals with intellectual disabilities.

~~33.~~32. "In-house day" means a day that a client was actually receiving services in the intermediate care facility ~~or residential habilitation~~for individuals with intellectual disabilities setting and was not on therapeutic leave, in the hospital, or absent.

~~34. "Independent habilitation" means formalized training and staff supports provided to clients on a less than daily basis. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the client's ability to independently reside and participate in an integrated community.~~

~~35.~~33. "Indirect program support costs" means costs that are neither direct care nor administrative, such as program development, supervision and quality assurance, and are not separately billable.

~~36.~~34. "In-home supports" means supports for a client residing with their primary caregiver and their family to prevent or delay unwanted out-of-home placement. Services may assist the client in activities of daily living, and help with maintaining health and safety.

~~37.~~35. "Interest" means the cost incurred with the use of borrowed funds.

~~38.~~36. "Intermediate care facility for individuals with intellectual disabilities" means a residential health facility operated pursuant to title 42, Code of Federal Regulations, parts 442 and 483, et seq.

~~39.~~37. "Land improvements" means any improvement to the land surrounding the facility used for client care and identified as such in the depreciation guidelines.

~~40.~~38. "Life-changing event" means a change in a client's life that will affect his or her support needs for six months or more, including a significant medical event, a crisis situation, a change in living arrangement, aging caregiver, significant medical or behavioral health event in the life of a caregiver, significant change in family functioning, or trauma.

~~41.~~39. "Medical assistance program" means the program that pays the cost of medical care and other services to eligible clients pursuant to North Dakota Century Code chapter 50-24.1.

~~42.~~40. "Movable equipment" means movable care and support services equipment generally used in a facility, including equipment identified as major movable equipment in the depreciation guidelines.

~~43.~~41. "Net investment in fixed assets" means the cost, less accumulated depreciation and the balance of notes and mortgages payable.

~~44.~~42. "Other asset" means any asset that has a life of more than one year and has a cost of five thousand dollars or greater.

~~45.~~43. "Parenting supports" means assisting clients who are or will be parents in parenting skills training that is individualized to assist with focusing on the health, welfare, and developmental needs of their child.

~~46.~~44. "Person-centered service plan" means an individual plan that identifies service needs of the eligible client, the services to be provided, and is developed by the client or client-authorized representative, or both, client select team, and developmental disabilities program manager considering all relevant input.

~~47.~~45. "Personal assistance retainer" means a payment used in residential habilitation to allow continued reimbursement during a client's temporary absence from the setting. The personal assistance retainer allows for payment while a client is hospitalized or otherwise away from the setting to ensure stability and continuity of staffing.

46. "Prevocational services" means formalized training, experiences, and staff supports designed to prepare clients for paid employment in integrated community settings. Services are structured to develop general abilities and skills that support employability in a work setting. Services are not directed at teaching job-specific skills, but at specific habilitative goals outlined in the client's person-centered service plan.

~~48.~~47. "Program support" means the direct and indirect program support costs that support providing services to a client.

~~49.~~48. "Program support staff" means employees whose duties are associated with client care but who are not actively providing direct support services to clients receiving a service from a provider agency.

~~50.~~49. "Property costs" means the cost category for allowable costs to operate the owned or leased property.

~~51.~~50. "Provider agency" means the organization or individual who has executed a Medicaid agreement with the department to provide services to individuals with developmental disabilities.

~~52.~~51. "Reasonable cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

~~53.~~52. "Related organization" means an organization which a provider agency is, to a significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider agency. Control exists when an individual or an organization has the power, directly or indirectly, significantly to influence or direct the action or policies of an organization or institution.

~~54.~~53. "Relief staff" means the replacement of direct care staff when the regular direct care staff are on leave and there is a cost component in the direct care hourly rate that covers the cost of relief staff.

~~55.~~54. "Residential ~~habilitation~~services" means formalized training and supports provided to clients ~~who require some level of ongoing daily support. This service is designed~~ to assist with and develop self-help, socialization, and adaptive skills that improve the client's ability to independently reside and participate in an integrated community. Residential services include residential habilitation and independent habilitation.

~~56. "Residential services" means services provided in an intermediate care facility for individuals with intellectual disabilities or residential habilitation.~~

~~57.~~55. "Room" means the cost associated with the provision of shelter, housekeeping staff or purchased housekeeping services and the maintenance thereof, including depreciation and interest or lease payments of a vehicle used for transportation of clients.

~~58.~~56. "Service" means the provision of living arrangements and programs of daily activities subject to licensure by the department.

~~59.~~57. "Staff training" means an organized program to improve staff performance.

~~60.~~58. "Statement of costs" means the department-approved form for reporting costs, statistical data, and other relevant information of the provider agency.

~~61.~~59. "Statement of costs year" means the fiscal year from July first through June thirtieth.

~~62.~~60. "Therapeutic leave day" means any day that a client is not in the intermediate care facility for individuals with intellectual disabilities, nursing facility, swing-bed facility, transitional care unit, subacute unit, another intermediate care facility for individuals with intellectual disabilities, a basic care facility, or an acute care setting, or if not in an institutional setting, is not receiving home- and community-based waiver services and is expected to return to the facility. A therapeutic leave day is only available to clients residing in an intermediate care facility for the intellectually disabled.

~~63.~~61. "Top management personnel" means owners; board members; corporate officers; general, regional, and district managers; administrators; and any other person performing functions ordinarily performed by such personnel.

~~64.~~62. "Units of service" for billing purposes means:

a. (1) In residential ~~services~~habilitation and intermediate care facility for individuals with intellectual disabilities, one client served for one 24-hour day;

(2) In day habilitation, prevocational services, employment supports, and independent habilitation settings, one client served for fifteen minutes; or

(3) In parenting supports and in-home support settings, one client served for one hour.

b. The day of admission and the day of death, but not the day of discharge, are treated as a day served for residential ~~services~~habilitation and intermediate care facility for individuals with intellectual disabilities.

~~65.~~63 "Vacancy factor" means ~~an opening in residential services where a client has not been admitted. A vacancy can occur when a client leaves a residence with no intent to return, or in a residence that has capacity for more clients than those who are currently living in the residence~~a cost component of the residential habilitation and intermediate care facility for individuals with intellectual disabilities rate intended to cover costs when a client is no longer in the setting, with no intent to return.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 2001; May 1, 2006; July 1, 2010; January 1, 2013; April 1, 2018; April 1, 2020.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-08. Financial reporting requirements.

1. **Records.**

a. The provider agency shall maintain on the premises the required census records and financial information sufficient to provide for a proper state and federal audit or review. Data must be available for any cost on the statement of costs as of the audit date to fully support the statement item.

b. If several programs are associated with a group and their accounting and reports are centrally prepared, additional fiscal information must be submitted for costs, undocumented at the reporting facility, with the statement of costs or provided prior to the audit or review of the facility. Accounting or financial information regarding related organizations must be readily available to substantiate cost.

c. Each provider agency shall maintain, for a period of not less than six years following the date of submission of the statement of costs to the department, financial and statistical records of the period covered by such statement of costs which are accurate and in sufficient detail to substantiate the cost data reported. If an audit has begun, but has not been finally resolved, the financial and statutory records relating to the audit must be retained until final resolution. Each provider agency shall make such records available upon reasonable demand to representatives of the department or to the secretary of health and human services or representatives thereof.

2. **Census records.**

a. Adequate census records for all clients, regardless of payer source, must be prepared and maintained on a daily basis by the provider agency to allow for proper audit of the census data. The daily census records must include:

(1) Identification of the client;

(2) Entries for all days that services are offered, including the duration of service, and not just by exception; and

(3) Identification of type of day, i.e., hospital, personal assistance retainer, or in-house day.

b. A maximum of fifteen days per occurrence may be allowed for payment by the medical assistance program for hospital leave day in an intermediate care facility for individuals with intellectual disabilities. Hospital leave days in excess of fifteen consecutive days are not billable to the medical assistance program.

c. A maximum of thirty therapeutic leave days per client per calendar year may be allowed for payment by the medical assistance program in an intermediate care facility for individuals with intellectual disabilities. Therapeutic leave days in excess of thirty per calendar year are not billable to the medical assistance program.

d. A maximum of thirty personal assistance retainer days per client per calendar year may be allowed for payment by the medical assistance program in residential habilitation. Personal assistance retainer days in excess of thirty per calendar year are not billable to the medical assistance program.

3. **Accounting and reporting requirements.**

a. The accounting system must be double entry.

b. The basis of accounting for reporting purposes must be accrual in accordance with generally accepted accounting principles. Ratesetting procedures will prevail if conflicts occur between ratesetting procedures and generally accepted accounting principles.

c. To properly facilitate auditing, the accounting system must be maintained in a manner that will allow cost accounts to be grouped by cost center and readily traceable to the statement of costs.

d. A provider agency who offers intermediate care facility for individuals with intellectual disability services may have an independent certified public accountant or the department complete an audit of the provider agency during the statement of costs year of each year to ensure the provider agency is in compliance with applicable state and federal regulations.

e. For each provider agency that chose to have an independent certified public accountant complete a department compliance audit report in compliance with state and federal regulations, shall provide to the department no later than October first of each year:

(1) A statement of costs for the statement of cost year on forms prescribed by the department.

(2) A copy of an audited report of the provider agency's financial records from an independent certified public accountant. The audit must be conducted in accordance with generally accepted auditing standards. The information must be reconciled to each provider agency's statement of costs and must include:

(a) A statement of assets and liabilities;

(b) An operations statement;

(c) A statement disclosing contract income and client wages;

(d) A statement of client fees or payments and their distribution, including private pay individuals;

(e) A statement of the assets and liabilities of any related organizations;

(f) A statement of ownership for the provider agency, including the name, address, and proportion of ownership of each owner;

[1] If a privately held or closely held corporation or partnership has an ownership interest in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in the provider agency's statement of costs must be identified regardless of the proportion of ownership interest; or

[2] If a publicly held corporation has an ownership interest of fifteen percent or more in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of fifteen percent or more;

(g) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the provider agency's facilities or a certification the content of the document remains unchanged since the most recent statement given pursuant to this subsection;

(h) Supplemental information reconciling the costs on the financial statements with costs on the statement of costs; and

(i) Independent audit report must comply with this chapter and follow:

[1] Medicare and Medicaid guidance and provider payment manual;

[2] Government auditing standards;

[3] North Dakota Century Code chapters 25-01.2 and 25-04;

[4] Titles 2, 42, and 45, Code of Federal Regulations, American institution of certified public accountants, financial accounting standards board, and government accounting standards board rules and regulations; and

[5] All other applicable state and federal regulations.

(3) The following information upon request by the department:

(a) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services claimed as allowable costs;

(b) Audited financial statements for any home or corporate office organization, excluding individual developmental disabilities provider agencies of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year; and

(c) Audited financial statements for every organization the facility conducts business and is owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year.

f. For each provider agency that chose not to have an independent certified public accountant complete a department compliance audit report in compliance with state and federal regulations, shall provide to the department no later than October first of each year:

(1) A statement of costs for the statement of cost year on forms prescribed by the department;

(2) Except for state-owned facilities and provider agencies that do not have an independent audit completed annually, a copy of an audited report of the provider agency's financial records from an independent certified public accountant. The audit must be conducted in accordance with generally accepted auditing standards. The information must be reconciled to each provider agency's statement of costs;

(3) A statement of assets and liabilities;

(4) An operations statement;

(5) A statement disclosing contract income and client wages;

(6) A statement of client fees or payments and their distribution, including private pay individuals;

(7) A statement of the assets and liabilities of any related organizations;

(8) A statement of ownership for the provider agency, including the name, address, and proportion of ownership of each owner;

(a) If a privately held or closely held corporation or partnership has an ownership interest in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in the provider agency's statement of costs must be identified regardless of the proportion of ownership interest; or

(b) If a publicly held corporation has an ownership interest of fifteen percent or more in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of fifteen percent or more;

(9) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the provider agency's facilities or a certification the content of the document remains unchanged since the most recent statement given pursuant to this subsection;

(10) Supplemental information reconciling the costs on the financial statements with costs on the statement of costs; and

(11) The following information upon request by the department:

(a) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services claimed as allowable costs;

(b) Audited financial statements for any home or corporate office organization, excluding individual developmental disabilities provider agencies of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year; and

(c) Audited financial statements for every organization the facility conducts business and is owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year.

g. A statement of costs must contain the actual costs, adjustments for nonallowable costs, and units of service. The mailing of a statement of costs by registered mail, return receipt requested, ensures documentation of the filing date.

h. Adjustments made by the audit unit, to determine allowable cost, though not meeting the criteria of fraud or abuse on their initial identification, may, if repeated on future cost filings, be considered as possible fraud or abuse.

i. The provider agency shall make all adjustments, allocations, and projections necessary to arrive at allowable costs. The department may reject any statement of costs when the information filed is incomplete or inaccurate. If a statement of costs is rejected, the department may reduce the current payment rate to ninety-five percent of its most recently established rate until the information is completely and accurately filed.

4. **Auditing.** In order to properly validate the accuracy and reasonableness of cost information reported by the provider agency, the department shall provide for audits as necessary.

a. A provider agency shall submit its statement of costs by October first of the statement of cost year.

b. A provider agency may request, and the department may grant, one thirty-day extension of the due date of the statement of costs for good cause.

