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JANUARY 2022

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7-04-05-01. Definitions.

1. "Moss ball" means the aquatic plant known as aegagropila linnaei or other common names.

2. "Zebra mussel" means an aquatic invasive invertebrate plant pest known as dressissena polymorpha.

History: Effective January 1, 2022.
General Authority: NDCC 4.1-23-02
Law Implemented: NDCC 4.1-23-01(8), 4.1-23-04

7-04-05-02. Regulated articles.

Regulated articles are as follows:

1. The aquatic plant known as aegagropila linnaei ("moss ball").

2. Any other aquatic species found to be infested with desissena polymorpha ("zebra mussel").

History: Effective January 1, 2022.

General Authority: NDCC 4.1-23-02
Law Implemented: NDCC 4.1-23-01(8), 4.1-23-04

7-04-05-03. Regulated areas.

The regulated quarantined area includes all states, districts, and territories of the United States.

History: Effective January 1, 2022.
General Authority: NDCC 4.1-23-02
Law Implemented: NDCC 4.1-23-04

7-04-05-04. Restrictions on regulated articles and conditions on the movement of regulated articles.

Regulated articles may not be transported into the state or moved within the state unless accompanied by a current certificate of inspection issued by the United States department of agriculture - animal plant health inspection service, the department of agriculture in the shipping state, or the aquatics invasive species regulatory agency in the shipping state.

History: Effective January 1, 2022.
General Authority: NDCC 4.1-23-02
Law Implemented: NDCC 4.1-23-04

7-04-05-05. Violations and penalties.

Any person violating these regulations is subject to penalties in accordance with North Dakota Century Code chapter 4.1-23-08.

History: Effective January 1, 2022.
General Authority: NDCC 4.1-23-02
Law Implemented: NDCC 4.1-23-04

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[Repealed effective January 1, 2022]

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ARTICLE 7-18
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CHAPTER 7-18-01
GENERAL PROVISIONS

7-18-01-01. Outstanding storage at license termination.

A warehouse licensee having outstanding storage at the termination of the license period, shall procure a license in the usual manner, even though the warehouse is closed, or will be closed.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-41

7-18-01-02. Storage in another warehouse.

All nontransit grain owned or held by a warehouse licensee under North Dakota Century Code chapter 60-02 must be held in a licensed and bonded warehouse, either within or outside the state. If grain is held in space that is not licensed capacity by the licensee under North Dakota Century Code chapter 60-02, a warehouse document issued for that grain must identify the originating warehouse as the receiptholder. If grain held subject to a warehouse receipt is stored in a warehouse that is not licensed under North Dakota Century Code chapter 60-02, the originating warehouse shall increase its bond to provide protection for that grain as well as its own licensed warehouse space.

Daily position records must include inventories held under nonnegotiable warehouse receipts issued by another licensed warehouse.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03
Law Implemented: NDDC 60-02-07.1

7-18-01-03. Change in capacity.

A warehouse licensee may not change its physical capacity without prior commissioner approval. A request to change capacity must be on a form provided by the commissioner with capacity being added or deleted. Deleted capacity must be physically disconnected from other licensed capacity. Added capacity must be properly bonded. Additions not previously licensed must be accompanied by a diagram showing the location and capacity of the space involved.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-09

7-18-01-04. Assumption of liability for transfer of grain.

A warehouse licensee that intends to acquire a facility operated by another licensee and to assume responsibility for grain obligations of the former licensee shall notify the commissioner of the assumption of the liability. The notice must be submitted on a form provided by the commissioner.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03, 60-02.1-03
Law Implemented: NDDC 60-02-40, 60-02.1-36

7-18-01-05. Delivery policy.

A licensed warehouse during July of each year, shall publish and post in a conspicuous place in each warehouse, the warehouse's policy for delivery of grain to a warehouse receiptholder. The policy must remain in effect at least through the following June and must outline how the warehouseman will charge or compensate the receiptholder for differences in quantity, kind, quality, and grade which exist between the grain described in the scale ticket and the grain that is actually delivered back to the receiptholder. A copy of the warehouse's policy for delivery must be provided to the commissioner as part of its annual warehouse license application. A copy of the policy also must be attached to each warehouse receipt issued to an owner of grain.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-17, 60-02-22

CHAPTER 7-18-02
LICENSING

7-18-02-01. License application.

An application for all licenses must be submitted online on the site provided by the commissioner. Every business organization or sole proprietor using a trade name other than its given name must be registered and in good standing with the secretary of state. The application must be complete and must include:

1. The required license fees.

2. A surety bond, which is signed by principal and surety company with valid power of attorney.

3. A copy of any receipt or credit sale contract to be used by the licensee.

4. Certificate of continuous insurance in the required amount, if applicable.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03, 60-02.1-03
Law Implemented: NDDC 60-02-07, 60-02.1-07

7-18-02-02. Financial requirements.

1. All license types must meet the following requirements based on purchased grain amount:

   a. Purchases less than one million: one hundred thousand dollars net worth.

   b. Purchases more than one million less than ten million: two hundred fifty thousand dollars net worth.

   c. Purchases more than ten million: five hundred thousand dollars net worth.

   d. Working capital ratio of at least 1.0.

2. For any licensee unable to meet these requirements the commissioner may:

   a. Deny a license;

   b. Require additional capital or net worth before approving license; and

   c. Require additional bonding to cover capital or net worth shortfall.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03, 60-02.1-03
Law Implemented: NDCC 60-02-06.2, 60-02.1-06.2

7-18-02-03. License renewal.

A license expires on July thirty-first of each year. A licensee shall submit a renewal application to the commissioner by July fifteenth online on the site provided by the commissioner. Every business organization or sole proprietor using a trade name must be in good standing with the secretary of state. An application that is not received renewed by July thirty-first will result in the expiration of the license on August first. Operation with an expired license must be treated as operation without a license and must be handled pursuant to North Dakota Century Code sections 60-02-12 and 60-02.1-13.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03, 60-02.1-03
Law Implemented: NDCC 60-02-07, 60-02.1-07

7-18-02-04. Business documents.

All licensees promptly shall notify the commissioner of a change in ownership, name, corporate structure, or format of any receipt or credit sale contract.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03, 60-02.1-03
Law Implemented: NDCC 60-02-03, 60-02.1-03

7-18-02-05. Physically disconnected lease space.

Grain warehouses that have facilities that are physically disconnected from licensed facilities may be leased to other entities for nonpublic use. These leased facilities are not part of the license. The lessee is responsible for its own content insurance, if any. The licensee need not bond the space. In the case of licensee insolvency, the contents of the leased facility are not a trust fund asset and the lessee is not entitled to protection for grain held therein. If the leased facility is owned by the licensee, lease agreements must be on file at the warehouse.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-09

7-18-02-06. Universal nonpublic use.

If an entire facility is owned under condominium arrangement or is leased to other entities for nonpublic use, the facility is not a public warehouse and a license is not required.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-44

CHAPTER 7-18-03
BONDING

7-18-03-01. Grain warehouse bonds.

A licensee's minimum bond is two and one-half percent of the licensee's total grain purchases in the state, based on a three-year rolling average during which the license has been active. A licensee shall report the value of purchases at renewal. A licensee's required minimum bond may not be less than one hundred thousand dollars.

1. A grain warehouse bond may not exceed two million five hundred thousand dollars.
2. The bond for any new applicant will be set based on projected purchases for the current license year.
3. The bond will continue to be based on total annual purchases until a three-year average is reached.

History: Effective January 1, 2022.
General Authority: NDCC 60-02-03
Law Implemented: NDCC 60-02-02, 60-02-07, 60-02-09

7-18-03-02. Processor bonds.

A licensee's minimum bond is five percent of the licensee's total grain purchases in the state, based on a three-year rolling average during which the license has been active. A licensee shall report the value of purchases at renewal. A licensee's required minimum bond may not be less than one hundred thousand dollars.

1. A processor bond may not exceed two million five hundred thousand dollars.
2. For new applicants, the bond will be set based on projected purchases for the current license year.
3. The bond will continue to be based on total annual purchases until a three-year average is reached.

History: Effective January 1, 2022.
General Authority: NDCC 60-02.1-03
Law Implemented: NDCC 60-02.1-03, 60-02.1-08

7-18-03-03. Grain buyer bonds.

A licensee's minimum bond is eight percent of the licensee's total grain purchases in the state, based on annual purchases as reported monthly to the commissioner. A licensee's required minimum bond may not be less than one hundred thousand dollars:

1. A roving grain buyer bond may not exceed two million five hundred thousand dollars.
2. For new applicants, the bond will be set based on projected purchases for the current license year.

History: Effective January 1, 2022.
General Authority: NDCC 60-02.1-03
Law Implemented: NDCC 60-02.1-03, 60-02.1-08

7-18-03-04. Broker bonds.

A licensee's minimum bond is one hundred thousand dollars. A broker bond may not exceed two million five hundred thousand dollars.

History: Effective January 1, 2022.
General Authority: NDCC 60-02.1-03
Law Implemented: NDCC 60-02.1-03, 60-02.1-08

TITLE 33.1

DEPARTMENT OF ENVIRONMENTAL QUALITY

JANUARY 2022

CHAPTER 33.1-14-01

33.1-14-01-01. Definitions.

As used in this article:

1. "Alteration" means a change in an item described on an original manufacturer's data report which affects the pressure retaining capability of the pressure retaining item. An alteration includes nonphysical changes, such as an increase in the maximum allowable internal or external working pressure, an increase in design temperature, or a reduction in minimum temperature. For boilers used in the power generation industry exceeding one hundred thousand pounds of steam per hour output, increases in steaming capacity may not be considered an alteration if a new baseline steaming capacity is established based on either an engineering evaluation or a review of the operating history and a conditional assessment of the boiler and its components. An engineering evaluation or conditional assessment must be made by the boiler owner with review and comment by the authorized inspection agency responsible for the in-service inspection of the boiler. Engineering evaluations and conditional assessments are subject to the review and approval of the chief boiler inspector.

2. "Apartments" means all multiple dwellings, including condominiums.

3. "Approved" means approved by the director.

4. "A.S.M.E. code" means the boiler and pressure vessel construction code of the American society of mechanical engineers of which sections I, II, IV, V, VIII (divisions 1, 2, and 3), IX, and X, ~~2019~~2021 edition, are hereby adopted by the director and incorporated by reference as a part of this article. A copy of the American Society of Mechanical Engineers Code is on file at the office of the boiler inspection program. The American Society of Mechanical Engineers Code may be obtained from the American Society of Mechanical Engineers headquarters at 2 Park Avenue, New York, New York 10016-5990 or from www.asme.org.

5. "Boiler" means a closed vessel in which water is heated, steam is generated, steam is superheated, or any combination thereof, under pressure or vacuum for use externally to itself by the direct application of heat from the combustion of fuels or from electricity or nuclear energy. The term boiler includes fired units for vaporizing liquids other than water when these units are separate from processing systems and are complete within themselves, as provided under subsection 1 of North Dakota Century Code section 23.1-16-01.

6. "Certificate inspection" means an inspection, the report of which is used by the chief boiler inspector to decide whether a certificate may be issued under North Dakota Century Code section 23.1-16-10.

7. "Certificate of competency" means a certificate issued by a jurisdiction indicating that a person has passed an examination prescribed by the national board of boiler and pressure vessel inspectors.

8. "Chief inspector" means the chief boiler inspector appointed by the director to serve in the capacity as stated by law.

9. "Condemned boiler" means a boiler that has been inspected and declared unsafe or disqualified by legal requirements by an inspector qualified to take such action who has applied a stamping or marking designating its rejection.

10. "Deputy inspector" means a boiler inspector or inspectors employed by the director to assist the chief inspector in making inspections of boilers.

11. "Director" means the director of the department of environmental quality.

12. "Existing installations" includes any boiler constructed, installed, or placed in operation before July 1, 1973.

13. "External inspection" means an inspection made when a boiler is in operation.

14. "Fusion welding" means a process of welding metals in a molten or molten and vaporous state, without the application of mechanical pressure or blows. Such welding may be accomplished by the oxyacetylene or oxyhydrogen flame or by the electric arc. Thermic welding is also classed as fusion.

15. "High-pressure, high-temperature water boiler" means a water boiler operating at pressures exceeding one hundred sixty pounds per square inch gauge [1103.17 kilopascals] or temperatures exceeding two hundred fifty degrees Fahrenheit [121.16 degrees Celsius]. For practical purposes it must be deemed the same as a power boiler.

16. "Hot water supply boiler" means a fired boiler used exclusively to supply hot water for purposes other than space heating and includes all service-type and domestic-type water heaters not otherwise exempt by North Dakota Century Code section 23.1-16-06.

17. "Inspector" means the chief boiler inspector or any deputy inspector or special inspector.

18. "Internal inspection" means an inspection made when a boiler is shut down and handholes and manholes are opened for inspection of the interior.

19. "Low pressure and heating boiler" means a boiler operated at pressures not exceeding fifteen pounds per square inch gauge [103 kilopascals] for steam or at pressures not exceeding one hundred sixty pounds per square inch gauge [1103.17 kilopascals] and temperatures not exceeding two hundred fifty degrees Fahrenheit [121.1 degrees Celsius] for water.

20. "Major repair" means a repair upon which the strength of a boiler would depend. Major repairs are those that are not of a routine nature as described in the National Board Inspection Code.

21. "Miniature boiler" means any boiler that does not exceed any of the following limits:

    a. Sixteen inch [40.64 centimeter] inside diameter of shell.

    b. Twenty square feet [1.86 square meter] heating surface.

    c. Five cubic feet [.142 cubic meter] gross volume, exclusive of casing and insulation.

    d. One hundred pounds per square inch gauge [689.48 kilopascals] maximum allowable working pressure.

22. "National board" means the national board of boiler and pressure vessel inspectors, 1055 Crupper Avenue, Columbus, Ohio 43229, whose membership is composed of the chief inspectors of government jurisdictions who are charged with the enforcement of the provisions of the American Society of Mechanical Engineers Code.

23. "National Board Inspection Code" means the manual for boiler and pressure vessel inspectors supplied by the national board. The National Board Inspection Code, ~~2019~~2021 edition, is hereby adopted by the director and incorporated by reference as a part of this article. Copies of this code may be obtained from the national board at 1055 Crupper Avenue, Columbus, Ohio 43229.

24. "New boiler installations" includes all boilers constructed, installed, or placed in operation after July 1, 1973.

25. "Nonstandard boiler" means a boiler that does not bear the state stamp, the national board stamping, the American society of mechanical engineers stamp, or the stamp of any state or political subdivision which has adopted a standard of construction equivalent to that required by this article.

26. "Owner or user" means any person, firm, corporation, state, or political subdivision owning or operating any boiler that is not specifically exempt under North Dakota Century Code section 23.1-16-06 within North Dakota.

27. "Power boiler" means a closed vessel in which steam or other vapor (to be used externally to itself) is generated at a pressure of more than fifteen pounds per square inch gauge [103 kilopascals] by the direct application of heat.

28. "Reciprocal commission" means a commission issued by the director to persons who have passed a written examination prescribed by the national board and who hold a national board commission issued by the national board, or to persons who have passed the written examination prescribed by the national board and are employed by an accredited national board owner/user inspection organization.

29. "Reinstalled boiler" means a boiler removed from its original setting and re-erected at the same location or erected at a new location without change of ownership.

30. "Reinstalled pressure vessel" means a pressure vessel removed from its original setting and re-erected at the same location or erected at a new location without change of ownership.

31. "Repair" is a restoration of any damaged or impaired part to an effective and safe condition.

32. "Secondhand boiler" means a boiler of which both the location and ownership have been changed after primary use.

33. "Secondhand pressure vessel" means a pressure vessel of which both the location and ownership have been changed after primary use.

34. "Service-type or domestic-type water heater" means a fired water heater of either instantaneous or storage type, used for heating or combined heating and storage of hot water to be used exclusively for domestic or sanitary purposes, with temperatures not exceeding two hundred ten degrees Fahrenheit [98.68 degrees Celsius], and a heat input not in excess of two hundred thousand British thermal units [2.11 x 10^8 joules] per hour, and pressure not to exceed one hundred sixty pounds per square inch [1103.17 kilopascals].

35. "Special inspector" means an inspector regularly employed by an accredited national board authorized inspection agency or an inspector who has passed the national board examination and is employed by an accredited national board owner/user inspection organization.

36. "Standard boiler" means a boiler that bears the stamp of North Dakota or of another state that has adopted a standard of construction equivalent to that required by this article or a boiler that bears the national board stamping or American society of mechanical engineers stamp.

37. "State of North Dakota boiler construction code" is used to designate the accepted reference for construction, installation, operation, and inspection of boilers and will be referred to as this article. Anything not amended or specifically covered in this article must be considered the same as the American society of mechanical engineers code.

38. "Steam traction engines" means boilers on wheels which are used solely for show at state fairs and other exhibitions in which the public is invited to attend.

History: Effective July 1, 2020; amended effective January 1, 2022.
General Authority: NDCC 23.1-16-01
Law Implemented: NDCC 23.1-16-01

CHAPTER 33.1-14-03

33.1-14-03-01.1. Boiler inspection fees.

The following will be charged for boiler inspections:

1. High pressure boilers.

	Fee
a. Internal inspections.	
- 50 square feet [4.65 square meters] or less of heating surface	$90.00
- Over 50 square feet [4.65 square meters] and not over 500 square feet [46.45 square meters]	$110.00
- Over 500 square feet [46.45 square meters] and not over 4,000 square feet [371.61 square meters]	$130.00
- Over 4,000 square feet [371.61 square meters] of heating surface	$160.00
b. External inspections.	
- 50 square feet [4.65 square meters] of heating surface or less; 100 KW or less	$70.00
- Over 50 square feet [4.65 square meters] of heating surface; over 100 KW	$90.00

c. Portable oilfield boilers. Internal and external inspections of portable oilfield boilers must be charged inspection fees of seventy-five dollars per hour, including travel time, plus expenses for meals, mileage, and lodging at current state rates.

2. Low pressure boilers.

a. Internal inspections.	
- Without manway	$85.00
- With manway	$95.00
b. External inspections.	
- Hot water heat and low-pressure steam	$60.00
- Hot water supply	$45.00

3. Steam traction engines.

- Internal	$70.00
- External	$65.00
- Hydrostatic test	$80.00
- Ultrasonic survey, per hour	$85.00

4. Certificate fee, per certificate as required by North Dakota Century Code section 23.1-16-10 ~~$20.00, per year of certificate issued~~

History: Effective July 1, 2020; amended effective January 1, 2022.

General Authority: NDCC 23.1-16-09
Law Implemented: NDCC 23.1-16-09

33.1-19-01-06. Fees for certification.

1. Fees for certification are ~~ten~~fifty dollars per examination.
2. Fees for annual renewals are ~~five~~twenty-five dollars per certificate.
3. The certification fee from a qualified applicant is nonrefundable and must be received by the department prior to the examination. Applicants will be notified of the results of the examinations. Papers and test material remain the property of the department. Applicants may, upon request, review the results with the department.
4. Fees received from operators whose application for certification has been rejected will be returned.

History: Effective January 1, 2019; amended effective January 1, 2022.
General Authority: NDCC 23.1-07-06~~; S.L. 2017, ch. 199, § 1~~
Law Implemented: NDCC 23.1-07-05, 23.1-07-06~~; S.L. 2017, ch. 199, § 22~~

CHAPTER 33.1-23-02

33.1-23-02-02. Definitions.

In this article, unless the context otherwise requires, the following definitions apply:

1. "Analyte" means the chemical substance, physical property, or organism determined in a sample.

2. "Analyte group" means a set of analytes that can be determined using the same method or technology.

3. "Biosolids" means sewage sludge or a solid, semisolid, or liquid residue generated during the treatment of domestic sewage in a treatment works. Biosolids includes domestic septage; scum or solids removed in primary, secondary, or advanced wastewater treatment processes; and a material derived from sewage sludge. Sewage sludge does not include ash generated during the firing of sewage sludge in a sewage sludge incinerator or grit and screenings generated during preliminary treatment of domestic sewage in a treatment works.

4. "Certified laboratory" means a laboratory that has a valid certification issued by the department.

5. "Client" means an entity that has arranged with a laboratory to perform tests and analyses to meet the requirements of a department issued permit or another department program or regulatory requirement.

6. "Coal Combustion Residual Rule" means the sampling and analysis requirements under title 40 Code of Federal Regulations, part 257 and appendices III and IV to part 257.

7. "Department" means the North Dakota department of environmental quality.

8. "Department program" means a program or rule administered by the department which requires submission of data for compliance reporting purposes that must come from a certified laboratory.

9. "Field of testing" means the combination of analyte, method, matrix, and program for which a laboratory may hold accreditation or certification.

10. "Initial application" means an application submitted by a laboratory that either has never had certification or has not met the requirements and qualifications for either a renewal or revised application.