(1) If a provider agency fails to file the required statement of costs on or before the due date, the department may reduce the current payment rate to ninety-five percent of its most recently established rate.

(2) Reinstatement of the rate must occur on the first of the month beginning after receipt of the required information, but is not retroactive.

c. The preliminary audit report shall be submitted to the provider agency no later than six months after the department receives the provider agency's statement of costs. The provider agency must be notified by facsimile transmission or electronic mail.

d. The provider agency may submit information, within thirty days after notification, to explain why the provider agency believes the desk adjustment is incorrect. The department shall review the information and make appropriate adjustments.

e. The final audit report shall be submitted to the provider agency within sixty days of the department's receipt of the provider agency's response.

f. Provider agency shall submit requests for information and responses to the department in writing. In computing any period of time prescribed or allowed in this subsection, the day of the act, event, or default from which the designated period of time begins to run may not be included. The last day of the period so computed must be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday. In determining whether the deadlines described in subdivision c, d, or e have been met, the department may not count any day that sufficient information has not been timely provided by a provider agency when the provider agency has shown good cause for its inability to provide the required information within the time periods prescribed in any one of those subdivisions.

5. **Penalties for false reports**.

a. A false report is when a provider agency knowingly supplies inaccurate or false information in a required statement of costs and supporting documentation that results in inaccurate costs.

b. If a false report is received, the department may:

(1) Place the provider agency's license on restricted status as defined in chapter 75-04-01;

(2) Terminate the department's agreement with the provider agency;

(3) Refer to law enforcement for investigation and prosecution under applicable state or federal law; or

(4) Use any combination of the foregoing actions.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; August 1, 1997; July 1, 2001; May 1, 2006; April 1, 2018; April 1, 2020.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-09. Rate payments.

1. The direct care hourly rate and components for each service are issued in a rate matrix established by the department. The components are:

a. The direct care hourly rate for intermediate care facilities for individuals with developmental disabilities must include direct care wage, employment-related costs, relief staff, administrative cost, vacancy factor, and program support, including room and board. Building depreciation and related interest costs will be calculated either by an

established percentage, or if a facility is acquired or built after January 1, 2010, the provider agency may choose the actual building depreciation and related interest costs relating to the facility for the life of the building to be added to the rate. For facilities acquired after January 1, 2010, subdivision c of subsection 3 of section 75-04-05-15 must be followed in determining remaining useful life. After the depreciable life is complete the established percentage for building depreciation and related interest costs will be utilized.

b. The direct care hourly rate for residential habilitation must include direct care wage, employment-related expenses, relief staff, program support, administrative costs, and ~~an absence~~a vacancy factor.

c. The direct care hourly rate for independent habilitation, day habilitation, prevocational services, individual employment supports, and small group employment supports must include direct care wage, employment-related expenses, relief staff, program support, and administrative costs.

~~d. The direct care hourly rate for in-home supports and parenting supports must include direct care wage, employment-related expenses, program support, and administrative costs.~~

2. For residential habilitation, intermediate care facility for individuals with intellectual disabilities, independent habilitation, day habilitation, prevocational services, and employment supports, the maximum authorized assessment score hours for a client ~~are:~~

~~a. For each of the above services the established payment~~ must be calculated by multiplying the rate from the rate matrix times the hours identified by the multiplier based on the client's assessment score from the standard assessment tool, except for residential ~~services~~supports provided in an intermediate care facility for individuals with intellectual disabilities, for which the established rate shall be the sum of all services identified for the client. A provider may request and the department may grant an outlier request for clients who have needs exceeding the client's assessment score.

~~b.~~3. Self-directed services or provider agency directed in-home supports do not require prior authorization based on the assessment score. Hours must be estimated by the program manager based on the person-centered services planning process with input from the client and the client-authorized representative, if applicable. These services are subject to the maximum annual hours as prescribed by the department.

~~3.~~4. Base staffing rate:

a. A provider agency may receive a base staffing rate when opening a new licensed group home or intermediate care facility for individuals with intellectual disabilities, including prior to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] certification and survey requirements.

b. A base staffing rate must be calculated based on minimum required staffing levels identified by the department.

c. A base staffing rate is effective for an intermediate care facility for individuals with intellectual disabilities on the date it is licensed by the department.

d. A provider agency shall receive a base staffing rate until the setting is fully occupied, or for three months, whichever comes first.

~~4. Vacancy:~~

~~a. A residential habilitation provider agency or intermediate care facility for individuals with intellectual disabilities may receive a vacancy rate add-on in the event of a vacancy.~~

~~b. A provider agency shall request the vacancy rate add-on within fifteen days of the vacancy.~~

~~c. A vacancy rate add-on is available only for residential habilitation or intermediate care facilities for individuals with intellectual disabilities.~~

~~d. The vacancy rate add-on is calculated using the rate of the client who vacated the setting. The vacancy rate add-on is evenly applied to all other client rates in the setting.~~

~~e. A provider agency shall receive a vacancy rate add-on until the vacancy is filled, but shall not exceed three months.~~

5. Room and board charges to clients may not exceed the maximum supplemental security income payment less one hundred dollars for the personal incidental costs of the client, plus the average dollar value of supplemental nutrition assistance program to the eligible clientele in the facility.

6. In ~~residential facilities~~group homes where rental assistance is available to individual clients or the facility, the rate for room costs chargeable to individual clients are established by the governmental unit providing the subsidy.

7. In ~~residential facilities~~group homes where energy assistance program benefits are available to individual clients or the facility, room and board rates are reduced to reflect the average annual dollar value of such benefits.

8. Income from client production must be applied to client wages and the cost of production. The department will not participate in the gains or losses associated with client production conducted pursuant to the applicable provision of title 29, Code of Federal Regulations, part 525.

9. A provider agency may not solicit or receive a payment from a client or any other individual to supplement the established rate of payment.

10. The rate of payment established must be no greater than the rate charged to a private payor for the same or similar service.

11. Limitations:

    a. The department shall accumulate and analyze statistics on costs incurred by provider agencies. Statistics may be used to establish reasonable ceiling limitations for needed services. Limitations may be established on the basis of cost of comparable facilities and services, or audited costs, and may be applied as ceilings on the overall costs, on the costs of providing services, or on the costs of specific areas of operations. The department may implement ceilings at any time, based upon the statistics available, or as required by guidelines, regulations, rules, or statutes.

    b. The department shall review, on an ongoing basis, aggregate payments to intermediate care facilities for the intellectually disabled to determine that payments do not exceed an amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. If aggregate payments to facilities exceed estimated payments under Medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under Medicare payment principles.

c. Provider agencies may not be reimbursed for services, rendered to a client, which exceed the rated occupancy of any facility as established by a fire prevention authority.

d. Provider agencies of residential ~~services~~habilitation and intermediate care facilities for individuals with intellectual disabilities shall offer services to each client three hundred sixty-five days per year, except for leap years in which three hundred sixty-six days must be offered. Provider agencies may not be reimbursed for those days in which services are not offered to a client.

e. Provider agencies of day services shall offer services to each client eight hours per day two hundred sixty days per year, except leap years in which two hundred sixty-one days must be offered, less any state-recognized holidays, unless a holiday exception is approved by the department. Provider agencies may not be reimbursed for hours of service in which the client is not in attendance.

f. Provider agencies of day services to clients of intermediate care facilities for individuals with intellectual disabilities shall bill the intermediate care facility for individuals with intellectual disabilities the day habilitation rate established for the client.

12. Adjustments and review procedures are as follows:

a. Adjustments may be made to correct errors. Statement of costs must be reviewed taking into consideration prior years' adjustments. The provider agency must be notified by facsimile transmission or electronic mail of any adjustments based on the desk review. A provider agency may submit information, within thirty days after notification, to explain why the desk adjustment is incorrect. The department shall review the information and make appropriate adjustments.

b. A provider agency may submit a request for reconsideration of the final statement of costs review in writing to the developmental disabilities division within fifteen days of the date of the final statement of costs review notification. A request for reconsideration must provide new evidence indicating why a new determination should be made or explain how the department has incorrectly interpreted the law. The department shall respond to a properly submitted request for reconsideration within ninety days of receipt of the request. The department may revise the final statement of costs review on its own motion.

c. A provider agency may appeal the decision within thirty days after the department mails the written notice of the decision on a request for reconsideration of the final review of the statement of costs.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 1995; April 1, 1996; August 1, 1997; July 1, 2001; May 1, 2006; July 1, 2012; January 1, 2013; April 1, 2018; April 1, 2020.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

75-04-05-11. Statement of costs allocations.

The statement of costs provides for the identification of the allowable expenditures and basic services subject to payment by the department. When costs are incurred solely for a basic service, the costs must be assigned directly to that basic service. When costs are incurred jointly for two or more basic services, and not able to be directly assigned, the costs must be allocated as follows:

1. Personnel. The total cost of all staff identified in payroll records must be listed by position title and distributed to basic services. Time studies may be performed for one week at least quarterly for allocation. When no time studies exist, the applicable units must be used for

allocation. When there is no definition of a unit of service, the department must use the unit of service for billing purposes ~~for residential settings~~.

2. Fringe benefits. The cost of fringe benefits must be allocated to basic services based on the ratio of the basic service personnel costs to total personnel costs. Personnel costs on which no fringe benefits are paid are excluded.

3. Equipment. The total cost of all equipment, whether rented, leased, purchased, or depreciated, must be distributed to basic services based on usage or applicable units.

4. Real property cost. The total of all property costs, whether rented, leased, purchased, or depreciated, must be allocated based on direct square footage. When multiple usage of direct use area occurs, the allocation is first done by square footage and then by applicable units.

5. Travel. The total of all unassigned travel costs must be included in administrative costs.

6. Supplies. The total of all unassigned supply costs must be included with administrative costs.

7. Food services. The total of all food costs must be allocated based on meals served. When the number of meals served has not been identified, applicable units must be used.

8. Insurance and bonds. The total of all such costs, except insurance costs representing real property costs or vehicle insurance costs applicable to vehicles used for one or more basic services, must be included as administrative costs.

9. Indirect program support costs. Total indirect program support costs, not including personnel and fringe benefits, must be allocated to basic service categories, exclusive of production, room, and board, based on actual units of service. When determining the day habilitative ratio of indirect program support costs, total day habilitation units are divided by thirty-two and rounded to the nearest whole number.

10. Administrative costs. Total administrative costs must be allocated to all service categories, exclusive of residential habilitation room, board, and production, based upon the ratio of the basic service cost to total cost excluding administrative and production costs. The percentage calculated for habilitation services must be based on total costs, including room and board, with the allocation made only to direct care costs, direct program support costs, and indirect program support costs.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 2001; May 1, 2006; April 1, 2018; April 1, 2020.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

CHAPTER 75-04-06
ELIGIBILITY FOR INTELLECTUAL DISABILITIES - DEVELOPMENTAL DISABILITIES PROGRAM MANAGEMENT SERVICES

75-04-06-08. Developmental disabilities program management caseload and responsibilities.

1. The average caseload of the developmental disabilities program managers must be no more than sixty clients per program manager.

2. The developmental disabilities program manager shall complete the following:

   a. Review client rights with eligible clients and applicants.

   b. Conduct service coordination and monitoring for eligible clients.

   c. Authorize appropriate services for eligible clients.

History: Effective April 1, 2020.
General Authority: NDCC 25-01.2-18
Law Implemented: NDCC 25-01.2-02, 25-01.2-18

ARTICLE 75-09.1
SUBSTANCE ABUSE TREATMENT PROGRAMS

CHAPTER 75-09.1-11

75-09.1-11-01. Definitions.

As used in this chapter, unless the context or subject matter otherwise requires:

1. "ASAM criteria" means the current edition of the criteria of the American society of addiction medicine.

2. "Certified recovery specialist" means a person who has been certified by a recognized training program to provide recovery support services to individuals who have a substance use disorder.

3. "Comprehensive biopsychosocial clinical assessment" means an assessment that integrates information regarding the biological, psychological, and social factors of an individual's life in determining the nature of the individual's substance use disorder and criteria for treatment.

4. "Department" means the North Dakota department of human services.

5. "Individual" means an individual who meets the identified eligibility criteria for services under the substance use disorder treatment voucher system.

6. "Outcomes measures" means the events or conditions that indicate the effectiveness of the substance use disorder treatment services.

7. "Process measures" means the steps and actions taken to implement the substance use disorder treatment services.

8. "Program" means a human being, partnership, association, corporation, or limited liability company that establishes, conducts, or maintains a substance abuse treatment program license in compliance with chapter 75-09.1-01 for the care of individuals with a substance use disorder. "Program" does not include a DUI seminar, which is governed by chapter 75-09.1-09 or a substance abuse treatment program operated by a state agency.

9. "Voucher" means funding issued by the department to a ~~private~~ licensed substance abuse treatment program, excluding human service centers and the state hospital, for the purpose of providing eligible individuals substance use disorder treatment and recovery services.

History: Effective July 1, 2016; amended effective April 1, 2020.
General Authority: NDCC 50-06-16
Law Implemented: ~~S.L. 2015, ch. 139, § 4~~NDCC 50-06-42

75-09.1-11-07. Individual eligibility for a substance use disorder treatment voucher.

1. The individual completes a voucher application in the form and manner prescribed by the department;

2. The individual resides in North Dakota;

3. The individual is ~~eighteen~~fourteen years of age or older;

4. A licensed professional operating within their scope of practice has determined the individual is in need of one or more of the services identified in section 75-09.1-11-06;

5. The individual grants the department access to treatment and payment records consistent with the confidentiality requirements found under title 42, Code of Federal Regulations, part 2 and title 45, Code of Federal Regulations, part 164;

6. The individual does not have resources to cover any care for treatment and the:

   a. Individual's third-party payment resources will not cover all costs for treatment;

   b. Individual has a pending application for medical assistance which presents a barrier to timely access to treatment; or

   c. Individual does not qualify for medical assistance and has no alternative third-party payment resources.

7. The individual has an annual income no greater than two hundred percent of federal poverty guidelines.

History: Effective July 1, 2016; amended effective April 1, 2020.
General Authority: NDCC 50-06-16
Law Implemented: ~~S.L. 2015, ch. 139, § 4~~NDCC 50-06-42

CHAPTER 75-09.1-12
LICENSING STANDARDS FOR MEDICATION UNITS

75-09.1-12-01. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Condition" means a violation of the requirements of any applicable law or regulation has occurred.
2. "Corrective action plan" means a plan developed by the medication unit and submitted to the division identifying how the medication unit will correct a condition.
3. "Department" means the North Dakota department of human services.
4. "Division" means the behavioral health division of the department.
5. "Home-base opioid treatment program" means the opioid treatment program licensed according to chapter 75-09.1-10 to operate the medication unit.
6. "Interim license" means the proposed medication unit has met state requirements to move forward with federal requirements. A medication unit may not perform the duties of a medication unit under an interim license.
7. "Medication unit" means a facility established as part of, but geographically separate from, an opioid treatment program from which licensed private medical practitioners or pharmacists dispense or administer an opioid agonist or antagonist treatment medication or collect biological specimen samples for drug testing or analysis. Medication units are not required to be free-standing entities and may be located within other facilities, including a hospital, homeless shelter, correctional program, or public health location.
8. "Medication unit license" means a medication unit has met all state and federal requirements to operate the medication unit.
9. "Patient" means an individual who undergoes treatment in an opioid treatment program who may receive partial services at the medication unit.
10. "Recommendation" means a suggestion offered by the licensure team to strengthen and enhance the medication unit and services offered by the medication unit.

History: Effective April 1, 2020.
General Authority: NDCC 50-31-09
Law Implemented: NDCC 50-31-09

75-09.1-12-02. Requirements for medication unit license - Application.

1. A medication unit application for licensure to operate a medication unit shall hold a current license in good standing as an opioid treatment program under chapter 75-09.1-01.

2. Before applying for a license, the home-based opioid treatment program shall submit an assessment of need for the proposed location of a medication unit and obtain written approval by the division. The assessment of need must include an assessment of the following criteria:

   a. A description of other existing services and medication units of the type proposed to meet the needs of the population proposed to be served in that location;

   b. Justification for the need of a medication unit in the location;

   c. Description of prospective operations for patient care at the medication unit; and

   d. Community relations plan developed in consultation with the county, city, or tribal authority, or designees.

3. Following written approval from the division to pursue licensure, the prospective medication unit shall submit a medication unit application, including required documentation and the application fee of one hundred fifty dollars to the department. Upon approval of the application requirements, the prospective medication unit may receive an interim license.

4. Within ninety days of receiving the interim license, a prospective medication unit shall submit to the division the following items for review:

   a. Documentation of the updated certification by the United States department of health and human services substance abuse and mental health services administration, including the application and required materials sent for certification; and

   b. Registration from the United States department of justice, drug enforcement administration.

5. To renew a medication unit license, the following must occur:

   a. A licensing renewal conducted by the division;

   b. Submission of application with required documentation to the division; and

   c. Application fee paid to the department.

History: Effective April 1, 2020.
General Authority: NDCC 50-31-03.1, 50-31-09
Law Implemented: NDCC 50-31-03.1, 50-31-09

75-09.1-12-03. Issuing license to medication unit.

The division shall issue a license following:

1. A review and approval of application materials for up to one year and subsequent licenses for three years;

2. A licensing review with no conditions issued; or

3. A review and approval of implementation of any corrective action plan required as a result of a licensing review or investigation.

History: Effective April 1, 2020.

General Authority: NDCC 50-31-09
Law Implemented: NDCC 50-31-09

75-09.1-12-04. Denial of application for medication unit.

The division shall deny an applicant's license:

1. When the applicant fails to meet the requirements of this chapter; or

2. The home-base opioid treatment program's license is not in good standing or has been suspended or revoked.

History: Effective April 1, 2020.
General Authority: NDCC 50-31-09
Law Implemented: NDCC 50-31-09

75-09.1-12-05. Licensing review requirements.

1. The division shall conduct a licensing review within one year of the initial license and at least every three years thereafter to determine continued compliance with the standards contained in this chapter.

2. The division may conduct scheduled or unscheduled visits at times other than routine licensing reviews.

3. Within thirty days of the licensing review, the division shall send a licensure review report to the medication unit.

4. A licensure review report must contain a description of:

   a. The medication unit reviewed;

   b. Any conditions issued; and

   c. Any recommendations.

5. A medication unit receiving a condition shall submit to the division a corrective action plan within thirty days from receipt identifying how the medication unit will become compliant with the standards contained in this article.

6. The medication unit has sixty days after the corrective action plan is submitted to implement the actions to become compliant with the standards contained in this chapter.

7. The division shall require documentation or conduct an onsite review or both to ensure the medication unit has implemented its corrective action plan.

History: Effective April 1, 2020.
General Authority: NDCC 50-31-09
Law Implemented: NDCC 50-31-09

75-09.1-12-06. Suspension and revocation of license for medication unit - Appeal.

1. The division may suspend or revoke a license for one or more of the following reasons:

   a. The home-based opioid treatment program's license has been suspended or revoked;

   b. The medication unit has violated any rules of the department; or

c. If the medication unit fails to correct conditions or fails to provide a sufficient explanation for its failure to take action, the division may suspend or revoke the medication unit's license or require other corrective measures from the medication unit.

2. An applicant for or a holder of a license may appeal a decision to deny, suspend, or revoke a license as set forth in section 75-09.1-01-27.

History: Effective April 1, 2020.
General Authority: NDCC 50-31-09
Law Implemented: NDCC 50-31-09

75-09.1-12-07. Medication unit requirements.

All licensed medication units shall:

1. Provide medication dosing and may provide urine screen collection and shall adhere to all state and federal regulations for those services. Any other services provided at the medication unit must have prior approval by the division;

2. Develop and implement a policy on the physical operations of a medication unit in conjunction with services at the home-based opioid treatment program;

3. Develop and implement a policy identifying the criteria a patient must meet to receive services offered at the medication unit;

4. Identify in a patient's treatment plan the services received at a medication unit;

5. Provide orientation to each patient regarding the services offered through the medication unit;

6. Develop treatment plans that reflect the utilization of a medication unit;

7. Develop and implement a process for a patient's continuity of care between services conducted at the medication unit and the home-based opioid treatment program;

8. Ensure all employee requirements required in chapter 75-09.1-10 occur for employees of the medication unit;

9. Ensure the facility is clean and well-maintained; and

10. Provide protection of patient confidentiality, in accordance with federal and state confidentiality requirements.

History: Effective April 1, 2020.
General Authority: NDCC 50-31-09
Law Implemented: NDCC 50-31-09

75-09.1-12-08. Health and safety.

A medication unit shall:

1. Maintain health and safety policies and procedures;

2. Develop and implement a written emergency plan that addresses provisions for dealing with bomb threats, active shooter and other violent actions, fires, medical emergencies, natural disasters, and power failures;

3. Have staff certified in basic first aid and basic cardiac life support, and trained to respond to a suspected overdose;

4. Have overdose reversal medication readily available;

5. Make readily available first-aid equipment and supplies; and

6. Implement a written policy that addresses the use of nicotine products.

History: Effective April 1, 2020.
General Authority: NDCC 50-31-09
Law Implemented: NDCC 50-31-09

75-09.1-12-09. Medication unit closures.

If a medication unit closes involuntarily or voluntarily, the home-based opioid treatment program shall:

1. Provide the division with a plan detailing the procedures to ensure continuity of care for patients; and

2. Notify the division of the anticipated closure at least ninety days prior to the closure and identify the rationale for closure and the efforts to establish continuity of care for patients.

History: Effective April 1, 2020.
General Authority: NDCC 50-31-09
Law Implemented: NDCC 50-31-09

TITLE 92

WORKFORCE SAFETY AND INSURANCE

APRIL 2020

CHAPTER 92-01-02
RULES OF PROCEDURE - NORTH DAKOTA WORKERS' COMPENSATION ACT

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

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

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

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

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

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

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

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

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

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

   c. The employer's name and address.

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

   e. A description of the nature of the injury.

   f. The location where the injury occurred.

   g. A description of how the injury occurred.

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

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

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

2. Following receipt of the employer's notice of injury, the organization shall determine whether a claim has been filed by the injured ~~worker~~employee. If no claim has been filed, the

organization shall notify the injured ~~worker~~employee by regular mail addressed to the ~~worker~~injured employee at the address given by the employer or at the last-known address of the ~~worker~~injured employee that the employer's notice has been received and shall inform the ~~worker~~injured employee of the filing requirements of North Dakota Century Code section 65-05-01.

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

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

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

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

92-01-02-02.6. Verification of disability.

If an injured employee's disability benefits are discontinued under subsection 6 of North Dakota Century Code section 65-05-08.1, and verification of disability is not received within one hundred twenty days from the date disability benefits are discontinued, the organization may not pay any further disability or vocational rehabilitation benefits, unless the injured employee meets the requirements of a reapplication as found in North Dakota Century Code section 65-05-08.

History: Effective April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-08.1

92-01-02-11. Attorneys.

Any party has a right to be represented by an attorney at any stage in the proceedings regarding a claim. An attorney who represents an injured ~~worker~~employee in a proceeding regarding a claim shall file a notice of legal representation signed by the injured employee prior to or together with the attorney's first communication with the organization. The notice of legal representation remains in effect for five years from the date it is signed by the injured ~~worker~~employee or until revoked by the injured ~~worker~~employee, whichever occurs first.

History: Amended effective June 1, 1990; April 1, 1997; April 1, 2008; July 1, 2017; April 1, 2020.
General Authority: NDCC 65-02-08, 65-10-03
Law Implemented: NDCC 65-02-08, 65-10-03

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

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

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

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

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

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

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

   c. ~~Five~~Six thousand ~~nine~~two hundred fifty dollars, plus reasonable costs incurred, if the employee prevails after the hearing is called to order by the administrative law judge.

   d. Six thousand ~~six~~nine hundred fifty dollars, plus reasonable costs incurred, if the employee's district court appeal is settled prior to submission of briefs. ~~Eight~~Nine thousand ~~eight~~three hundred ~~fifty~~ dollars, plus reasonable costs incurred, if the employee prevails after hearing by the district court.

   e. ~~Ten~~Eleven thousand ~~six~~one hundred fifty dollars, plus reasonable costs incurred, if the employee's North Dakota supreme court appeal is settled prior to hearing. ~~Eleven~~Twelve thousand ~~six~~two hundred fifty dollars, plus reasonable costs incurred, if the employee prevails after hearing by the supreme court.

   f. One thousand ~~seven~~eight hundred fifty dollars, plus reasonable costs incurred, if the employee requests binding dispute resolution and prevails.

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

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

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

6. If the organization is obligated to pay the employee's attorney's fees, the attorney shall submit to the organization a final statement upon resolution of the matter. All statements must show the name of the employee, claim number, date of the statement, the issue, date of each service or charge, itemization and a reasonable description of the legal work performed for each service or charge, time and amount billed for each item, and total time and amounts billed. The employee's attorney must sign the fee statement. The organization may deny fees and costs that are determined to be excessive or frivolous.

7. The following costs will be reimbursed:

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

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

   c. Copying charges, at eight cents per page.

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

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

8. The following costs will not be reimbursed:

   a. Facsimile charges.

   b. Express mail.

   c. Additional copies of transcripts.

   d. Costs incurred to obtain medical records.

   e. Online computer-assisted legal research.

   f. Copy charges for documents provided by the organization.

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

History: Effective June 1, 1990; amended effective November 1, 1991; January 1, 1994; January 1, 1996; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012; April 1, 2014; April 1, 2016; January 1, 2018; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-15
Law Implemented: NDCC 65-02-08, 65-02-15, 65-10-03

92-01-02-14. Procedure for penalizing employers accounts for failure to pay premium or failure to submit payroll reports.

1. The organization shall bill each employer ~~annually~~ for premiums as provided by North Dakota Century Code chapter 65-04. If an employer has an open account with the organization, the

organization may send to the employer ~~annually~~ a payroll report on which the employer shall submit payroll expenditures from the preceding payroll year. The employer shall provide on the payroll report all information requested by the organization, including the name, social security number, rate classification, and gross payroll for each employee. ~~An~~The employer shall submit an electronic report of payroll information in a format approved by the organization~~ is acceptable. The employer shall complete the report and send it to the organization either by regular mail or electronic transmission~~. The report must be received by the organization by the last day of the month following the expiration date of the employer's payroll period. The organization shall consider an unsigned or incomplete submission to be a failure or refusal to furnish the report.