11. "Laboratory" means a facility that performs analyses on potable water, nonpotable water, a hazardous liquid, or solid matrix.

12. "Manual for the Certification of Laboratories Analyzing Drinking Water" means the environmental protection agency publication "Manual for the Certification of Laboratories Analyzing Drinking Water", 5th edition and including supplement 1 to the 5th edition of the "Manual for the Certification of Laboratories Analyzing Drinking Water" and supplement 2 to the 5th edition of the "Manual for the Certification of Laboratories Analyzing Drinking Water".

13. "Method" means an environmental protection agency promulgated or environmental protection agency accepted published scientific technique for performing a specific measurement. Method includes instructions for sample preparation, sample preservation, and sample analysis.

14. "Method defined parameter" means parameters that are physical or chemical properties of materials determined with specific methods used to evaluate whether the materials comply

with certain Resource Conservation and Recovery Act of 1976, 42 U.S.C. section 6901 et seq., subtitle C regulations.

15. "National Primary Drinking Water Regulations" means the federal program authorized under title 40 Code of Federal Regulations, part 141, section 141.1 et seq.

16. "National pollutant discharge elimination system" means the federal program authorized under title 40 Code of Federal Regulations, part 136, section 136.1 et seq.

17. "Nonpotable water" means water not suitable for drinking. It is a matrix in the Clean Water Act Program, the Resource Conservation and Recovery Act program and the Coal Combustion Residuals Rule program.

18. "North Dakota Environmental Laboratory Certification Program Manual" means the manual used by the environmental laboratory certification program for chemistry parameters. It is available on the department's website and is the Rev. November 2019 edition.

19. "Parameter" means the chemical substance, physical property, or organism being determined.

20. "Point value" means the numerical increments which represent the amount necessary to cover costs of reviewing applications, issuing certifications, conducting laboratory evaluations, training, collecting fees, and providing compliance assistance and other anticipated costs of administering the environmental laboratory certification program.

21. "Potable water" means water suitable for drinking. It is the matrix in the Safe Drinking Water Act program.

22. "Proficiency test" means the process of testing and reporting of test results performed by a laboratory for a specific analyte or analyte group to determine the ability of a laboratory to employ applicable analytical methods and to produce an accurate measurement of the concentration of the analyte or analyte group in the sample.

23. "Reciprocal certification" means a reciprocal or secondary certification that is based on a primary certification.

24. "Renewal application" means an application submitted by a laboratory to renew an existing certification.

25. "Reporting limit" means the lowest level of an analyte that can be accurately recovered from the matrix of interest. This limit is equivalent to a level of quantitation.

26. "Resource Conservation and Recovery Act" means the federal law found under 42 U.S.C. section 6901 et seq. (1976) and its corresponding regulations found under title 40, Code of Federal Regulations, parts 239 through 282.

27. "Revised application" means an application that is submitted to make changes to an existing certification.

28. "SW-846" means the environmental protection agency guidance for using the "Test Methods for Evaluation Solid Waste: Physical/Chemical Methods", Publication SW-846, United States environmental protection department (2019). This guidance consists of three main parts: chapters, methods, and supporting documents and is the environmental protection agency SW-846 compendium.

29. "Test methods for evaluating solid waste: physical/chemical methods" means the environmental protection agency publication also known as SW-846.

History: Effective July 1, 2020; amended effective January 1, 2022.

General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

33.1-23-02-03. General requirements for required methods.

The analytical methods, sample collection, and preservation procedures used to analyze samples for programs required by a federal agency must meet the requirements specified in the relevant parts of the Code of Federal Regulations as stated herein. The laboratory's analytical methods, sample collection, and preservation procedures also must meet the requirements specified by the department program. Certification requirements are based on the analysis of regulated parameters by promulgated methods unless otherwise specified or required by a department program.

History: Effective July 1, 2020; amended effective January 1, 2022.
General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

33.1-23-02-04. Biosolids program methods.

For analysis of sewage sludge samples required by state and federal rules, laboratories shall use the methods and test procedures in title 40, Code of Federal Regulations, part 503, and publication SW-846.

History: Effective July 1, 2020; amended effective January 1, 2022.
General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

33.1-23-02-05. Clean Water Act program methods.

For analysis of water or wastewater samples required by state and federal clean water rules, laboratories shall use the methods and test procedures in title 40, Code of Federal Regulations, part 136.

History: Effective July 1, 2020; amended effective January 1, 2022.
General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

33.1-23-02-06. Coal Combustion Residuals Rule program methods.

For analysis of water or wastewater samples required by state and federal coal combustion residuals in landfills and surface impoundments rules and regulations as amended, laboratories shall use methods appropriate for groundwater sampling and that accurately measure hazardous constituents and other monitoring parameters in groundwater samples. Metals analysis must be for "total recoverable" concentrations. Parameters are found at appendix III to part 257 and appendix IV to part 257.

History: Effective July 1, 2020; amended effective January 1, 2022.
General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

33.1-23-02-07. Nonpotable water program methods.

For analysis of water or wastewater samples as requested by the department or to support studies of specific industries or for use in broad national surveys, laboratories shall use validated methods and test procedures. Environmental protection agency methods are preferred but other state approved and validated methods may be acceptable.

History: Effective July 1, 2020; amended effective January 1, 2022.

General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

33.1-23-02-08. Potable water program methods.

For analysis of suitable drinking water samples as requested by the department or to support studies of specific industries or for use in broad national surveys, laboratories shall use validated methods and test procedures. Environmental protection agency methods are preferred, but other state approved and validated methods may be acceptable.

History: Effective July 1, 2020; amended effective January 1, 2022.
General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

33.1-23-02-10. Safe Drinking Water Act program methods.

For analysis of drinking water samples required by state and federal Safe Drinking Water Act rules, laboratories shall use the methods and test procedures in title 40 Code of Federal Regulations, part 141. Laboratories also shall comply with the "Manual for the Certification of Laboratories Analyzing Drinking Water" requirements.

History: Effective July 1, 2020; amended effective January 1, 2022.
General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

33.1-23-02-11. Alternate methods.

Provisions for the use of alternate methods to be used in the Safe Drinking Water Act program and the Clean Water Act program are found within the corresponding federal laws and regulations. A laboratory may request approval for alternate methods by following the instructions provided in the appropriate sections of the federal laws and regulations for the Clean Water Act program and the Safe Drinking Water Act program.

History: Effective July 1, 2020; amended effective January 1, 2022.
General Authority: NDCC 23.1-01-14
Law Implemented: NDCC 23.1-01-14

TITLE 38

HIGHWAY PATROL

JANUARY 2022

CHAPTER 38-04-01

38-04-01-02. Adoption of regulations.

The following parts of title 49, Code of Federal Regulations, including amendments are adopted by reference:

1. Part 382 - Controlled Substances and Alcohol Use and Testing.
2. Part 385 - Subpart A - General.
3. Part 385 - Subpart B - Safety Monitoring System for Mexico-Domiciled Carriers.
4. Part 385 - Subpart C - Certification of Safety Auditors, Safety Investigators, and Safety Inspectors.
~~3.~~5. Part 385 - Subpart D - New Entrant Safety Assurance Program.
~~4.~~6. Part 385 - Subpart E - Hazardous Materials Safety Permits.
~~5.~~7. Part 386 - Subpart F - Injunctions and Imminent Hazards.
8. Part 386 - Subpart G - Penalities.
9. Part 387 - Minimum Levels of Financial Responsibility for Motor Carriers.
~~6.~~10. Part 390 - Federal Motor Carrier Safety Regulations: General.
~~7.~~11. Part 391 - Qualifications of Drivers.
~~8.~~12. Part 392 - Driving of Motor Vehicles.
~~9.~~13. Part 393 - Parts and Accessories Necessary for Safe Operation.
~~10.~~14. Part 395 - Hours of Service of Drivers.
~~11.~~15. Part 396 - Inspection, Repair and Maintenance.
~~12.~~16. Part 397 - Transportation of Hazardous Materials; Driving.

Intrastate commercial motor vehicles with a gross vehicle weight, gross vehicle weight rating, gross combination weight, and gross combination weight rating of twenty-six thousand pounds [11793.52 kilograms] or less are exempt from all federal motor carrier safety regulations unless the vehicle is used to transport hazardous materials requiring a placard, the vehicle is designed to transport more than

eight passengers, including the driver, for compensation, or unless the vehicle is designed to transport more than fifteen people, including the driver not for compensation.

History: Effective October 1, 1983; amended effective February 1, 1999; February 1, 2000; April 1, 2008; July 1, 2013; January 1, 2022.
General Authority: NDCC 28-32-02, 39-32-02
Law Implemented: NDCC 39-21-46

38-06-02-07. Travel restrictions.

1. Permits may not be issued for overdimensional movements between one-half hour after sunset and one-half hour before sunrise unless otherwise authorized by the superintendent.

2. Except as authorized in this section, single trip permits for overwidth exceeding sixteen feet [4.88 meters] may not be issued authorizing movements on Saturday after twelve noon, all day Sunday, and on holidays of New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. No overwidth permit exceeding sixteen feet [4.88 meters] will be valid from twelve noon the day before the holiday until sunrise the day after the holiday.

3. The superintendent may authorize a single trip permit for weekends or holidays.

4. Permits do not authorize movements when inclement weather prevails, highways are slippery, or when visibility is ~~poor~~one-half mile [0.8 kilometers] or less.

5. Permits do not authorize travel on shoulders of road.

6. A single trip permit is required for each movement that is overdimensional or overweight. An annual permit for overwidth or overlength vehicle and load movements can be used in lieu of the single trip permit issued for overwidth or overlength movements.

7. A minimum distance of one thousand feet [304.80 meters] is required between vehicles in a convoy of two or more vehicles.

History: Effective January 1, 1988; amended effective August 1, 1993; February 1, 1999; April 1, 2008; July 1, 2013; January 1, 2016; July 1, 2019; January 1, 2022.
General Authority: NDCC 39-12-02
Law Implemented: NDCC 39-12-02

CHAPTER 38-06-03

38-06-03-01. Permit fees.

The following fees are in addition to those found in North Dakota Century Code section 39-12-02:

1. ~~The single trip permit fee for exceeding the federal gross vehicle weight limitation of eighty thousand pounds [36287 kilograms] on the interstate highway system is ten dollars.~~

~~2.~~ The fee for a seasonal permit is fifty dollars per year. The seasonal permit is issued to vehicles referenced in subdivision d of subsection 1 of North Dakota Century Code section 39-12-04.

~~3.~~2. There is a graduated fee schedule for overweight single trip movements exceeding one hundred fifty thousand pounds [68035 kilograms] gross vehicle weight.

Gross Vehicle Weight	Permit Fee
150,001 - 160,000 lbs. [68039-72574 kilograms]	$30
160,001 - 170,000 lbs. [72575-77110 kilograms]	$40
170,001 - 180,000 lbs. [77111-81646 kilograms]	$50
180,001 - 190,000 lbs. [81647-86182 kilograms]	$60
190,001 lbs. and over [86183 kilograms and over]	$70

~~4.~~3. There is an additional ton/mile [907 kilogram/1.6 kilometers] fee of $.05 per ton per mile on all those movements that exceed two hundred thousand pounds [90718 kilograms] gross vehicle weight. The ton/mile [907 kilogram/1.6 kilometers] fee is only assessed upon that portion of gross vehicle weight exceeding two hundred thousand pounds [90718 kilograms] gross vehicle weight.

~~5.~~4. The superintendent shall assess a fee of fifty cents per mile [1.6 kilometers] or fifty dollars per hour, or both, per trooper, on those movements of extraordinary size or weight when an escort by the highway patrol is required or when the highway patrol is requested to weigh a vehicle with portable scales.

~~6.~~5. The fee for an equipment approval certificate is fifteen dollars.

~~7.~~6. The ton-mile [907 kilogram-1.6 kilometers] fee for a vehicle or load movement that exceeds the weight limits on highways during the spring thaw or on highways with load limits year-round is as follows:

a. One dollar per ton-mile [907 kilogram-1.6 kilometers] when exceeding axle weight limits.

b. The fees for vehicle or vehicle combinations hauling a load and in excess of the gross vehicle weight limit:

(1) One dollar per mile [1.6 kilometers] when the gross vehicle weight exceeds one hundred five thousand five hundred pounds [47853 kilograms] and travel is on highways restricted by legal weight or eight-ton [7257 kilograms] and seven-ton [6350 kilograms] designated state highways.

(a) Vehicles authorized by the director of the department of transportation to haul construction equipment to state highway construction projects are exempt from one dollar per mile [1.6 kilometers] fee.

(b) The total number of single trip permits for a state highway construction project that may be waived from the one dollar per mile [1.6 kilometers] fee may not exceed ten single trip permits.

(2) Five dollars per ton-mile [907 kilograms-1.6 kilometers] when the gross vehicle weight exceeds:

(a) One hundred thirty thousand pounds [58967 kilograms] on highways restricted by legal weight.

(b) One hundred twenty thousand pounds [54431 kilograms] on eight-ton [7257 kilograms] highways.

(c) One hundred ten thousand pounds [49895 kilograms] on seven-ton [6350 kilograms] highways.

(d) Eighty thousand pounds [36287 kilograms] on six-ton [5443 kilograms] highways.

(3) The five dollar per ton-mile [907 kilograms-1.6 kilometers] fee for self-propelled special mobile equipment is assessed when the gross vehicle weight exceeds:

(a) One hundred five thousand five hundred pounds [47853 kilograms] on highways restricted by legal weight.

(b) One hundred five thousand five hundred pounds [47853 kilograms] on eight-ton [7257 kilograms] highways.

(c) One hundred five thousand five hundred pounds [47853 kilograms] on seven-ton [6350 kilograms] highways.

(d) Eighty thousand pounds [36287 kilograms] on six-ton [5443 kilograms] highways.

c. Loads permitted by the one-hundred-twenty-nine-thousand-pound [58513-kilogram] primary network permit are exempt from fees on highways restricted to legal weight.

~~8.~~7. The fee for a weight increase on a work-over service rig is nine hundred ninety dollars. The fee shall be assessed on a work-over service rig that exceeds six hundred seventy pounds [303 kilograms] per inch [2.54 centimeters] of tire width on a single or tandem axle, exceeds sixty thousand pounds [27215 kilograms] on a triple axle, and sixty-eight thousand pounds [30844 kilograms] on a four-axle group.

a. The weight increase is valid for ~~a calendar year~~three hundred sixty-five days.

b. The weight increase can only be assessed on model year 2010 work-over service rigs and older.

~~9.~~8. All permit fees must be deposited into the state highway distribution fund.

History: Effective January 1, 1988; amended effective May 1, 1988; January 1, 1992; August 1, 1993; February 1, 1999; February 1, 2000; April 1, 2008, July 1, 2013; January 1, 2016; July 1, 2019; January 1, 2022.
General Authority: NDCC 39-12-02, 39-12-03, 39-12-04, 39-12-05.3
Law Implemented: NDCC 39-12-02, 39-12-04, 39-12-05.3

ARTICLE 38-09
SAFETY STANDARDS FOR PASSENGER CONTRACT CARRIERS

[Repealed effective January 1, 2022]

~~Chapter~~
~~38-09-01 Safety Standards for Passenger Contract Carriers~~

TITLE 60

PESTICIDE CONTROL BOARD

JANUARY 2022

CHAPTER 60-03-03

60-03-03-03. Adoption of worker protection standard.

The environmental protection agency worker protection standard regulations effective as of ~~December 12, 2008~~January 1, 2016, as provided under title 40, Code of Federal Regulations, part 170, are hereby adopted by the board and incorporated by reference and made a part of this title. Copies of title 40, Code of Federal Regulations, part 170, are available upon request by contacting the board at its inquiry address listed in section 60-01-01-01.

History: Effective July 1, 2004; amended effective January 1, 2013; January 1, 2022.
General Authority: NDCC 4.1-33-03
Law Implemented: NDCC 4.1-33-03

TITLE 61

STATE BOARD OF PHARMACY

JANUARY 2022

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 member of the military or 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; January 1, 2022.
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 member of the military or 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; January 1, 2022.
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 61-04-04

61-04-04-01. Definition of unprofessional conduct.

The definition of "unprofessional conduct" for purposes of subdivision i of subsection 1 of North Dakota Century Code section 43-15-10 for disciplinary purposes includes, but is not limited to, the following:

1. The violating or attempting to violate, directly, indirectly, through actions of another, or assisting in or abetting the violation of, or conspiring to violate, any provision or term of North Dakota Century Code chapter 43-15, the Prescription Drug Marketing Act, the Robinson-Patman Act, or of the applicable federal and state laws and rules governing pharmacies or pharmacists.

2. Failure to establish and maintain effective controls against diversion of prescription drugs into other than legitimate medical, scientific, or industrial channels as provided by state or federal laws or rules.

3. Making or filing a report or record which a pharmacist or pharmacy knows to be false, intentionally or negligently failing to file a report or record required by federal or state law, or rules, willfully impeding or obstructing such filing, or inducing another person to do so. Such reports or records include only those which the pharmacist or pharmacy is required to make or file in the capacity as a licensed pharmacist or pharmacy.

4. Being unable to practice pharmacy with reasonable skill and safety by reason of illness, use of drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or physical condition. A pharmacist affected under this subsection shall at reasonable intervals be afforded an opportunity to demonstrate that the pharmacist can resume the competent practice of pharmacy with reasonable skill and safety to the pharmacist's customers.

5. Knowingly dispensed a prescription drug after the death of a patient.

6. Using a facsimile machine to circumvent documentation, authenticity, verification, or other standards of pharmacy practice.

7. Billing or charging for quantities greater than delivered, or for a brand when a generic is dispensed.

8. Submits fraudulent billing or reports to a third-party payor of prescription charges.

9. Refuses to provide information or answer questions when requested to do so by the patient, which affect the patient's use of medications prescribed and dispensed by the pharmacy.

10. Does not address or attempt to resolve and document a possible prescription error or situation of potential harm to the patient when apparent or should have been apparent to the pharmacist.

11. Does not attempt to affect the possible addiction or dependency of a patient to a drug dispensed by the pharmacist, if there is reason to believe that patient may be so dependent or addicted.

12. The assertion or inference in a public manner of material claims of professional superiority in the practice of pharmacy that cannot be substantiated.

13. The publication or circulation of false, misleading, or otherwise deceptive statements concerning the practice of pharmacy.

14. Refusing to compound and dispense prescriptions that may reasonably be expected to be compounded or dispensed in pharmacies by a pharmacist.

15. Participation in agreements or arrangements with any person, corporation, partnership, association, firm, or others involving rebates, kickbacks, fee-splitting, or special charges in exchange for professional pharmaceutical services, including, but not limited to, the giving, selling, donating, or otherwise furnishing or transferring, or the offer to give, sell, donate, or otherwise furnish or transfer money, goods, or services free or below cost to any licensed health care facility or the owner, operator, or administrator of a licensed health care facility as compensation or inducement for placement of business with that pharmacy or pharmacist. Monetary rebates or discounts which are returned to the actual purchaser of drugs as a cost-justified discount or to meet competition are permitted if the rebates of discounts conform with other existing state and federal rules and regulations.

16. Discriminating in any manner between patients or groups of patients for reasons of religion, race, creed, color, sex, age, or national origin.

17. Disclosing to others the nature of professional pharmaceutical services rendered to a patient without the patient's authorization or by order or direction of a court or as otherwise permitted by law. This does not prevent pharmacies from providing information copies of prescriptions to other pharmacies or to the person to whom the prescription was issued and does not prevent pharmacists from providing drug therapy information to physicians for their patients.

18. Improper advertising. Prescription drug price information may be provided to the public by a pharmacy, if all the following conditions are met: No representation or suggestion concerning the drug's safety, effectiveness, or indications for use, is made. No reference is made to controlled substances listed in schedules II-V of the latest revision of the Federal Controlled Substances Act, North Dakota Uniform Controlled Substances Act, and the rules of the state board of pharmacy.

19. Failure to report to the prescription drug monitoring program as required by North Dakota Century Code chapter 19-03.5.

20. Failure to comply with the reporting requirement of North Dakota Century Code section 43-15-42.3, including:

a. Actions that affect the licensee's or registrant's practice privileges in a facility.

b. Actions that result in the loss of the licensee's or registrant's employment or membership in a professional organization due to alleged incompetence, negligence, unethical or unprofessional conduct, or physical, mental, or chemical impairment.

c. Actions based on a professional liability claim against the licensee or registrant, such as an adverse judgment or settlement, a refusal to issue or renew coverage, or a cancellation of coverage.

d. Actions resulting in the loss of the licensee's or registrant's authorization to practice by any state or jurisdiction.

e. Conviction of the licensee or registrant of any misdemeanor or felony in this or any other state, territory, or jurisdiction.