2. The organization shall send the first billing statement to the employer by regular mail to the employer's last-known address or by electronic transmission. The first billing statement must identify the amount due from the employer. The statement must explain the installment payment option. The payment due date for an employer's account is thirty days from the date of billing indicated on the ~~premium~~ billing statement. If a previous delinquency exists on the employer account, the billing statement indicates a past-due status.

3. If the organization does not receive full payment or the minimum installment payment indicated on the ~~premium~~ billing statement, on or before the payment due date, the organization shall send a second billing statement.

4. If the minimum installment payment remains unpaid thirty days after the organization sends the second billing statement to the employer, the organization shall notify the employer by regular mail to the employer's last-known address or by electronic transmission that:

   a. The employer is in default and may be assessed a penalty of two hundred fifty dollars plus two percent of the amount of premium, penalties, and interest in default;

   b. The employer's account has been referred to the collections unit of the policyholder services department; and

   c. Workforce safety and insurance may cancel the employer's account.

5. The organization may extend coverage ~~by written binder~~ if the organization and the employer have agreed in writing to a payment schedule on a delinquent account. If the employer ~~is in default of~~defaults on the agreed payment schedule~~, however,~~ that employer is not insured.

6. If the employer's payroll report is not timely received by the organization, the organization shall notify the employer, by electronic transmission or regular mail addressed to the last-known address of the employer of the ~~delinquency~~employer's failure to submit the payroll report. The notification must indicate that the organization may assess a penalty of up to two thousand dollars against the employer's account.

7. If the payroll report is not received within forty-five days following the expiration of the employer's payroll year, the organization shall assess a penalty of fifty dollars. The organization shall notify the employer of the penalty by electronic transmission or regular mail addressed to the employer's last-known address.

8. At any time after sixty days following the expiration of the employer's payroll year, when the employer has failed to submit a payroll report, the organization may bill the employer consistent with North Dakota Century Code section 65-04-19. An employer whose premium has been calculated under this subsection may submit actual wages on an employer payroll report for the period billed and the organization shall adjust the employer's account. The organization may also cancel the employer's account.

9. If the organization receives an employer payroll report more than sixty days after the expiration of the employer's ~~premium~~ billing statement may ~~have~~show a past-due premium billing due date. Any employer account billed without benefit of the employer payroll report may ~~have~~show a past-due ~~premium~~ billing due date.

10. If the employer does not have an open account with the organization, the organization shall send the employer an application for coverage by regular mail or by electronic transmission. The organization shall notify the employer of the penalties provided by North Dakota Century Code chapter 65-04 and this section.

11. Upon receipt of an incomplete or unsigned payroll report, the employer shall submit the completed payroll report within fifteen days of the organization's request. The organization shall consider an unsigned or incomplete submission to be a failure or refusal to furnish the report. If the payroll report is not timely received by the organization, the organization may assess a penalty of up to two thousand dollars and shall notify the employer that the employer is uninsured.

History: Effective June 1, 1990; amended effective January 1, 1994; January 1, 1996; May 1, 2002; March 1, 2003; July 1, 2006; April 1, 2009; July 1, 2010; April 1, 2016; January 1, 2018; April 1, 2020.
General Authority: NDCC 65-02-08, 65-04-06, 65-04-33
Law Implemented: NDCC 65-04-33

92-01-02-17. Reporting payroll for period of noncompliance.

If the noncompliance period of a new account is less than twelve months, the organization must prorate the payroll based on one-twelfth of the statutory payroll cap per employee, per month, for the period of time involved. If the payroll is less than one-twelfth of the statutory payroll cap per employee, per month, the full ~~amount~~month is reportable. An account in noncompliance is uninsured until a completed application for workers' compensation insurance coverage is received by the organization and the premium is paid.

History: Effective June 1, 1990; amended effective January 1, 1994; January 1, 1996; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-09-01

92-01-02-19. Employer relief after third-party recovery.

Upon third-party recovery pursuant to North Dakota Century Code section 65-01-09 in claims which have been accepted by the organization and when the employer's experience rating has been affected, relief will be given to the employer from the date of injury to the balance of the experience rating period. Relief will be given to the extent of the actual net recovery made by or on behalf of the organization, after deduction from the gross recovery of the costs and attorney fees allowable under North Dakota Century Code section 65-01-09.

"Relief will be given" indicates that the amount of money recovered by the organization in a third-party action will be deducted from the amount charged against the employer's experience rating. This may result in a decreased premium for policy periods impacted by the revised experience rates. An account that has been canceled is not entitled to relief under this section.

Relief will also be given to the extent of the employer reimbursement paid by the employer pursuant to North Dakota Century Code section ~~65-05-07.2~~65-04-04.4, provided that the net recovery made by or on behalf of the organization is equal to or exceeds the total chargeable expenditures made by the organization on the claim plus the reimbursement made by the employer. An employer who has not timely paid reimbursement under North Dakota Century Code section ~~65-05-07.2~~65-04-04.4 forfeits any right to relief for that reimbursement.

History: Effective June 1, 1990; amended effective January 1, 1996; May 1, 2002; July 1, 2004; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-09, 65-04-04.3, 65-04-04.4, 65-04-17~~, 65-05-07.2~~

92-01-02-20. Classification of employments - Premium rates.

Classifications and premium rates must be those classifications contained in the documents entitled "Classification Manual" and "Workforce Safety and Insurance Rates". When classifying employment or assigning a premium rate, the organization must use the edition of the manuals in effect during the policy period in which the premium is incurred. Rate classifications are assigned by the organization. Rate classifications of any employer may be modified by the organization at any time. Premium rates must be adjusted annually as recommended by the organization's actuaries based upon the criteria found in North Dakota Century Code section 65-04-01.

History: Effective June 1, 1990; amended effective July 1, 1990; July 1, 1991; July 1, 1992; July 1, 1993; July 1, 1994; July 1, 1996; May 1, 2002; July 1, 2006; April 1, 2020.
General Authority: NDCC 65-02-08, 65-04-01
Law Implemented: NDCC 65-04-01

92-01-02-23. Interest rate - Installment payment of premiums.

1. On March thirty-first of each year, the organization shall establish the interest rate to be charged to accounts with policy periods renewing between July first and June thirtieth of the following year, which elect to pay premium by installments. For the purposes of North Dakota Century Code sections 65-04-20 and 65-04-33, the interest rate is the base rate posted by the Bank of North Dakota plus two and one-half percent. The interest rate may not be lower than six percent.

2. Premium subject to installments ~~will be~~is limited to the premium for the advance premium only. Prior period premium deficiencies must be paid in full within the original premium due date. All payments made by an employer are applied to the oldest balance first. The organization may apply alternative installment options. ~~Prior period premium deficiencies must be paid in full within the original premium due date.~~

3. Default of any installment payment causes the entire premium balance to be due immediately.

History: Effective November 1, 1991; amended effective January 1, 1996; May 1, 2002; April 1, 2014; April 1, 2020.
General Authority: NDCC 65-02-08, 65-04-20
Law Implemented: NDCC 65-04-20, 65-04-24

92-01-02-23.1. Payment by credit card.

The organization, in its sole discretion, may accept payment by credit card for premiums, assessments, penalties, interest, reimbursements, or any other payment that is due the organization.

History: Effective January 1, 1996; amended effective April 1, 1997; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 54-06-08.2

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

1. Definitions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. "Medical dispute" means an employee has reached maximum medical improvement in connection with a work injury and has been evaluated for permanent impairment, and there is a disagreement between ~~doctors~~health care providers arising from the physical

evaluation that affects the amount of the award. The dispute to be reviewed must clearly summarize the underlying medical condition. It does not include disputes regarding proper interpretation or application of the American medical association guides to the evaluation of permanent impairment, sixth edition. It does not include disputes arising from an impairment percentage rating or an impairment opinion given by a ~~doctor~~health care provider when the ~~doctor~~health care provider is not trained in the American medical association guides to the evaluation of permanent impairment, sixth edition, and when the ~~doctor's~~health care provider's impairment percentage rating or impairment opinion do not meet the requirements of subsection 5 of North Dakota Century Code section 65-05-12.2.

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

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

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

3. The organization shall schedule an evaluation with a ~~doctor~~health care provider who has the training and experience necessary to conduct an evaluation of permanent impairment and apply the American medical association guides to the evaluation of permanent impairment, sixth edition. The organization may not ~~schedule~~use nor consider a permanent impairment evaluation ~~with~~conducted by the employee's treating ~~doctor~~health care provider or ~~a doctor~~any health care provider who has treated the injured employee for the work-related injury. In the event of a medical dispute, the organization will identify qualified specialists and submit all objective medical documentation regarding the dispute to specialists who have the knowledge, training, and experience in the application of the American medical association guides to the evaluation of permanent impairment, sixth edition.

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

a. Pain impairment ratings. A permanent impairment award may not be made upon a rating solely under chapter 3 of the sixth edition.

b. Mental and behavioral ~~disorder impairment ratings. Any evaluating doctor determining permanent mental or behavioral disorder impairment per chapter 14 of the sixth edition shall include a written summary of the mental evaluation in the evaluation report~~disorders are not independently compensable and are encompassed within the rating for physical impairment.

c. In chapters that include assessment of the functional history as one of the nonkey factors to adjust the final impairment rating within a class by using a self-report tool, the examining ~~doctor~~health care provider is to score the self-report tool and assess results for consistency and credibility before adjusting the impairment rating higher or lower than

the default value. The evaluating ~~doctor~~health care provider must provide rationale for deciding that functional test results are clinically consistent and credible.

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

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

5. Pollicization procedures will be rated as an impairment under subsection 11 of North Dakota Century Code section 65-05-12.2, relating to scheduled injury, and may not be rated as a whole body impairment, unless otherwise specified under subsection 11 of North Dakota Century Code section 65-05-12.2.

6. Errata sheets and guides updates. Any updates, additions, or revisions by the editors of the sixth edition of the guides to the evaluation of permanent impairment as of April 1, 2012, are adopted as an update, addition, or revision by the organization.

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; May 1, 1998; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2009; July 1, 2010; April 1, 2012; July 1, 2017; January 1, 2018; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-12.2

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

Maximum medical and hospital fees paid by the organization, including reimbursement for pharmaceuticals and durable medical equipment, are determined in accordance with the most current edition of the ~~publication entitled "Workforce Safety and Insurance Medical and Hospital Fees" (Fee Schedules)~~organization's fee schedule guidelines. Reimbursement for services and procedures not addressed within the fee schedules will be determined on a "by report" basis, in which case a description of the nature, extent and need for the procedure or service, including the time, skills, equipment, and any other pertinent facts necessary to furnish the procedure or service, must be provided to the organization.

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

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

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

1. ~~"Attending doctor" means a doctor who is primarily responsible for the treatment of a claimant's compensable injury.~~

~~2.~~ "Bill audit" means the review of medical bills and associated medical records by the organization or the managed care vendor, including review for duplications, omissions, actual delivery of billed services and items, accuracy of charges and associated coding, coding documentation guidelines, coverage, concurrent billing for covered and noncovered services, and application of fee schedules.

~~3.~~2. "Case management" means the ongoing coordination of medical services provided to a claimant, including:

a. Developing a treatment plan to provide appropriate medical services to a claimant.

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

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

d. Ensuring the claimant is following the prescribed medical plan.

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

~~4.~~3. "Concurrent review" means the monitoring by the organization or the managed care vendor for medical necessity and appropriateness, throughout the period of time in which designated medical services are being provided to the claimant, of the claimant's condition, treatments, procedures, and length of stay.

~~5.~~4. "Consulting ~~doctor~~health care provider" means a licensed ~~doctor~~health care provider who examines ~~a claimant~~an injured employee, or the ~~claimant's~~injured employee's medical record, at the request of the ~~attending doctor~~primary health care provider to aid in diagnosis or treatment. A consulting ~~doctor~~health care provider, at the request of the ~~attending doctor~~primary care provider, may provide specialized treatment of the compensable injury and give advice or an opinion regarding the treatment being rendered or considered for ~~a claimant's~~an injured employee's injury.

~~6.~~5. "Debilitating side effects" means an adverse effect to a treatment or medication which in and of itself precludes return to employment or participation in vocational rehabilitation services.

~~7.~~6. "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.

~~8.~~7. "Emergency" means a medical condition that manifests itself by symptoms of sufficient severity, which may include severe pain, to cause a prudent layperson possessing an average knowledge of health and medicine to reasonably conclude that immediate medical treatment is required to avoid serious impairment of a bodily function, or serious dysfunction of any body part, or jeopardizing the person's life.

~~9.~~8. "Fee schedule" means the publication entitled "Workforce Safety and Insurance Medical and Hospital Fees".

~~10.~~9. "Functional capacity evaluation" means an objective, directly observed, measurement of a claimant's ability to perform a variety of physical tasks combined with subjective analyses of abilities by the claimant and the evaluator. A physical tolerance screening and a Blankenship's functional evaluation are functional capacity evaluations.

~~11.~~10. "Improved pain control" means the effectiveness of a treatment or medication which results in at least thirty percent reduction in pain scores.

~~12.~~11. "Increase in function" means the effectiveness of a treatment or medication which results in either a resumption of activities of daily living, a return to employment, or participation in vocational rehabilitation services.