21. Notwithstanding any other provision, a practitioner who diagnoses a sexually transmitted disease, such as chlamydia, gonorrhea, or any other sexually transmitted infection, in an individual patient may prescribe or dispense, and a pharmacist may dispense, prescription antibiotic drugs to that patient's sexual partner or partners, without there having been an examination of that patient's sexual partner or partners.

22. Improper marketing. Utilizing an entity for the purpose of soliciting prescriptions from a consumer, patient, or provider without the involvement of a pharmacist at the pharmacy intervening with the patient to determine clinical appropriateness of any additional prescription.

Interpretation of this definition of unprofessional conduct is not intended to hinder or impede the innovative practice of pharmacy, the ability of the pharmacist to compound, alter, or prepare medications, subsequent to a practitioner's order for the appropriate treatment of patients. Further, it is not intended to restrict the exercise of professional judgment of the pharmacist when practicing in the best interest of the pharmacist's patient.

History: Effective November 1, 1991; amended effective December 1, 2003; October 1, 2007; January 1, 2009; January 1, 2022.
General Authority: NDCC 28-32-02, 43-15-10(1)(i)(12)(14)
Law Implemented: NDCC 28-32-02

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 an appropriate study or training pertaining to the administration of drugs and maintains continuing competency according to the standard of care.

2. "Authority" means 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. "Qualified pharmacy technician" means a registered pharmacy technician who has successfully completed an appropriate study or training pertaining to the administration of injections and maintains continuing competency.

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

History: Effective May 1, 2002; amended effective April 1, 2020; January 1, 2022.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

61-04-11-09. Qualified pharmacy technician administration of medications.

An authorized pharmacist may delegate the administration of a subcutaneous or intramuscular injectable medication to a qualified pharmacy technician given the following:

1. The medication administration has been delegated by the authorized pharmacist;

2. The authorized pharmacist is readily and immediately available to the qualified pharmacy technician either in-person or by way of an audio and video link;

3. The qualified technician has completed a practical training program that is approved by the board. This training program must include hands-on injection technique and the recognition and treatment of emergency reactions;

4. The qualified technician maintains a continuing competency on injections of medications which are expected to be performed;

5. The qualified technician has and maintains a current certification in cardiopulmonary resuscitation or basic cardiac life support; and

6. The authorized pharmacist maintains the responsibility for all administrations that are delegated to a qualified pharmacy technician. This involves recordkeeping, adverse event reporting, and ensuring the pharmacy technician remains qualified.

History: Effective January 1, 2022.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10, 43-15-31.5

CHAPTER 61-04-14
LIMITED PRESCRIPTIVE AUTHORITY FOR IMMUNIZATIONS

61-04-14-01. Definitions.

For purposes of this chapter:

1. "ACIP" means the centers for disease control and prevention's advisory committee on immunization practices.

2. "Authorized pharmacist" means a pharmacist who has successfully completed an appropriate study or training pertaining to the administration of drugs and maintains continuing competency according to the standard of care.

3. "Immunization" has the same meaning as, and may be used interchangeable with, the term "vaccination".

4. "Statewide protocol" refers to protocols developed by the board for the purpose of an authorized pharmacist ordering and administrating immunizations.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02, 43-15-10
Law Implemented: NDCC 23-01-42, 43-15-10(24)

61-04-14-02. Ordering and administration of immunization.

1. Authorized immunizations. The immunizations authorized to be ordered and administered pursuant to a statewide protocol to patients ages three or older must include an immunization recommended by ACIP in its approved vaccination schedule, any other emergency immunization in response to a public health emergency, and an immunization recommended by the centers for disease control and prevention for international travel.

2. Authorized pharmacist. An authorized pharmacist shall meet the standards in section 61-04-11-02 to obtain and maintain authority to administer immunizations.

3. Assessment. An authorized pharmacist shall assess a patient for appropriateness for receiving a vaccination before ordering and administering a vaccine pursuant to the statewide protocol.

4. Verification and reporting. Before ordering and administration of an immunization pursuant to a statewide protocol, the authorized pharmacist shall consult and review the statewide immunization registry. The authorized pharmacist or the authorized pharmacist's designee shall report any immunization ordered and administered to the state immunization registry. The pharmacist may provide the patient with a record of the vaccine administered.

5. Records. The prescribing pharmacist shall maintain records of all immunizations ordered and administered through the statewide protocol. Informed consent must be documented in accordance with the statewide protocol. Records must be maintained at least five years from date of administration.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02, 43-15-10
Law Implemented: NDCC 23-01-42, 43-15-10(24)

CHAPTER 61-04-15
LIMITED PRESCRIPTIVE AUTHORITY FOR TOBACCO CESSATION THERAPIES

61-04-15-01. Definitions.

For purposes of this chapter:

1. "Authorized pharmacist" means a pharmacist who has successfully completed an appropriate study or training to meet the requirements in this rule.

2. "Statewide protocol" refers to protocols developed by the board for the purpose of an authorized pharmacist ordering tobacco cessation therapies for patients utilizing tobacco, electronic nicotine delivery systems, or alternative nicotine products.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02, 43-15-10
Law Implemented: NDCC 23-01-42, 43-15-10(24)

61-04-15-02. Ordering of tobacco cessation therapies.

1. Statewide protocol.

   a. Prescriptive authority for tobacco cessation therapy must be exercised solely in accordance with the statewide protocol approved by the board.

   b. An authorized pharmacist exercising prescriptive authority shall maintain and have readily available a current copy of the statewide protocol approved by the board.

2. Education and training.

   a. An authorized pharmacist shall successfully complete a course of training approved by the board in the subject area of tobacco cessation drug therapy.

   b. Training must include study and instruction in the following content areas:

      (1) Mechanisms of action for contraindications, drug interactions, and monitoring cessation.

      (2) Current standards for prescribing tobacco cessation therapies.

      (3) Identifying indications for the use of tobacco cessation therapies.

      (4) Interviewing a patient to establish need for tobacco cessation therapy.

      (5) Counseling a patient regarding the safety, efficacy, and potential adverse effects of drug products for tobacco cessation.

      (6) Evaluating a patient's medical profile for drug interactions.

      (7) Referring patient followup care with a primary health care provider.

      (8) Informed consent.

      (9) Record management.

(10) Management of adverse events, including identification, appropriate response, documentation, and reporting.

3. Authorized drugs. Prescriptive authority is limited to those drugs delineated in the statewide protocol approved by the board which include prescription and nonprescription therapies.

4. Labeling. Tobacco cessation therapies ordered and dispensed must be labeled in accordance with chapter 61-04-06.

5. Reporting. As soon as reasonably possible, the authorized pharmacist shall notify the patient's primary health care provider of the tobacco cessation therapy provided to the patient. If the patient does not have a primary health care provider, the pharmacist may provide the patient with a record of the tobacco cessation therapy provided.

6. Records. An authorized pharmacist shall maintain records of the care provided and any tobacco cessation products ordered and dispensed pursuant to the statewide protocol. Informed consent must be documented in accordance with the statewide protocol. All records should be maintained for five years.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02, 43-15-10
Law Implemented: NDCC 23-01-42, 43-15-10(24)

TITLE 67

PUBLIC INSTRUCTION, SUPERINTENDENT OF

JANUARY 2022

ARTICLE 67-11
EDUCATION PROFESSIONAL CREDENTIALS

CHAPTER 67-11-24
CERTIFICATES OF COMPLETION FOR SCHOOL HEALTH TECHNICIANS

67-11-24-01. Definition.

For purposes of this chapter, "school health technician" means an individual who has demonstrated an understanding of common school health needs and can respond appropriately and efficiently in a school setting and determine when referrals are needed.

History: Effective January 1, 2022.
General Authority: NDCC 15.1□02□16, 28□32□02
Law Implemented: NDCC 15.1□02□16

67-11-24-02. Certificate of completion required.

Individuals providing services as a school health technician in educational settings shall hold the North Dakota certificate of completion for school health technicians.

History: Effective January 1, 2022.
General Authority: NDCC 15.1-02-16, 28-32-02
Law Implemented: NDCC 15.1-02-16

67-11-24-03. Issuing agency.

The North Dakota certificate of completion for a school health technician is issued by the:

Superintendent of Public Instruction
Department of Public Instruction
600 East Boulevard Avenue, Dept. 201
Bismarck, ND 58505-0440

History: Effective January 1, 2022.
General Authority: NDCC 15.1-02-16, 28-32-02
Law Implemented: NDCC 15.1-02-16

67-11-24-04. Certificate of completion standards.

To obtain a North Dakota certificate of completion as a school health technician, an individual shall submit a completed application, using the online format if available, and have completed the following training approved by the department of public instruction and the North Dakota department of health and human services:

1. Successful completion of first aid, cardiopulmonary resuscitation, and automated external defibrillator training;

2. Successful completion of a medication administration course taught by a registered nurse; and

3. Successful completion of online training as may be adopted by the department of public instruction and the North Dakota department of health and human services which may be based on school health guidelines, emergency guidelines, and disease control guidelines.

History: Effective January 1, 2022.

General Authority: NDCC 15.1-02-16, 28-32-02
Law Implemented: NDCC 15.1-02-16

67-11-24-05. School health technician services.

1. While working in the role of a school health technician, an individual may perform the duties outlined in the required training.

2. While working in the role of a school health technician, an individual shall comply with all Health Insurance Portability and Accountability Act and Family Educational Rights and Privacy Act regulations.

3. While working in the role of a school health technician, the individual may not:

   a. Perform the duties of a school nurse, as set forth in North Dakota Century Code chapter 43-12.1; or

   b. Perform the duties of an unlicensed assistive person, as set forth in North Dakota Century Code chapter 43-12.1.

History: Effective January 1, 2022.
General Authority: NDCC 15.1-02-16, 28-32-02
Law Implemented: NDCC 15.1-02-16

67-11-24-06. Renewal.

The certificate of completion for the school health technician must be renewed every two years. In order to renew the certificate, an individual shall complete the following renewal-level training approved by the department of public instruction and the North Dakota department of health and human services:

1. Shall possess current certification in first aid, cardiopulmonary resuscitation, and automated external defibrillator training;

2. Successful completion of a medication administration course taught by a registered nurse; and

3. Successful completion of online training as may be adopted by the department of public instruction and the North Dakota department of health and human services and may be based on school health guidelines, emergency guidelines, and disease control guidelines.

History: Effective January 1, 2022.
General Authority: NDCC 15.1-02-16, 28-32-02
Law Implemented: NDCC 15.1-02-16

67-11-24-07. Reconsideration.

1. If an application for a school health technician certificate of completion is denied, the applicant must be notified of the opportunity for reconsideration. Upon receipt of a written denial, the applicant may request a reconsideration of the denial. A request for reconsideration must be in writing and must be received by the superintendent of public instruction within twenty-one days of the date the denial was mailed to the applicant by the superintendent of public instruction. Untimely requests may not be considered. The request for reconsideration must discuss:

   a. The fact, law, or rule the applicant believes was erroneously interpreted or applied; and

   b. The applicant's arguments on how the fact, law, or rule should have been applied, giving specific reasons and a thorough analysis.

2. The superintendent of public instruction shall issue a final written response on the reconsideration request within twenty-one days after receiving a complete and timely reconsideration request. If the superintendent's written response denies the reconsideration request, the superintendent's written response must notify the applicant of the applicant's right to a hearing conducted pursuant to North Dakota Century Code chapter 28-32. The applicant shall request the hearing within thirty days.

History: Effective January 1, 2022.
General Authority: NDCC 15.1-02-16, 28-32-02
Law Implemented: NDCC 15.1-02-16

ARTICLE 67-19
ACCREDITATION: PROCEDURES, STANDARDS, AND CRITERIA

CHAPTER 67-19-04
EDUCATIONAL OPPORTUNITIES WITH SPONSORING ENTITIES

67-19-04-01. Local policy.

In order to provide educational opportunities through sponsoring entities, boards of school districts and governing boards of nonpublic schools shall adopt a local policy in accordance with North Dakota Century Code section 15.1-07-35.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-07-35

67-19-04-02. Creation of proposal.

Any proposal submitted by an eligible sponsoring entity to a board of a school district or governing board of a nonpublic school under subsection 5 of North Dakota Century Code section 15.1-07-35 must include:

1. The name and information of the sponsoring entity;
2. The course title for each course provided by the sponsoring entity;
3. The state course code number for each course provided by the sponsoring entity;
4. A teacher of record who is employed by the school district or nonpublic school, is licensed under North Dakota Century Code chapter 15.1-18, and has approved the proposal;
5. An assurance that courses meet course content standards, as determined by the superintendent of public instruction; and
6. A statement of how students will demonstrate proficiency and how students will be evaluated.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-07-35

67-19-04-03. Submission of proposal.

1. Because of the dual nature of the kindergarten through grade twelve education coordination council review and department of public instruction approval, the department will act as a liaison between the schools and the kindergarten through grade twelve education coordination council. Proposals approved by the board of a school district or governing board of a nonpublic school must be submitted to the following address:

   North Dakota Department of Public Instruction
   Attn: North Dakota K-12 Education Coordination Council
   600 East Boulevard Avenue, Department 201
   Bismarck, ND 58505-0440

   ndk12ecc@nd.gov

2. For educational opportunities during the 2022-23 school year, proposals must be submitted to the director of the office of school approval and opportunity:

   a. No earlier than January 23, 2022, or later than February 1, 2022; or

   b. No earlier than May 23, 2022, and no later than June 1, 2022.

3. Beginning with the 2023-24 school year, proposals must be received by the director of the office of school approval and opportunity:

   a. No earlier than October twenty-third and no later than November first of the preceding school year; or

   b. No earlier than May twenty-third and no later than June first of the preceding school year.

4. All proposals must include the local policy and the school board meeting minutes documenting the adoption of the local policy and the approval of the proposal from the sponsoring entity.

5. Upon receiving the proposal, the director of the office of school approval and opportunity shall submit the proposal to the president of the kindergarten through grade twelve education coordination council for review.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-07-35

67-19-04-04. Review and approval of proposals.

1. Within sixty days of receiving the proposal, the kindergarten through grade twelve education coordination council shall review the proposal to ensure compliance with section 67-19-04-02, request further information as needed, and submit the proposal to the superintendent of public instruction to approve or deny the proposal.

2. Following review by the kindergarten through grade twelve education coordination council, the superintendent of public instruction shall approve or deny the proposal, in accordance with subsection 6 of North Dakota Century Code section 15.1-07-35.

3. In accordance with subsection 6 of North Dakota Century Code section 15.1-07-35, the department of public instruction shall notify boards of school districts and governing boards of nonpublic schools of their approval status.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02

Law Implemented: NDCC 15.1-07-35

67-19-04-05. Program evaluation data.

No later than June thirtieth of each school year, school districts or nonpublic schools providing educational opportunities with sponsoring entities shall provide program evaluation data to the superintendent of public instruction. Program evaluation data submitted may include:

1. Academic indicators, such as:
   a. Proficiency scales;
   b. Self-assessments;
   c. Assessments from supervisor;
   d. Career-ready standards met; and
   e. Content standards met;
2. Descriptions of how the program:
   a. Improved the delivery of education;
   b. Improved the administration of education;
   c. Provided increased education opportunities for students; and
   d. Improved the academic success for students; and
3. Other evaluation measures, such as attendance, disciplinary incidents, student engagement, student voice, student and parent surveys, and evidence of improved instructional practices.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-07-35

67-19-04-06. Revocation of proposal.

1. If program evaluation data indicate that a proposal is not providing success for students, the superintendent of public instruction may:
   a. Make recommendations for improvement; or
   b. Revoke the proposal.
2. If the superintendent of public instruction revokes a proposal as authorized in subsection 10 of North Dakota Century Code section 15.1-07-35, school districts and nonpublic schools must be allowed to revise and resubmit their proposal to the department for approval. The department shall notify school districts and nonpublic schools of their resubmission status within thirty days of resubmission.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-07-35

CHAPTER 67-23-03

67-23-03-02. Application for federal funds under part B of IDEA.

To apply for available federal funds, each district shall file forms provided by the department relative to the December child count requirement, the IDEA data reports, and the application form prescribed by the department.

1. The December child count requirement means reporting students who have an IEP, individualized service plan, or service plan for home education, and are receiving special education and related services as of December first of the current year.

2. The IDEA data reports mean the following:

   a. Data on each student who exited special education during the past year; and

   b. A report on special education and related services personnel needed and employed.

3. Applications for federal funds include collection of the following information:

   a. Maintenance of effort, meaning expenditures from state and local sources for special education, for the most current three years;

   b. Project participants;

   c. Project narratives;

   d. Budget summary;

   e. Assurances; and

   f. Required signatures.

History: Effective February 1, 2000; amended effective January 1, 2008; January 1, 2022.
General Authority: NDCC 15.1-32-09
Law Implemented: NDCC 15.1-32-02, 15.1-32-07, 15.1-32-21; 20 USC 1400-1419

ARTICLE 67-30
VIRTUAL LEARNING

CHAPTER 67-30-01
VIRTUAL LEARNING BECAUSE OF WEATHER OR OTHER CONDITIONS

67-30-01-01. Definitions.

As used in this chapter:

1. "Cancel hours of instruction" means that a school district or nonpublic school has decided not to hold in-person instruction for all or part of a previously scheduled school day. This may include one or more students not being able to attend school due to extenuating circumstances because of weather or other conditions.

2. "Virtual instruction" means teaching and learning that takes place remotely and can be synchronous or asynchronous.

3. "Weather or other conditions" means inclement weather, other unforeseen circumstances that render the school building unusable or inaccessible, or other conditions that temporarily warrant remote instruction.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4

67-30-01-02. Local policy.

If the board of a school district or governing board of a nonpublic school that operates a physical plant chooses to provide virtual instruction when the decision is made to cancel hours of instruction because of weather or other conditions, that board shall adopt a local policy to define those procedures. Instruction under this chapter is limited to nine calendar weeks. If, due to extenuating circumstances because of weather or other conditions, the building closure lasts longer than nine calendar weeks, the school district or nonpublic school shall contact the department of public instruction to request an extension.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4, 15.1-27-23

67-30-01-03. Average daily membership payments.

1. In order to receive average daily membership payments for days covered under this chapter, school districts shall provide virtual instruction based on the policy approved by the local school board or governing board of a nonpublic school.

2. The school district shall determine the method of virtual instruction provided to students on days of virtual instruction when the decision is made to cancel hours of instruction because of weather or other conditions.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4, 15.1-27-23

67-30-01-04. Reporting days of virtual learning under this chapter.

At the conclusion of each school year, the school district or nonpublic school shall report in the manner required by the superintendent of public instruction the days in which virtual instruction was provided under this chapter.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4

CHAPTER 67-30-02
VIRTUAL SCHOOLS

67-30-02-01. Definitions.

As used in this chapter:

1. "Academic pacing guide" means a document created or adopted by the school district or nonpublic school which outlines the amount of course content covered during each portion of the school year.

2. "Educational equity" means every student has access to the resources and educational rigor they need at the right moment in their education regardless of race, gender, ethnicity, language, disability, family background, or family income.

3. "Virtual instruction" means teaching and learning that takes place through digital means and can be synchronous or asynchronous.

4. "Virtual school" means an educational institution operated by a school district or nonpublic school in this state which offers virtual instruction. Virtual schools generally do not maintain a physical facility, and students and teachers are geographically remote from one another.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4

67-30-02-02. General provisions.

1. If the board of a school district or governing board of a nonpublic school that operates a physical plant chooses to provide virtual instruction under North Dakota Century Code sections 15.1-06-04 and 15.1-07-25.4 as part of a virtual school, that board shall adopt a local policy relating to virtual instruction.

2. Virtual instruction under this chapter may be only conducted as part of a virtual school.

3. Virtual schools under this chapter may not be established for temporary purposes.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4

67-30-02-03. Local policy.

Local policy regarding virtual schools must address:

1. Procedures for transferring into or out of the virtual school.

2. Procedures for engaging parents or legal guardians to assist in making the decision to enroll students in the virtual school.

3. Attendance policies for the virtual school, in accordance with section 67-30-02-05.

4. Standards and curriculum for virtual instruction, in accordance with section 67-30-02-06.

5. Procedures for standards-based professional development specific to virtual learning and support for virtual school staff.

6. Educational equity needs of all students enrolled in the virtual school.

7. Cost-sharing agreements with other school districts.

8. Procedures for child find and evaluation obligations under requirements of Public Law No. 94-142 [89 Stat. 773] and section 504 of the Rehabilitation Act of 1973, as amended.

9. Procedures for administering annually administered statewide summative assessments.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4

67-30-02-04. Approval of virtual schools.

1. No later than June first prior to the school year that a virtual school is to begin operating, the board of the school district or governing board of a nonpublic school shall submit the following to the superintendent of public instruction:

   a. Approved school board minutes establishing local policy on virtual schools; and

   b. Approved school board minutes stating the name and grade configuration of the virtual school.