~~13.~~12. "Managed care" means services performed by the organization or a managed care vendor, including utilization review, preservice reviews, disability management services, case

management services, ambulatory reviews, concurrent reviews, retrospective reviews, preadmission reviews, and medical bill audit.

~~14.~~13. "Managed care vendor" means an organization that is retained by the organization to provide managed care services.

~~15.~~14. "Medical service" means a medical, surgical, chiropractic, psychological, dental, hospital, nursing, ambulance, and other related or ancillary service, including physical and occupational therapy and drugs, medicine, crutches, a prosthetic appliance, braces, and supports, and physical restoration and diagnostic services, or a service outlined in section 92-01-02-30.

~~16.~~15. "Medical service provider" means ~~a~~an allied health care ~~provider~~professional, hospital, medical clinic, or vendor of medical services.

~~17.~~16. "Medically stationary" means the "date of maximum medical improvement" as defined in North Dakota Century Code section 65-01-02 has been reached.

~~18.~~17. "Notice of nonpayment" means the form by which a claimant is notified of charges denied by the organization which are the claimant's personal responsibility.

~~19.~~18. "Palliative care" means a medical service rendered to alleviate symptoms without curing the underlying condition.

19. "Pharmacy services" means any prescribed medication, including over the counter variations requested at the direction of an allied health care professional's rendered treatment.

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

21. "Preservice review" means the evaluation by the organization or a managed care vendor of a proposed medical service for medical necessity, appropriateness, and efficiency prior to the services being performed.

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

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

~~23.~~24. "Retrospective review" means the organization's or a managed care vendor's review of a medical service for medical necessity, appropriateness, and efficiency after treatment has occurred.

~~24.~~25. "Special report" means ~~a medical service provider's~~an allied health care professional's written response to a specific request from the organization for information, including information on causation, aggravation, preexisting conditions, and clarification of complex medical conditions, requiring the creation of a new document or the previously unperformed analysis of existing data. The explanatory reports required for procedures designated as "by report" under section 92-01-02-27 are not special reports.

~~25.~~26. "Utilization review" means an evaluation of the necessity, appropriateness, efficiency, and quality of medical services provided to a claimant, based on medically accepted standards and an objective evaluation of the medical services.

~~26.~~27. "Utilization review department" means the organization's utilization review department.

~~27.~~28. "Work hardening" means an individualized, medically prescribed and monitored, work-oriented treatment process which involves the claimant participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the claimant to a specified job.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2014; April 1, 2016; April 1, 2020.
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. A medical service or supply necessary to diagnose or treat a compensable injury, which is appropriate to the location of service, is medically necessary if it is widely accepted by the practicing peer group and has been determined to be safe and effective based on published, peer-reviewed, scientific studies.

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

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

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

   b. Chemonucleolysis; 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).

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

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

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

   f. Intradiscal electrothermal annuloplasty (IDET).

   g. Prolotherapy (sclerotherapy).

h. Surface electromyography (surface EMG).

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

j. Spine strengthening program (e.g. MedX or SpineX or other substantially equivalent program).

k. Electrodiagnostic studies performed by electromyographers who are not certified or eligible for certification by the American board of electrodiagnostic medicine, American board of physical medicine and rehabilitation, or the American board of neurology and psychiatry's certification in the specialty of clinical neurophysiology. Nerve conduction study reports must include either laboratory reference values or literature-documented normal values in addition to the test values to be eligible for payment.

l. Trigger point injections. No more than twenty injections may be paid over the life of a claim. If a trigger point injection is administered, the organization may not pay for additional modalities such as cryotherapy and osteopathic manipulations performed in conjunction with the trigger point injection. For purposes of this paragraph, injections billed under CPT code 20552 or 20553 count as a single injection.

m. Acupuncture therapy. No more than eighteen treatments may be paid for the life of the claim. The organization may waive this requirement in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured workers and providers.

n. Dry needling.

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

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

1. An injured ~~worker~~employee must obtain ~~an attending doctor's~~a primary health care provider's order of medical necessity supported by objective medical findings before the purchase of a specially equipped motor vehicle or modification of a vehicle may be approved. The ~~attending doctor's~~primary health care provider's order must contain the following:

   a. Patient's name;

   b. Date of patient's face-to-face examination;

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

   d. Description of what is ordered;

   e. Length of need;

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

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

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

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

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

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

6. Cost quotes must be itemized.

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

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

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

92-01-02-29.4. Home modifications.

1. An injured ~~worker~~employee must obtain ~~an attending doctor's~~a primary health care provider's order of medical necessity supported by objective medical findings before the payment for home modifications can be approved. The ~~attending doctor's~~primary health care provider's orders must contain the following:

   a. Patient's name;

   b. Date of patient's face-to-face examination;

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

   d. Description of what is ordered;

   e. Length of need;

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

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

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

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

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

5. Cost quotes must be itemized.

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

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

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

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

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

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

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

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

1. An injured employee must obtain ~~an attending doctor's~~a primary health care provider's order of medical necessity supported by objective medical findings before the purchase of a power mobility device may be approved by the organization. The ~~attending doctor's~~primary health care provider's order must contain the following:

   a. Patient's name;

   b. Date of patient's face-to-face examination;

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

   d. Description of what is ordered;

   e. Length of need;

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

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

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

3. ~~An attending doctor~~A primary health care provider must make a referral for a mobility assessment and the assessment must be performed by a licensed or certified occupational therapist or physical therapist with specific training and experience in rehabilitation mobility or wheelchair evaluations. The assessment must be completed prior to the approval of a power mobility device.

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

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

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

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

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

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

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

92-01-02-29.6. Footwear.

1. An injured employee shall obtain the primary health care provider's order of medical necessity supported by objective medical findings before the purchase of footwear may be approved by the organization. The primary health care provider's order must contain the following:

   a. Patient's name;

   b. Date of patient's face-to-face examination;

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

   d. Specific description of the type or brand or both of footwear being requested;

   e. Primary health care provider's signature; and

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

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

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

4. The organization shall reimburse for modifications to regular footwear purchased by an injured employee if the modifications are due to the work injury and there is objective medical evidence to support the necessity of the modifications.

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

6. The organization must approve the footwear prior to purchase. If the footwear is approved, the organization shall reimburse an injured employee after a receipt is received. The organization may not prepay an injured employee to purchase footwear and may not place orders for footwear for an injured employee.

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

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

92-01-02-30. Medical services.

1. Medical services.

   a. Medical services that are not medically necessary are not reimbursable.

   b. 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 organization or the managed care vendor. The organization may require evidence of the efficacy of treatment.

2. Medical services may be reimbursed only when provided according to a written treatment plan. A copy of the treatment plan, signed by the ~~attending medical service provider~~allied health care professional, must be provided to the organization 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. However, a treatment plan is not required for a short course of treatment consisting of one or two visits.

3. For purposes of this section, a treatment plan must include:

   a. Objectives, including the degree of restoration anticipated.

   b. Measurable goals.

   c. Modalities and specific therapies to be used.

   d. Frequency and duration of treatments to be provided.

   e. Condition of the claimant which may require periodic modification of the plan of care based on:

      (1) Improvements in the claimant's status.

      (2) Failure of the claimant to improve as expected.

      (3) Intervention of care rendered, including education of the claimant, when appropriate.

      (4) Specific operative reports, test results, and consultation reports.

4. The cost of preparing a written treatment plan and supplying progress notes under this section is included in the fee for the medical service.

5. The treatment plan requirements of this section may be modified or waived by the organization.

6. 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 organization or the managed care vendor, original x-ray films must be forwarded to the organization or the managed care vendor. Films must be returned to the vendor. A reasonable charge may be made for the costs of delivery of films.

7. A generic brand of therapeutic equivalence must be dispensed, provided the generic medication costs less. If the injured ~~worker~~employee does not accept the generic equivalent at a lower price, the injured ~~worker~~employee is responsible for the cost difference between the generic and brand name prescription medication. A branded equivalent of a generically available medication requires prior approval by the organization and will be covered only when ~~documentation~~objective medical evidence exists that the injured ~~worker~~employee developed an adverse response to the generic medication.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; October 1, 2006; April 1, 2020.
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 be reimbursed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. Pattern of submission of inaccurate or misleading bills.

k. Pattern of submission of false or erroneous diagnosis.

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

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

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

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

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

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

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

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

t. Disciplinary action by a licensing board.

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

92-01-02-32. Physician assistant ~~and nurse practitioner~~ rules.

Physician assistants ~~and nurse practitioners~~ may be reimbursed within the scope of their licenses for services performed under the supervision of a licensed physician ~~that are required by their licensure~~.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2009; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-32.1. Physical therapy assistants, certified occupational therapy assistants, and certified athletic trainers.

Physical therapist assistants, certified occupational therapist assistants, and certified athletic trainers may be reimbursed when providing treatment under the direction and general supervision of the physical therapist or occupational therapist. Physical and occupational therapists are responsible for the assistants under their direction and supervision. Examination, evaluation, diagnosis, prognosis, and outcomes are the sole responsibility of the physical therapist and occupational therapist. Physical therapist assistants, certified occupational therapist assistants, and certified athletic trainers are not allowed to perform functional capacity evaluations. Treatment by physical therapy aides or physical therapy technicians is neither recognized nor will be reimbursed.

History: Effective July 1, 2017; amended effective April 1, 2020.
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.

The organization has instituted a program of utilization review and quality assurance to monitor and control the use of health care services. The organization shall develop and identify the mode and manner of submissions for utilization review and quality assurance requests.

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

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

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

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

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

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; July 1, 2006; April 1, 2012; July 1, 2017; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

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

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

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

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

   a. Durable medical equipment.

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

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

      (3) Equipment costing less than five hundred dollars does not require prior authorization~~ except for the following: adult undergarments, ambulatory aids (including roller aids and scooters, walkers and walker accessories and attachments, wheelchairs and wheelchair accessories), catheters, commodes and bath and toilet aids (including chairs and railings), continuous passive motion devices (CPM), CPAP units, electromedical devices (including combination units [All-Stim], neuromuscular stimulators, and TENS units), eyewear (including frames, lenses, contact lenses, anti-reflective coating, polarization, progressive lenses, and scratch resistant or tinting coating), hearing aids and hearing aid batteries and filters, home traction units, nebulizers, orthotic footwear (including inserts [customized or molded], shoes or boots, and miscellaneous customized shoe~~

~~additions), paraffin bath units, prosthetics, and wound VAC dressings~~, but remains subject to the organization's durable medical equipment guidelines.

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

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

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

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

d. ~~Telemedicine~~Telehealth. The organization may pay for audio and video telecommunications instead of a face-to-face "hands on" appointment for ~~the following appointments: office or other outpatient visits; new and established evaluation and management visits; individual psychotherapy visits; and pharmacologic management visits~~CPT codes designated by the American medical association as teleheath codes. As a condition of payment, the patient must be present and participating in the telemedicine appointment. The professional fee payable is equal to the fee schedule amount for the service provided. The organization may pay the originating site a facility fee~~, not to exceed twenty dollars~~ at the scheduled amount.

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

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

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

b. All nonemergent major surgery. When the ~~attending doctor~~primary health care provider or consulting ~~doctor~~health care provider believes elective surgery is needed to treat a compensable injury, the ~~attending doctor~~primary health care provider or the consulting

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

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

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

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

f. Thermography.

g. Intra-articular injection of hyaluronic acid.

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

~~i.~~ Facet joint injections.

~~j.~~i. Sacroiliac joint injections.

~~k.~~j. Facet nerve blocks.

~~l.~~k. Epidural steroid injections.

~~m.~~l. Nerve root blocks.

~~n.~~m. Peripheral nerve blocks.

~~o.~~n. Botox injections.

~~p.~~o. Stellate ganglion blocks.

~~q.~~p. Cryoablation.

~~r.~~q. Radio frequency lesioning.

~~s.~~r. Facet rhizotomy.

~~t.~~s. Implantation of stimulators and pumps.

~~u. Acupuncture therapy. No more than eighteen treatments may be paid for the life of the claim. The organization may waive this requirement in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured workers and providers.~~

~~v.~~t. Speech therapy.

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

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

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

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

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

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

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

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

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

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

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

92-01-02-38. Changes of ~~doctors~~health care providers.

1. All changes from one ~~doctor~~health care provider to another must be approved by the organization. Normally, changes will be allowed only after the ~~claimant~~injured employee has been under the care of the ~~attending doctor~~primary health care provider for sufficient time for the ~~doctor~~health care provider 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~~health care provider. For purposes of this rule, the following are not considered changes of ~~doctor~~health care provider by the ~~claimant~~injured employee:

   a. Emergency services by a ~~doctor~~health care provider;

   b. Examinations at the request of the organization;

c. Consultations or referrals initiated by the ~~attending doctor~~health care provider;

d. Referrals to radiologists and pathologists for diagnostic studies;

e. When ~~claimants~~injured employees are required to change ~~doctors~~health care providers to receive compensable medical services, palliative care or time loss authorization because their health care provider is no longer qualified as ~~an attending doctor~~a primary health care provider; or

f. Changes of ~~attending doctor~~primary health care provider required due to conditions beyond the ~~claimant's~~injured employee's control. This would include when the ~~doctor~~health care provider terminates practice or leaves the area.

3. The ~~claimant~~injured employee must be advised when and why a change is denied. The organization reserves the right to require ~~a claimant~~an injured employee to select another ~~doctor~~health care provider or specialist for treatment:

a. When more conveniently located ~~doctors~~health care providers, qualified to provide the necessary treatment, are available;

b. When the attending ~~doctor~~health care provider fails to observe or comply with the organization's rules;

c. When, in a time loss case, reasonable progress toward return to work is not shown;

d. When ~~a claimant~~an injured employee requires specialized treatment, which the ~~attending doctor~~health care provider is not qualified to render, or which is outside the scope of the ~~attending doctor's~~primary health care provider's license to practice; or

e. When the ~~attending doctor~~health care provider is not qualified to treat each of several accepted conditions. This does not preclude concurrent care when indicated as outlined in section 92-01-02-34.

4. When the organization finds the change of ~~doctor~~health care provider to be appropriate and has requested the ~~claimant~~injured employee to change under this rule, the organization may select a new ~~attending doctor~~primary health care provider if the ~~claimant~~injured employee unreasonably refuses or delays in selecting another ~~attending doctor~~health care provider.

5. The organization in its discretion may authorize a change when it finds that a change is in the best interest of returning the ~~claimant~~injured employee to a productive role in society.

History: Effective January 1, 1994; amended effective April 1, 1997; January 1, 2000; April 1, 2020.
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. After the injured employee has become medically stationary, palliative care is compensable without prior approval from the organization only when it is necessary to monitor administration of prescription medication required to maintain the ~~claimant~~injured employee in a medically stationary condition or to monitor the status of a prosthetic device.

2. If the organization or its managed care vendor believes palliative care provided under subsection 1 is excessive, inappropriate, ineffectual, or in violation of the rules regarding the performance of medical services, review must be performed according to section 92-01-02-46.

3. After the ~~claimant~~injured employee has reached medically stationary status and the ~~claimant's doctor~~injured employee's health care provider believes that palliative care is necessary, the

~~doctor~~health care provider shall request authorization for palliative care through the managed care vendor 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. ~~Before the date on which centers for Medicare and Medicaid services implements ICD-10-CM, identify the medical condition by ICD-9-CM diagnosis for which the palliative treatment is proposed. On and after the date on which centers for Medicare and Medicaid services implements ICD-10-CM, identify~~Identify the medical condition by ICD-10-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~~allied health care professional who will perform the treatment, and the frequency and duration of the care to be given.

d. Describe how the requested palliative care is related to the accepted compensable condition.

e. Describe how the proposed treatment will enable the ~~claimant~~injured employee to continue employment or to perform the activities of daily living, and what the adverse effect would be to the ~~claimant~~injured employee if the palliative care is not approved.

f. Any other information the organization or managed care vendor may request.

4. The managed care vendor shall approve palliative care only when:

a. Other methods of care, including patient self-care, structural rehabilitative exercises, and lifestyle modifications are being utilized and documented;

b. Palliative care reduces both the severity and frequency of exacerbations that are clinically related to the compensable injury; and

c. Repeated attempts have been made to lengthen the time between treatments and clinical results clearly document that a significant deterioration of the compensable condition has resulted.

5. If the ~~attending doctor~~allied health care professional does not receive written notice from the organization within thirty days of the receipt of the request for palliative care, which approves or disapproves the care, the request will be considered approved.

6. When the request for palliative care is not approved, the organization shall provide, in writing, specific reasons for not approving the care.

7. When the organization approves or disapproves the requested palliative care, the ~~attending doctor~~allied health care professional, employer, or ~~claimant~~injured employee may request binding dispute resolution under section 92-01-02-46.

8. ~~For the purposes of this section only, a claimant's condition must be determined to be medically stationary when the attending doctor or a preponderance of medical evidence indicates the claimant is "medically stationary" or uses other language meaning the same thing. When there is a conflict in the medical opinions, 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 on clear and concise reasoning. When expert analysis is important, deference must be given to the opinion of the doctor with the greatest expertise in the diagnosed condition. The date a claimant is medically stationary is the earliest date that a~~

~~preponderance is established under this section.~~ The date of the examination, not the date of the report, controls the medically stationary date. When a specific date is not indicated but the medical opinion states the ~~claimant~~injured employee is medically stationary, the ~~claimant~~injured employee is presumed medically stationary on the date of the last examination. This subsection does not govern determination of maximum medical improvement relating to a permanent impairment award.

History: Effective January 1, 1994; amended effective October 1, 1998; May 1, 2002; July 1, 2004; April 1, 2014; April 1, 2020.
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 - Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. As used in subsection 3 of North Dakota Century Code section 65-05-28 regarding ~~doctors~~allied health care professionals designated or approved by the organization, "duly qualified ~~doctor~~allied health care professional" means a person chosen by the organization who is ~~a doctor of medicine or osteopathy, chiropractor, dentist, optometrist, podiatrist, or psychologist~~an allied health care professional who has the specialization necessary to perform an independent medical examination or an independent medical review. The organization's determination of whether an individual it has chosen is a duly qualified ~~doctor~~allied health care professional and the organization's choice of the duly qualified ~~doctor~~allied health care professional who will perform an independent medical examination or an independent medical review are not appealable decisions and these decisions may not be considered when determining whether a claimant has failed to submit to, or in any way intentionally obstructed, or refused to reasonably participate in an independent medical examination.

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

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

92-01-02-43. Home nursing care.

1. When the ~~attending doctor~~primary health care provider believes special or attendant (home nurse) care is needed, the ~~doctor~~health care provider shall submit the following information:

   a. A description of the special or home nursing care required, including the 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; or 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. Fees for home nurse or attendant care are based upon the organization's established fee schedule.

3. The organization may authorize and pay for visiting nurse care necessary for evaluation or instruction of a home health care provider.

4. When the ~~claimant~~injured employee or ~~claimant's~~injured employee's family makes arrangements for caregivers, the organization shall reimburse those providing the home nursing care.

5. Payment to individuals who provide services under this section does not constitute an employer and employee relationship between the organization and the provider of care.

6. The organization may not pay a rate for home nursing care which exceeds the cost of nursing facility care under the applicable case-mix classification in section 75-02-06-17.

History: Effective January 1, 1994; amended effective October 1, 1998; July 1, 2006; April 1, 2008; April 1, 2020.
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.

The organization may enter into special agreements for services provided by, or under the direction of, licensed medical service providers authorized to bill the organization. Special agreements may be made for services not covered under the fee schedule and may include multidisciplinary or interdisciplinary programs such as pain management, work hardening, and physical conditioning. Special programs include new programs and pilot projects to streamline, waive, or modify selected managed care rules to provide medical care for ~~claimants~~injured employees with greater efficiency.

The organization shall establish payment rates for special agreements and may establish outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, special reporting requirements, and other criteria to ensure ~~claimants~~injured employees receive good quality and effective services at a reasonable cost. The organization may terminate special agreements and programs upon thirty days' notice to the medical service provider.

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998; April 1, 2020.
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. Organization responsibilities.

1. As soon as reasonably possible after receiving a bill, the organization shall:

   a. Pay the charge or any portion of the bill that is not denied;

   b. Deny all or a portion of the bill on the basis that the injury is not compensable, or the service or charge is excessive or not medically necessary; or

   c. Request specific additional information to determine whether the charge or service is excessive or not medically necessary or whether the condition is compensable.

2. The organization shall provide ~~written~~ notice of nonpayment to the ~~claimant~~injured employee when the ~~claimant~~injured employee is personally responsible for the payment of a charge. The organization shall provide ~~written~~ notice of nonpayment to the medical service provider through a remittance advice of denial of part or all of a charge, or shall provide ~~written~~ notice to the medical service provider for any request for additional information. The ~~written~~ notice must include:

   a. The basis for denying all or part of a charge because the treatment was not for a compensable injury.

   b. The basis for denying or reducing excessive charges and the specific amounts denied or reduced.

   c. The basis for denying the charge for an excessive service.

   d. The basis for denying a charge as not being medically necessary.

e. A request for records or other information needed to allow proper determination of the bill.

3. Any payment incorrectly made to a medical service provider may be recovered from the medical service provider by the organization.

4. The organization will pay a reasonable fee for a special report as defined in section 92-01-02-29 prepared at the request of the organization. The ~~health care provider or doctor~~allied health care professional shall include in the special report the time required to prepare the report or the organization may not pay for the report. Time spent and the complexity of the issues will be considered when determining the reasonableness of the fee. Such services should be billed under current procedural terminology code 99080 with a description of "special report".

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998; April 1, 2020.
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~~Medical service provider responsibilities and billings.

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

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

~~2.~~3. All bills must be fully itemized, including ICD codes, and services must be identified by code numbers found in the fee schedules or as provided in these rules. The definitions of commonality in the guidelines found in the current procedural terminology must be used as guides governing the descriptions of services, except as provided in the fee schedules or in these rules. All bills must be submitted to the organization within one year of the date of service or within one year of the date the organization accepts liability for the work injury or condition. ~~Before the date on which centers for Medicare and Medicaid services implements ICD-10-CM, all bills must be coded with ICD-9-CM codes. On and after the date on which centers for Medicare and Medicaid services implements ICD-10-CM, all bills must be coded with ICD-10-CM codes.~~

~~3.~~4. All medical service providers shall submit ~~bills referring to one claim only for medical services on current form~~changes for medical services on the most current version of the UB 04 ~~or form~~, CMS 1500, ~~except for dental billings which must be submitted on American dental association J510 dental claim forms and~~or ADA form, or the corresponding electronic versions of each. All pharmacy ~~billings which~~charges must be submitted electronically to the organization's pharmacy managed care vendor using the current pharmacy transaction standard. ~~Bills and reports must include~~Accepted electronic medical billing formats are outlines in section 92-01-02-45.2. Medical service bills may not include charges for more than one workers' compensation claim, and must include the following:

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

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

c. Date and nature of injury;

d. ~~Before the date on which centers for Medicare and Medicaid services implements ICD-10-CM, area of body treated, including ICD-9-CM code identifying right or left, as appropriate. On and after the date on which centers for Medicare and Medicaid services~~

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

e. Date of service;

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

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

h. ~~Physician's or supplier's billing~~Billing facility's name, address, zip code, telephone number; ~~physician's national provider identifier (~~medical service provider's NPI~~); physician assistant's North Dakota state license or certification number; physical therapist's North Dakota state license number; or advanced practice registered nurse's NPI or North Dakota state license number~~ and tax identification number; along with the billing facility's NPI;

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

j. ~~Type~~Place of service;

k. Appropriate procedure code or hospital revenue code;

l. ~~Description of service;~~

~~m.~~ Charge for each service;

~~n.~~m. Units of service;

~~o.~~n. If dental, tooth numbers;

~~p.~~o. Total bill charge~~;~~

~~q. Name of medical service provider providing service along with the provider's tax identification number, provider's national provider identifier (NPI); and~~

~~r. Date of bills~~.

~~4.~~5. All records submitted by medical service providers, including notes, except those provided by an emergency room ~~physician~~health care provider and those on forms provided by the organization, must be typed to ensure that they are legible and reproducible. Copies of office or progress notes are required for all followup visits. Documentation must be authentic to the visit and may not include cloned, copied, or irrelevant documentation for purposes of up-coding a service. Office notes are not acceptable in lieu of requested narrative reports. Communications may not refer to more than one claim. Addendums and late entries to notes or reports must be signed and must include the date they were created. Addendums or late entries to notes or reports created more than sixty calendar days after the date of service may be accepted at the organization's sole discretion.

~~5.~~6. ~~Providers~~Medical service providers shall submit with each bill a copy of medical records or reports which ~~substantiate~~support the ~~nature and~~ necessity of a service being billed and its relationship to the work injury, including the level, type, and extent of the service provided to ~~claimants~~injured employees. Documentation required includes:

a. Laboratory and pathology reports;

b. X-ray findings;

c. Operative reports;

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

e. Consultation reports;

f. History, physical examination, and discharge summaries;

g. Special diagnostic study reports; and

h. Special or other requested narrative reports.

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

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

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

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

b. The ~~claimant~~injured employee sought treatment from that medical service provider which was not prescribed by the ~~claimant's attending doctor~~injured employee's primary health care provider. This includes ongoing treatment by the ~~provider who is a nonattending doctor~~allied health care professional.

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

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

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

f. The ~~claimant~~injured employee is subject to North Dakota Century Code section 65-05-28.2, and the health care provider requesting payment is not a preferred provider

and has not been approved as an alternative health care provider under subsection 2, 3, or 4 of North Dakota Century Code section 65-05-28.2.

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

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

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

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

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

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

~~15.~~14. When there is a dispute over the amount of a bill or the necessity of services rendered, the organization shall pay the undisputed portion of the bill and provide specific reasons for nonpayment or reduction of each medical service code.

~~16.~~15. If medical documentation outlines that a non-work-related condition is being treated concurrently with the compensable injury and that condition has no effect on the compensable injury, the organization may reduce the charges submitted for treatment. In addition, the ~~attending doctor~~allied health care professional must notify the organization immediately and submit:

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

b. A description of the treatment being rendered.

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

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

~~17.~~16. In cases of questionable liability when the organization has not rendered a decision on compensability, the medical service provider has billed the ~~claimant~~injured employee or other insurance, and the claim is subsequently allowed, the medical service provider shall refund the ~~claimant~~injured employee or other insurer in full and bill the organization for services rendered.