2. In the event of an extenuating circumstance, the superintendent of public instruction may accept approved school board minutes for virtual schools after June first.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4

67-30-02-05. Attendance.

Virtual schools shall measure student attendance based on course content that the student has completed according to academic pacing guides. Academic pacing guides, as well as the amount of content that is comparable to a day of instruction, must be determined at the discretion of the board of the school district or the governing body of the nonpublic school.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4

67-30-02-06. Standards.

When operating a virtual school, the board of a school district or governing board of a nonpublic school shall address how quality virtual instruction is being provided through adoption of quality virtual learning standards.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 15.1-06-04, 15.1-07-25.4

TITLE 69

PUBLIC SERVICE COMMISSION

JANUARY 2022

CHAPTER 69-06-01

69-06-01-01. Definitions.

The terms used throughout this article have the same meanings as in North Dakota Century Code chapter 49-22, and in addition:

1. "Act" means the North Dakota Energy Conversion and Transmission Facility Siting Act, North Dakota Century Code chapter 49-22.

2. "Avoidance criteria" means criteria that remove areas from consideration for energy conversion facility sites and transmission facility routes unless it is shown that under the circumstances there are no reasonable alternatives.

3. "Criteria" means policy statements that guide and govern the preparation of the inventory of exclusion and avoidance areas, and the energy conversion facility site and transmission facility corridor and route suitability evaluation process.

4. "Designated corridor" means a corridor for which a certificate has been issued by the commission.

5. "Designated route" means a route for which a permit has been issued by the commission.

6. "Designated site" means a site for which a certificate has been issued by the commission.

7. "Extractive resources" means natural resources that are removed during the construction of a facility, including sand, gravel, soil, rock, and other similar materials.

8. "Exclusion criteria" means criteria that remove areas from consideration for energy conversion facility sites and transmission facility routes.

9. "Height of the turbine" means the distance from the base of the wind turbine to the turbine blade tip when it is in its highest position.

10. "Historical resource" means a district, site, building, structure, or other object which possesses significance in history, archaeology, paleontology, or architecture, or has other cultural value to the state or local community.

11. "Party aggrieved" means a person who will be affected in a manner different from the effect on the general public.

12. "Policy criteria" means criteria that guide and govern the selection of energy conversion facility sites and transmission facility corridors and routes in order to maximize benefits during the construction and operation of a facility.

13. "Refinement" means the action or process of purifying.

14. "Selection criteria" means criteria that guide and govern the selection of energy conversion facility sites and transmission facility corridors and routes in order to minimize adverse human and environmental impact after the exclusion and avoidance criteria have been applied.

15. "Siting rules" means this article adopted by the commission pursuant to North Dakota Century Code ~~chapter~~chapters 49-22 and 49-22.1.

16. "Wetland" means an aquatic area important to the life stages of certain wildlife species as defined by the United States fish and wildlife service.

History: Amended effective August 1, 1979; April 1, 2013; January 1, 2022.
General Authority: NDCC 49-22-18
Law Implemented: NDCC 49-22-01, 49-22-03, 49-22-05.1, 49-22-07, 49-22-08, 49-22-08.1, 49-22-19

69-06-01-05. Designated agencies and officers.

The following are the designated state agencies and officers entitled to notice when so referred to in this article:

1. Aeronautics commission.
2. Attorney general.
3. Department of agriculture.
4. State department of health.
5. Department of human services.
6. ~~Labor department~~Department of labor and human rights.
7. Department of career and technical education.
8. Department of commerce.
9. Energy ~~development~~infrastructure and impact office.
10. Game and fish department.
11. Industrial commission.
12. ~~Governor~~Governor's office.
13. Department of transportation.
14. State historical society of North Dakota.
15. Indian affairs commission.
16. Job service North Dakota.
17. Department of trust lands.
18. Parks and recreation department.

19. ~~Soil~~Natural resources conservation ~~committee~~service.

20. State water commission.

21. United States department of defense.

22. United States fish and wildlife service.

23. United States army corps of engineers.

24. Federal aviation administration.

25. The county commission of the county or counties where the project is located.

26. North Dakota transmission authority.

27. North Dakota pipeline authority.

28. Department of environmental quality.

29. North Dakota geological survey.

30. North Dakota forest service.

31. Federal bureau of land management.

32. Military aviation and installation assurance siting clearinghouse.

33. Twentieth airforce ninety-first missile wing.

34. Minot air force base.

35. Grand Forks air force base.

History: Effective August 1, 1979; amended effective July 1, 2008; April 1, 2013; January 1, 2022.
General Authority: NDCC 49-22-18
Law Implemented: NDCC 49-22-08, 49-22-08.1

69-06-01-06. Siting fee refund.

After all siting permits and certificates are issued by the commission and after all ~~notice and hearing costs and~~siting process and project inspection expenses are paid, ~~the commission will refund to the applicant all of the application fee paid by the applicant except five thousand dollars or the amount of the fee remaining if that amount is less than five thousand dollars. When construction and all postconstruction inspections are~~ complete and when the commission has determined that any required tree mitigation is satisfactory, any remaining balance of the application fee will be refunded to the applicant. ~~No refunds for less than fifty dollars will be processed.~~

History: Effective July 1, 2008; amended effective January 1, 2022.
General Authority: NDCC 49-22-18
Law Implemented: NDCC 49-22-22

CHAPTER 69-06-02

69-06-02-02. Filing.

1. ~~Ten copies of each~~A ten-year plan must be filed with the commission, and one copy of each plan must be filed with the county auditor of each county in which any part of a site or corridor is proposed to be located.

2. Notice of the filing of each plan must be given by the utility to each agency and officer entitled to notice as designated in section 69-06-01-05.

History: Amended effective August 1, 1979; April 1, 2013; January 1, 2022.
General Authority: NDCC 49-22-18
Law Implemented: NDCC 49-22-04

CHAPTER 69-06-04

69-06-04-01. Application.

1. **Form.** An application must be reproduced and bound to eight and one-half-inch by eleven-inch size. Accompanying maps must be folded to eight and one-half inches by eleven inches with the title block appearing in the lower right-hand corner.

2. **Contents.** The application must contain:

   a. A description of:

      (1) The type of energy conversion facility proposed;

      (2) The gross design capacity;

      (3) The net design capacity;

      (4) The estimated thermal efficiency of the energy conversion process and the assumptions upon which the estimate is based;

      (5) The number of acres that the proposed facility will occupy; and

      (6) The anticipated time schedule for:

         (a) Obtaining the certificate of site compatibility;

         (b) Completing land acquisition;

         (c) Starting construction;

         (d) Completing construction;

         (e) Testing operations;

         (f) Commencing commercial production; and

         (g) Beginning any expansions or additions.

   b. Copies of any evaluative studies or assessments of the environmental impact of the proposed facility submitted to any federal, regional, state, or local agency.

   c. An analysis of the need for the proposed facility based on present and projected demand for the product or products to be produced by the proposed facility, including the most recent system studies supporting the analysis of the need.

   d. A description of any feasible alternative methods of serving the need.

   e. A study area that includes the proposed facility site, of sufficient size to enable the commission to evaluate the factors addressed in North Dakota Century Code section 49-22-09.

   f. A discussion of the utility's policies and commitments to limit the environmental impact of its facilities, including copies of board resolutions and management directives.

   g. A map identifying the criteria that provides the basis for the specific location of the proposed facility within the study area.

h. A discussion of the criteria evaluated within the study area, including exclusion areas, avoidance areas, selection criteria, policy criteria, design and construction limitations, and economic considerations.

i. A discussion of the mitigative measures that the applicant will take to minimize adverse impacts which result from the location, construction, and operation of the proposed facility.

j. The qualifications of each person involved in the facility site location study.

k. A map of the study area showing the location of the proposed facility and the criteria evaluated.

l. An eight and one-half-inch by eleven-inch black and white map suitable for newspaper publication depicting the site area.

m. A discussion of present and future natural resource development in the area.

n. Map and GIS requirements. The applicant shall provide information that is complete, current, presented clearly and concisely, and supported by appropriate references to technical and other written material available to the commission. The information must provide the location of the proposed facilities, the proposed site, and the criteria evaluated.

Data must be submitted in the ESRI shapefile or geodatabase format. If the applicant cannot submit the data in the ESRI format, an alternate format may be submitted with written approval by commission staff. Data must include appropriate attribute data for the included features. Relevant and complete metadata in compliance with FGDC metadata standards must be provided with all files. Supporting documents such as base maps, figures, cross sections, and reports must be submitted in the portable document file (PDF). If the supporting documents were derived from GID/Cad files, the supporting GIS/Cad files must also be included in the submittal. Aerial photos (raster images) must be georeferenced and submitted in TIFF, GEOTIFF, or MrSID image file formats with the associated word files. Appropriate metadata must be provided with all files, such as the source for the raster images, dates of aerial photography, and the type of the imagery, color bands, i.e., black and white, color, color infrared, and any other pertinent data. All GIS base map data must be referenced to a published geographic or projected coordinate system. The appropriate systems would be North Dakota coordinate system of 1983, north and/or south zones US survey feet (NAD 83), UTM zone 13N or 14N meters (NAD 83), or geographic coordinate system (WGS 84) meters. The vertical datum must be the North American vertical datum of 1988. Tabular data (i.e., laboratory analytical data, water level evaluation data, monitor well construction data, well and boring X and Y location data, grain size analysis data, hydraulic conductivity data, etc.) must be submitted in either a Microsoft Excel or Microsoft Access database format or both if both are used. Textural data may be submitted in Microsoft Word or PDF format. The application may be submitted to the commission on the following media:

Compact disc (CD-ROM (CD-R)), digital versatile disc (DVD-R or DVD+R), or other media upon commission approval.

3. **Filing.** The applicant shall file an original and ~~ten~~four copies of an application with the commission. The applicant shall provide additional paper copies upon commission request.

4. **Notice of filing.** The commission shall serve a notice of filing of a complete application on the following:

a. The chairman of the board of county commissioners and the auditor of each county in which any part of the site is proposed to be located.

b. The chief executive officer of each city in a county in which any part of an energy conversion facility is proposed to be located.

c. The chief executive officer of each city within a proposed site for a transmission facility.

d. The agencies and officers entitled to notice as designated in section 69-06-01-05.

e. The state senators and representatives of each legislative district in which any part of the site is proposed to be located.