~~18.~~17. The organization may not pay for the cost of duplicating records when covering the treatment received by the ~~claimant~~injured employee. If the organization requests records in addition to those listed in subsection 5 or records prior to the date of injury, the organization shall pay a charge of no more than twenty dollars for the first twenty-five pages and seventy-five cents per page after twenty-five pages. In an electronic, digital, or other computerized format, the organization shall pay a charge of thirty dollars for the first twenty-five pages and twenty-five cents per page after twenty-five pages. This charge includes any administration fee, retrieval fee, and postage expense.

~~19.~~18. The medical service provider shall assign the correct approved billing code for the service rendered using the appropriate provider group designation. Bills received without codes will be returned to the medical service provider.

~~20.~~19. Billing codes must be found in the most recent edition of the physician's current procedural terminology; health care financing administration common procedure coding system; code on dental procedures and nomenclature maintained by the American dental association; or any other code listed in the fee schedules.

~~21.~~20. A medical service provider shall comply within thirty calendar days with the organization's request for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the organization's determination of compensability, medical necessity, or excessiveness or the organization may refuse payment for services provided by that medical service provider.

~~22.~~21. A medical service provider may not bill ~~a claimant~~an injured employee a fee for the difference between the maximum allowable fee set forth in the organization's fee schedule and usual and customary charges, or bill the claimant any other fee in addition to the fee paid, or to be paid, by the organization for individual treatments, equipment, and products.

History: Effective January 1, 1994; amended effective April 1, 1996; October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2008; July 1, 2010; April 1. 2012; April 1, 2014; April 1, 2016; July 1, 2017; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07, 65-05-28.2

92-01-02-45.2. Medical service provider electronic billing responsibilities.

When submitting an electronic medical bill transaction, all medical service providers shall use the most current version of the following electronic medical bill processing standards:

1. Professional billing - ASC X12 837P;

2. Institutional/hospital billing - ASC X12 8371; or

3. Dental billing - ASC X12 837D.

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

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

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

2. When the organization denies payment for a medical service charge because the medical service provider did not properly request prior authorization or preservice review for that service, the medical service provider may request a retrospective review of that service. Requests for retrospective review must be made in writing, within thirty days after the notice that payment for the service is denied, addressed to the organization claims ~~analyst~~adjuster assigned to handle the ~~claimant's~~injured employee's claim. Requests for retrospective review should not be sent to the managed care vendor. The request must contain:

   a. The ~~claimant's~~injured employee's name.

   b. The claim number.

   c. The date of service.

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

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

   If the medical service provider knew or should have known that the patient may have a compensable work injury when the medical services for that injury were provided, the request for retrospective review must be denied. If the medical service provider did not know and should not have known that the patient may have a compensable work injury when the medical services for that injury were provided, a retrospective preservice review or preauthorization must be done in accordance with this chapter. If the organization continues to deny payment for the service, the medical service provider may request binding dispute resolution under this rule.

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

   a. The ~~claimant's~~injured employee's name.

   b. The claim number.

   c. All relevant medical information and documentation.

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

   e. The specific relief sought.

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

   a. The ~~claimant's~~injured employee's name.

   b. The claim number.

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

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

   e. The specific relief sought.

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

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

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

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

92-01-02-46.1. Pharmacy services disputes.

1. Binding dispute resolution must be used for disputing managed care recommendations, including point of sale alterations or denials for pharmacy services. Disputes not arising from managed care must follow the reconsideration and hearing procedures provided by North Dakota Century Code section 65-01-16.

2. When the organization denies payment for a pharmacy service charge the medical service provider or injured employee may request review of that service. Requests for review must be made in writing, within thirty days after the initial denial of payment, addressed to the organization claims adjuster assigned to handle the injured employee's claim. Requests for review may not be sent to the managed care vendor. The request must contain:

   a. The injured employee's name.

   b. The claim number.

   c. The date of service and service denied.

   d. The specific relief sought.

e. The information required to perform a review of the service. If the organization continues to deny payment for the service, the medical service provider may request binding dispute resolution under this rule.

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

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

History: Effective April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-20

92-01-02-48. Elements of filing.

1. For purposes of this section, unless the context otherwise requires:

   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 of an injury, which is adequate to verify the level, type, and extent of services provided.

   b. "Bill" 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 workforce safety and insurance and may include review for duplications, omissions, actual delivery of billed services and items, accuracy of charges and associated coding, and improper concurrent bills for services involving evaluation or treatment of work-related and non-work-related problems.

   d. "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 benefits are satisfied when the organization has received:

   a. The first report of injury form completed and signed by the employee ~~or the employer, or if the~~. The employer's report ~~is~~may be deemed admitted pursuant to North Dakota Century Code ~~section~~sections 65-01-16 or 65-05-01.4;

   b. Wage verification as requested by the organization, if disability benefits are claimed; and

   c. Appropriate records from the provider necessary to determine the type, nature, extent, and potential work-relatedness of the injury or disability.

3. The elements of filing for a reapplication are satisfied when the organization is in receipt of:

   a. The C4 form or other correspondence requesting benefits signed by the employee;

   b. Wage verification as requested by the organization, if disability benefits are claimed; and

c. Appropriate records from the provider.

4. The elements of filing for payment of a medical bill are satisfied when a bill review is completed and after the organization has received:

   a. A bill from the provider or employee; and

   b. Appropriate records from the provider or employee.

5. If the organization requests additional information from the employee needed to process a reapplication and the employee does not provide the information, elements of filing are not satisfied until the employee provides the requested information.

6. The organization may waive elements of filing in conjunction with programs established for the expedited processing of selected claims.

History: Effective January 1, 1994; amended effective January 1, 1996; April 1, 1997; February 1, 1998; January 1, 2000; July 1, 2006; April 1, 2016; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

92-01-02-50. Other states' coverage.

1. The terms used in this section have the same meaning as in North Dakota Century Code title 65 and in North Dakota Administrative Code title 92, except:

   a. "Covered employment" means hazardous employment principally localized in this state which involves incidental operations in another state. The term "covered employment" does not include employment in which the employer is required by the laws of that other state to purchase workers' compensation coverage in that other state.

   b. "Employee" means any North Dakota employee as that term is defined in North Dakota Century Code section 65-01-02 who engages in covered employment and who is eligible to file for workers' compensation benefits in another state if the employee suffers a work-related illness or injury or dies as a result of work activities in that state. The term "employee" also includes a person with optional workers' compensation coverage in this state under North Dakota Century Code section 65-04-29 or 65-07-01 who engages in covered employment and is eligible to file for workers' compensation benefits in another state if that person suffers a work-related illness or injury or dies as a result of work activities in that state.

   c. "Employer" means an employer as defined in North Dakota Century Code section 65-01-02, who is not materially delinquent in payment of premium, and who has employees engaged in covered employment. An employer is not materially delinquent in payment of premium if the premium is no more than thirty days delinquent.

   d. "Incidental operations" means business operations of an employer for fewer than thirty consecutive days in which the employer has no contacts sufficient, under the workers' compensation laws of that other state to subject the employer to liability for payment of workers' compensation premium in that other state and which operations do not require the employer to purchase workers' compensation insurance under the laws of that state.

2. If an employee, hired in this state for covered employment by an employer covered by the Workers' Compensation Act of this state, receives an injury while employed in incidental operations outside this state, the injury is subject to the provisions of this section if the employee elects to receive benefits under the workers' compensation laws of that other state in lieu of a claim for benefits in this state. This section applies only if the workers'

compensation laws of the other state allow the employee to elect to receive benefits under the laws of that state. If the employee does not or cannot elect coverage under the laws of another state, the injury is subject to the provisions of North Dakota Century Code chapter 65-08.

The provisions of this section do not apply to:

a. States having a monopolistic state fund.

b. States having a reciprocal agreement with this state regarding extraterritorial coverage.

c. Compensation received under any federal act.

d. Foreign countries.

e. Maritime employment.

f. Employer's liability or "stop-gap" coverage.

3. An employee who elects to receive benefits under the workers' compensation laws of another state waives the right to seek compensation under North Dakota Century Code title 65.

4. The organization may pay, on behalf of an employer, any regular workers' compensation benefits the employer is obligated to pay under the workers' compensation laws of a state other than North Dakota, with respect to personal injury, illness, or death sustained as a result of work activities by an employee engaged in covered employment in that state, if the employee or the employee's dependents elect to receive benefits under the other state's laws in lieu of benefits available under the North Dakota Workers' Compensation Act. The term "dependents" includes an employee's spouse. The organization may pay benefits on behalf of an employer but may not act nor be deemed as an insurer, nor may the organization indemnify an employer for any liabilities, except as specifically provided in this section.

   The benefits provided by this section are those mandated by the workers' compensation laws of the elected state. This includes benefits for injuries that are deemed compensable in that other state but are not compensable under North Dakota Century Code chapters 65-05 and 65-08. Medical benefits provided pursuant to this section are subject to any fee schedule and other limitations imposed by the workers' compensation law of the elected state. The North Dakota fee schedule does not apply to this section.

   The organization may reimburse an employer covered by this section for legal costs and for reasonable attorney's fees incurred. Reimbursement will be considered only if the employer is sued in tort in another state by an injured employee or an injured employee's dependents relative to a work-related illness, injury, or death; or if the employer is alleged to have failed to make payment of workers' compensation premium in that other state by the workers' compensation authorities of that state. This reimbursement may be made only if it is determined by the organization or by a court of competent jurisdiction that the employer is subject to the provisions of this section and was not required to purchase workers' coverage in that other state relative to the employment of the injured employee. Attorney fees and costs will be paid as set forth in section 92-01-02-11.1. If the other state has an appeal process that differs from the organization, the organization may pay fees consistent with, but may not exceed the fees and caps set forth in section 92-01-02-11.1.

   The organization may not reimburse any legal costs, attorney's fees, nor any other costs to a coemployee sued in tort by an injured employee.

5. If a claim for workers' compensation benefits is compensable in this state and a claim for workers' compensation benefits for the same injury or death is filed in another state, the

organization may defend, at the organization's expense, using counsel and resources of the organization's choosing, any claim, proceeding, or suit against a North Dakota covered employer. The organization may exceed the fees and caps set forth in section 92-01-02-11.1 for this subsection. The organization has the right to investigate and settle these claims, proceedings, or suits.

The organization may not defend a claim for workers' compensation benefits, proceeding, or suit if that claim for workers' compensation benefits is not compensable in this state.

6. The organization may contract with a qualified third-party administrator to adjust and administer claims arising under this chapter. The organization shall pay the costs of the third-party administrator from the general fund.

~~6.~~7. Benefits paid on behalf of an employer pursuant to this section will be charged against the employer's account for experience rating purposes. The experience rating loss will be equal to the actual claim costs. The assessment charge plus appropriate penalties and interest, if any, levied pursuant to North Dakota Century Code section ~~65-05-07.2~~65-04-04.4, will be assessed on all claims brought under this section.

~~7.~~8. The employer shall notify the organization when a claim is filed in another state by an employee covered by this section. The employer shall notify the organization of the claim in writing. The employer has thirty days after actual knowledge of the filing of a claim in which to notify the organization. That time can be extended for thirty days by the organization if the employer shows good cause for failing to timely notify the organization. If the employer fails to timely notify the organization when a claim is filed in another state by an employee covered under this section, the organization may not pay benefits under this section.

The organization may not pay costs, charges, or penalties charged against an employer for late reporting of an injury or claim to the workers' compensation authorities of the state of injury.

~~8.~~9. The exclusive remedy provisions of North Dakota Century Code sections 65-01-01, 65-01-08, 65-04-28, and 65-05-06 apply to this section.

History: Effective January 1, 1994; amended effective April 1, 1997; July 1, 2004; July 1, 2006; July 1, 2010; April 1, 2014; April 1, 2016; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08.1-02, 65-08.1-05

92-01-02-55. Dividend programs.

The organization may offer dividends to qualifying employers. Eligibility and distribution:

1. Dividends are not guaranteed.

2. If an employer's account has been in effect for less than an entire premium year, any dividend offered shall be prorated by the number of months the employer's account has been active with the organization. Premiums paid and losses incurred during a dividend review period defined by the organization, and other criteria identified by the organization, may be used to determine the amount of the dividend. Minimum premium and volunteer accounts are not eligible for dividend payments.

3. The organization shall offset past-due balances on any account by the dividend earned on that account.

4. The distribution of a dividend may not reduce an employer's premium below the minimum premium.

5. An employer who is noncompliant, delinquent, uninsured, or who has failed to submit a payroll report may be ineligible for a dividend for the payroll period following the year in which the employer was noncompliant, delinquent, uninsured, or failed to submit a payroll report.

History: Effective May 1, 2000; amended effective July 1, 2004; July 1, 2006; July 1, 2010; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.3

92-01-02-57. Medical expense assessments.

An employer may file an incident report with the organization through the organization's web site. If an incident report is filed with the organization by midnight central time of the next organization business day following the workplace injury or incident and a claim is filed for benefits within fourteen calendar days of the date of injury, the organization shall waive the two hundred fifty dollar medical expense assessment.

The organization shall notify an employer by electronic transmission or by regular mail of the ~~employer's~~assessment of a medical expense assessment ~~billing statement or by electronic transmission of the organization's decision to assess a medical expense assessment against an employer's account~~. The billing statement must inform the employer of the ability to appeal the decision of the organization.

History: Effective July 1, 2006; amended effective April 1, 2008; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-04.4, 65-04-19.3~~, 65-05-07.2~~

TITLE 96

BOARD OF CLINICAL LABORATORY PRACTICE

APRIL 2020

CHAPTER 96-02-02
LICENSURE

96-02-02-01.1. Military spouse licensure.

1. The board shall license individuals that meet the definition of military spouse set forth in North Dakota Century Code section 43-51-01 who, through the submission of a completed application form, demonstrate the following:

   a. The military spouse demonstrates competency in clinical laboratory practice through methods or standards determined by the board which must include experience in clinical laboratory practice for at least two of the four years preceding application.

   b. The board determines the issuance of the license will not substantially increase risk of harm to the public.

2. The board may require the submission of any information it deems necessary to assist it in making its determination. The board may deny a license if the board determines the applicant does not meet the above requirements. If the board determines the applicant substantially meets the above requirements, the board may issue a provisional license. When issuing a provisional license, the board may explain the steps necessary for the applicant to fully meet the above requirements and be issued a nonprovisional license. A provisional license must be granted automatically by the board if the board does not deny or grant the license within thirty days of application. The board may place conditions on any license or provisional license. Military spouses may not be assessed fees for the issuance of a license or provisional license under this section. A provisional license may be valid for up to two years. Provisional licenses expire for reasons, including:

   a. The board grants the application for license.

   b. The board denies the application for licensure.

c. The provisional license expires.

d. The board revokes the provisional license to protect the public safety.

e. The applicant fails to meet any steps or conditions the board placed on the provisional license.

History: Effective April 1, 2020.
General Authority: NDCC 43-48-04
Law Implemented: NDCC 43-48-04, 43-48-08, 43-48-09, 43-48-13, 43-51-11.1

96-02-02-02. Requirements for specific licenses.

1. Medical technologist (clinical laboratory scientist) must have earned a bachelor's degree in a science-related discipline ~~and have passed a national certifying examination approved by the board~~, completed the academic requirements of a structured clinical educational program recognized by the board, and passed a national certifying examination approved by the board.

2. A clinical laboratory specialist must have a bachelor's or higher degree with a major in one of the chemical, physical, or biological sciences and may only perform functions directly related to the person's particular specialty.

   A clinical laboratory specialist must pass a national certifying examination approved by the board in a specialty area. A license issued to a clinical laboratory specialist will designate the area of specialty.

3. A categorical license issued to a clinical laboratory specialist must designate the area of specialty. Specialty areas include:

   a. Blood bank or immunohematology.

   b. Chemistry.

   c. Hematology.

   d. Microbiology.

4. A clinical laboratory technician or medical laboratory technician must successfully complete the academic requirements of a structured clinical educational program recognized by the board and must pass a national certifying examination approved by the board.

~~4.~~5. The board may issue a provisional permit to a person who has applied for licensure and is eligible to take a board-recognized national certifying examination.

   The provisional permit may not exceed one year. At the board's discretion, the permit may be renewed a maximum of two consecutive times for a period of one year each.

History: Effective June 1, 1991; amended effective May 1, 2002; July 1, 2017; April 1, 2020.
General Authority: NDCC 43-48-04
Law Implemented: NDCC 43-48-04, 43-48-07, 43-48-08, 43-48-09, 43-48-11

96-02-02-03. Reciprocity.

1. The board will evaluate the submission of requests for reciprocity for licensure on an individual basis and grant such only upon a finding that the requirements for licensure in another state or jurisdiction are equal to or more stringent than those of North Dakota and that the applicant's license in another state or jurisdiction is in good standing.

2. The board may deny a request for reciprocity for licensure if the applicant has had disciplinary action taken against him or her or has engaged in conduct that violates the standards of section 96-02-09-02 or conduct that meets the requirements for discipline under North Dakota Century Code section 43-48-15 even if the applicant is currently in good standing in another state or jurisdiction.

3. If an individual applying for licensure by reciprocity under this section has been licensed previously by the board to practice in North Dakota, the individual must also meet the continuing education requirements of section 96-02-04-01 before being licensed under this section.

History: Effective June 1, 1991; amended effective May 1, 2002; July 1, 2017; April 1, 2020.
General Authority: NDCC 43-48-04
Law Implemented: NDCC 43-48-04

CHAPTER 96-02-10

96-02-10-01. Exempt tests and methods.

An individual~~,~~ is exempt from the provisions of North Dakota Century Code chapter 43-48 if the individual is supervised either by an individual licensed by the board, an advanced practice registered nurse, or a physician and the individual is performing the following food and drug administration-waived tests and using the following methods, or performing tests determined by the board to be equivalent to those listed in this section~~, is exempt from the provisions of North Dakota Century Code chapter 43-48~~:

1. Any of the following tests by nonautomated or automated urinalysis by dipstick:
   a. Bilirubin.
   b. Blood.
   c. Glucose.
   d. Ketone.
   e. Leukocyte.
   f. Nitrate.
   g. Potential of hydrogen (pH).
   h. Protein.
   i. Specific gravity.
   j. Urobilinogen.
2. Fecal occult blood by any accepted method.
3. Ovulation test by visual color comparison.
4. Qualitative urine pregnancy test by visual color comparison.
5. Erythrocyte sedimentation rate by any accepted nonautomated method.
6. Whole blood glucose by any accepted single analyte method.
7. Spun microhematocrit by any accepted method.
8. Hemoglobin by single analyte instrument or manual copper sulfate method.
9. Any of the following tests by immunoassay using a rapid test device that detects antibodies or antigens:
   a. Helicobacter pylori.
   b. Influenza.
   c. Mononucleosis.
   d. Streptococcus group A.
   e. Hepatitis C virus.
   f. Respiratory syncytial virus.

10. Prothrombin time international normalized ratio by mechanical endpoint.

11. Antibodies to human immunodeficiency virus types 1 and 2 by clearview complete HIV 1/2 assay.

12. ~~Total cholesterol by~~Alere cholestech analyzer, but only for the following analytes:

    a. Total cholesterol; and

    b. High-density lipoprotein (HDL) cholesterol.

13. ~~High-density lipoprotein cholesterol by cholestech analyzer.~~

~~14.~~ Syphilis health check.

~~15.~~14. CoaguCheck XS system.

~~16.~~15. UltraCrit hematocrit.

~~17.~~16. Abaxis ~~Piccolo Xpress~~piccolo xpress analyzer whole blood methods, but only for the following analytes: ~~total~~

    a. Total cholesterol~~,~~.

    b. HDL cholesterol~~, triglycerides, and glucose~~.

    c. Triglycerides.

    d. Glucose.

    e. Blood urea nitrogen (BUN).

    f. Creatinine.

    g. Sodium.

    h. Potassium.

    i. Bicarbonate.

    k. Total protein.

    l. Total biliruin.

    m. Aspartate aminotransferase (AST).

    n. Alanine aminotransferase (ALT)

    o. Albumin.

    p. Total calcium.

    q. Alkaline phosphatase.

~~18.~~17. i-STAT creatinine when performed by radiology technologists or technicians.

18. Alere affinion AS100 glcosylated hemoglobin (A1C).

History: Effective January 1, 2006; amended effective January 1, 2008; April 1, 2012; April 1, 2013; July 1, 2017; April 1, 2020.

General Authority: NDCC 43-48-03, 43-48-04
Law Implemented: NDCC 43-48-03

96-02-10-01.1. Exempt test and method.

An individual, supervised by an individual licensed by the board, advanced practice registered nurse, or physician performing total protein tests by Reichert digital refractometer, is exempt from the provisions of North Dakota Century Code chapter 43-48.

History: Effective January 1, 2010; amended effective April 1, 2020.
General Authority: NDCC 43-48-03, 43-48-04
Law Implemented: NDCC 43-48-03

TITLE 114

MEDICAL IMAGING AND RADIATION THERAPY BOARD

APRIL 2020

CHAPTER 114-01-01

114-01-01-01. Organization of medical imaging and radiation therapy board.

1. **History and function.** The 2015 legislative assembly passed the medical imaging and radiation therapy board practices act, codified as North Dakota Century Code chapter 43-62. This chapter requires the governor to appoint the board of medical imaging and radiation therapy board. The function of the board is to regulate the practice of medical imaging and radiation therapy modalities by licensing qualified individuals.

2. **Board membership.** The board consists of nine members appointed by the governor. Five members are medical imaging or radiation therapy professionals, one each chosen from the primary modalities of nuclear medicine technology, radiation therapy, radiography, sonography, magnetic resonance imaging and medical imaging or radiation therapy education, one member is a radiologist, one is a medical physicist, one is a physician from a rural area, and one public member. Members of the board serve four-year terms. The terms are so arranged that no more than four terms expire on July thirty-first of each year. No member may be appointed for more than two consecutive four-year terms.

3. **Compensation.** Board members are entitled to receive expenses from board funds for each day or a portion of the day spent in board work as provided for other state officers in North Dakota Century Code section 54-06-09. In addition to the expenses incurred while engaged in the performance of their duties, each board member is entitled to receive a per diem fee set by the board, not to exceed the fee established by law for the legislative assembly.

4. **Executive secretary.** The board shall employ personnel necessary to carry out North Dakota Century Code chapter 43-62 and this title will be responsible for the administration of the board's office and activities.

5. **Executive director.** The board may hire an executive director to oversee the administrative duties of the board, and who will answer to the board.

6. **Inquiries.** Inquiries regarding the board may be addressed to:

   Medical Imaging and Radiation Therapy Board
   P.O. Box 398
   Bismarck, North Dakota 58502-0398

History: Effective April 1, 2018; amended effective April 1, 2020.
General Authority: NDCC 28-32
Law Implemented: NDCC 43-62

CHAPTER 114-02-03
LICENSURE BY ENDORSEMENT

114-02-03-01.1. Limited x-ray machine operator in nonlicensure state endorsement requirements.

1. A limited x-ray machine operator in another jurisdiction that regulates the profession but does not license, may apply for licensure by endorsement. The applicant may not have an encumbered license or other restricted practice in any jurisdiction, shall meet board requirements, and shall submit the following:

   a. A completed endorsement application and pay the nonrefundable fee as required in chapter 114-01-03.

   b. Verification of active practice as a limited x-ray machine operator from a department manager or employer that the individual has:

      (1) Been practicing actively for three or more of the five years immediately preceding the endorsement application; and

      (2) Been proven to be clinically competent in performing limited scope imaging examinations.

   c. Otherwise the applicant shall meet the unique licensure or practice standard requirements established by the board.

2. The applicant biennially shall complete the continuing education.

3. The applicant shall complete a criminal history record check as required in section 114-03-02-01.

4. The expiration date of the license must be consistent with the two-year cycle. An applicant who is licensed after September first in the second year of a two-year cycle, must be issued a license that expires at the conclusion of the following two-year cycle.

History: Effective April 1, 2020.
General Authority: NDCC 43-62
Law Implemented: NDCC 12-60-24, 43-62-14(4)(6)

114-02-03-02. Military spouses - Licensure.

~~1. Applicants licensed for medical imaging or radiation therapy in another jurisdiction may apply for a license. A military spouse applicant may not have an encumbered license or other restricted practice in any jurisdiction, shall meet board requirements, and shall submit a completed application and pay the nonrefundable fee as required in chapter 114-01-03 and:~~

~~a Evidence that demonstrates continued competency in one or more medical imaging or radiation therapy modalities, which must include verification of experience for at least three years or more of the five years preceding the date of application; or~~

~~b. Otherwise the applicant shall meet the unique licensure or practice standard requirements established by the board under subsection 7 of North Dakota Century Code section 43-62-14.~~

~~2. The applicant shall complete a criminal history record check as required in section 114-03-02-01.~~

~~3. A military spouse issued a license under this section has the same rights and duties as other licensees.~~

~~4. A military spouse who does not meet the practice requirements outlined above may apply for licensure pursuant to section 114-02-03-01.~~Military spouses may be licensed pursuant to the procedure outlines in North Dakota Century Code section 43-51-11.1.

History: Effective April 1, 2018; amended effective April 1, 2020.
General Authority: NDCC 43-62
Law Implemented: NDCC 12-60-24, 43-51-11.1

CHAPTER 114-02-05

114-02-05-01. Recognized certification organizations and credentials.

~~1.~~ The applicant's licensing title must be on the certificate including all modalities in which the licensee holds current certification and registration. The board recognizes the following certification organizations and their credentials:

~~a.~~1. American registry for diagnostic medical sonography (ARDMS);

~~b.~~2. American registry of magnetic resonance imaging technologists (ARMRIT);

~~c.~~3. American registry of radiologic technologists (ARRT);

~~d.~~4. Canadian association of medical radiation technologists (CAMRT);

~~e.~~5. Cardiovascular credentialing international (CCI);

~~f.~~6. Certification board of radiology practitioner assistants (CBRPA);

~~g.~~7. International society for clinical densitometry (ISCD);

~~h.~~8. Nuclear medicine technology certification board (NMTCB);

~~i.~~9. Sonography Canada; and

~~2.~~10. Other successor organizations as recognized by the board.

History: Effective April 1, 2018; amended effective April 1, 2020.
General Authority: NDCC 43-62
Law Implemented: NDCC 43-62-09, 43-62-14