5. **Amendment of application.** The commission may allow an applicant to amend its application, consistent with North Dakota Century Code chapter 28-32 and North Dakota Administrative Code article 69-02, at any time during the pendency of an application. A rehearing may be required if the commission determines that a proposed amendment, which is received after the hearing process has been completed, materially changes the authority sought.

6. **Reapplication.** When a certificate is denied and the commission specifies a modification that would make it acceptable, the applicant may reapply. In a reapplication:

a. The reapplication must be heard as specified in section 69-06-01-02.

b. The utility shall indicate its acceptance or rejection of the suggested modification.

c. If a suggested modification is rejected by the applicant, it shall propose an alternative modification.

d. Include a filing fee and any additional fees as specified in North Dakota Century Code chapter 49-22.

e. Reapplication must be made within six months of the order denying an application.

History: Amended effective August 1, 1979; April 1, 2013; January 1, 2022.
General Authority: NDCC 49-22-18
Law Implemented: NDCC 49-22-08, 49-22-08.1

CHAPTER 69-06-05

69-06-05-01. Application.

1. **Form.** An application must be reproduced and bound to eight and one-half-inch by eleven-inch size. Accompanying maps must be folded to eight and one-half inches by eleven inches with the title block appearing in the lower right-hand corner.

2. **Contents.** The application must contain:

   a. A description of the following:

      (1) The type of facility proposed.

      (2) The purpose of the facility.

      (3) The technology to be deployed.

      (4) The type of product to be transmitted.

      (5) The source of the product to be transmitted.

      (6) The final destination of the product to be transmitted.

      (7) The proposed size and design and any alternate size or design that was considered, including:

         (a) The width of right of way;

         (b) The approximate length of facility;

         (c) The estimated span length for electric facilities;

         (d) The anticipated type of structure for electric facilities;

         (e) The voltage for electric facilities;

         (f) The requirement for and general location of any new associated facilities;

         (g) The estimated distance between surface structures for pipeline facilities;

         (h) The pipe size for pipeline facilities;

         (i) The maximum design operating pressure and temperature for pipeline facilities;

         (j) The maximum design flow rate for pipeline facilities; and

         (k) The number and general location of compressor or pumping stations.

   b. The anticipated time schedule for accomplishing major events, including:

      (1) Obtaining the certification of corridor compatibility;

      (2) Obtaining the route permit;

      (3) Completing right-of-way acquisition;

      (4) Starting construction;

(5) Completing construction;

(6) Testing operations; and

(7) Commencing operations.

c. A copy of each evaluative study or assessment of the environmental impact of the proposed facility submitted to the agencies listed in section 69-06-01-05 and each response received.

d. An analysis of the need for the proposed facility based on present and projected demand for the product transmitted, including the most recent system studies supporting the analysis of the need.

e. A description of any feasible alternative methods for serving the need

f. The width of a corridor must be at least ten percent of its length, but not less than one mile [1.61 kilometers] or greater than six miles [9.66 kilometers] unless another appropriate width is determined by the commission.

g. A study area that includes a proposed corridor of sufficient width to enable the commission to evaluate the factors addressed in North Dakota Century Code section 49-22-09.

h. A discussion of the factors in North Dakota Century Code section 49-22-09 to aid the commission's evaluation of the proposed route.

i. A discussion of the applicant's policies and commitments to limit the environmental impact of its facilities, including copies of board resolutions and management directives.

j. Identification and map of the criteria that led to the proposed route location within the designated corridor, including exclusion areas, avoidance areas, selection criteria, policy criteria, design construction limitations, and economic considerations.

k. A discussion of the relative value of each criteria and how the applicant selected the proposed corridor location, giving consideration to all criteria and how the location, construction, and operation of the facility will affect each criteria.

l. A discussion of the general mitigative measures that the applicant will take to minimize adverse impacts that result from a route location in the proposed corridor and the construction and operation of the facility.

m. The qualifications of each person involved in the corridor location study.

n. A map identifying the criteria that led to the proposed route location within the designated corridor and the location of any new associated facilities. Several different criteria may be shown on each map depending on the map scale and the density and nature of the criteria.

o. An eight and one-half-inch by eleven-inch black and white map suitable for newspaper publication depicting the site area.

p. A discussion of present and future natural resource development in the area.

q. Map and GIS requirements. The applicant shall provide information that is complete, current, presented clearly and concisely, and supported by appropriate references to technical and other written material available to the commission. The information must provide the location of the proposed facilities, the proposed corridor and route, and the

criteria evaluated. Data must be submitted in the ESRI shapefile or geodatabase format. If the applicant cannot submit the data in the ESRI format, an alternate format may be submitted with written approval by commission staff. Data must include appropriate attribute data for the included features. Relevant and complete metadata in compliance with FGDC metadata standards must be provided with all files. Supporting documents such as base maps, figures, cross sections, and reports must be submitted in the portable document file (PDF). If the supporting documents were derived from GIS/Cad files the supporting GIS/Cad files must also be included in the submittal. Aerial photos (raster images) must be georeferenced and submitted in TIFF, GEOTIFF, or MrSID image file formats with the associated word files. Appropriate metadata must be provided with all files, such as the source for the raster images, dates of aerial photography, and the type of imagery, color bands, i.e., black and white, color, color infrared, and any other pertinent data. All GIS base map data must be referenced to a published geographic or projected coordinate system. The appropriate systems would be North Dakota coordinate system of 1983, north and/or south zones US survey feet (NAD 83). UTM zone 13N or 14N meters (NAD 83), or geographic coordinate system (WGS 84) meters. The vertical datum must be the North American vertical datum of 1988. Tabular data (i.e., laboratory analytical data, water level evaluation data, monitor well construction data, well and boring X and Y location data, grain size analysis data, hydraulic conductivity data, etc.) must be submitted in either a Microsoft Excel or Microsoft Access database format or both if both are used. Textural data may be submitted in Microsoft Word or PDF format. The application may be submitted to the commission on the following media:

Compact disc (CD-ROM (CD-R)), digital versatile disc (DVD-R or DVD+R), or other media upon commission approval.

3. **Filing.** The applicant shall file an original and ~~ten~~four copies of an application with the commission. The applicant shall provide additional paper copies upon commission request.

4. **Service.** The applicant shall serve one copy of a complete application on the county auditor in each county in which any part of the designated corridor is located.

5. **Notice of filing.** The commission shall serve a notice of the filing of a complete application on the following:

   a. The chief executive officer of each city within the designated corridor.

   b. The agencies and officers entitled to notice as designated in section 69-06-01-05.

   c. The chairman of the board of county commissioners of each county in which any part of the designated corridor is located.

   d. The state senators and representatives of each legislative district in which any part of the designated corridor is located.

History: Amended effective August 1, 1979; April 1, 2013; January 1, 2022.
General Authority: NDCC 49-22-18
Law Implemented: NDCC 49-22-08.1

69-06-05-02. Designation of corridor and route.

1. **Issuance of a permit.** An order approving the issuance of a permit must:

   a. Describe the authority granted.

   b. Contain any special conditions that the commission may require.

c. Specify any required modifications in the type, design, routing, right-of-way preparation, or construction of the facility.

d. Contain findings that the application, with modifications, if any, meets the corridor evaluation process requirements of the Act, and any special conditions the commission may require.

2. **Issuance of a certificate.** When a corridor is approved, the commission shall issue a certificate in accordance with the order.

3. **Deviations.** The commission may permit a deviation from the designated route before or during construction if the deviation does not violate any of the exclusion and avoidance area criteria of this article. After construction is complete a deviation is governed by North Dakota Century Code section 49-22-03.

4. **Variance from permit conditions.** The commission may allow a variance from any special condition upon a request demonstrating the existence of good cause.

~~5. **Corridor width.** The width of a corridor must be at least ten percent of its length, but not less than one mile [1.61 kilometers] or greater than six miles [9.66 kilometers] unless otherwise determined by the commission.~~

History: Amended effective August 1, 1979; April 1, 2013; January 1, 2022.
General Authority: NDCC 49-22-18
Law Implemented: NDCC 49-22-08.1

CHAPTER 69-06-08

69-06-08-01. Energy conversion facility siting criteria.

The following criteria must guide and govern the preparation of the inventory of exclusion and avoidance areas, and the site suitability evaluation process.

1. **Exclusion areas.** The following geographical areas must be excluded in the consideration of a site for an energy conversion facility.

   a. Designated or registered national: parks; memorial parks; historic sites and landmarks; natural landmarks; historic districts; monuments; wilderness areas; wildlife areas; wild, scenic, or recreational rivers; wildlife refuges; and grasslands.

   b. Designated or registered state: parks; forests; forest management lands; historic sites; monuments; historical markers; archaeological sites; grasslands; wild, scenic, or recreational rivers; game refuges; game management areas; management areas; and nature preserves.

   c. County parks and recreational areas; municipal parks; parks owned or administered by other governmental subdivisions; hardwood draws; and enrolled woodlands.

   d. Areas critical to the life stages of threatened or endangered animal or plant species.

   e. Areas where animal or plant species that are unique or rare to this state would be irreversibly damaged.

   f. Areas within one thousand two hundred feet of the geographic center of an intercontinental ballistic missile (ICBM) launch or launch control facility.

   g. Areas within thirty feet [9.14 meters] on either side of a direct line between an intercontinental ballistic missile (ICBM) launch facility and a missile alert or launch control facilities to avoid microwave interference. This restriction only applies to aboveground structures, not to surface features, such as roads, or belowground infrastructure.

2. **Additional exclusion areas for wind energy conversion facilities.** The following geographical areas must be excluded in the consideration of a site for a wind energy conversion facility:

   a. Areas within:

      (1) One and one-tenth times the height of the turbine from the nearest edge of an interstate or state roadway right of way;

      (2) One and one-tenth times the height of the turbine plus seventy-five feet from the centerline of any county or maintained township roadway;

      (3) One and one-tenth times the height of the turbine from the nearest edge of railroad right of way;

      (4) One and one-tenth times the height of the turbine from the nearest edge of a one hundred fifteen kilovolt or higher transmission line right of way; and

      (5) One and one-tenth times the height of the turbine from the property line of a nonparticipating landowner and three times the height of the turbine from an inhabited rural residence of a nonparticipating landowner, unless a variance is granted. A variance may be granted if an authorized representative or agent of the permittee, the nonparticipating landowner, and affected parties with associated wind

rights file a written agreement expressing all parties' support for a variance to reduce the setback requirement in this subsection. A nonparticipating landowner is a landowner that has not signed a wind option or an easement agreement with the permittee of the wind energy conversion facility as defined in North Dakota Century Code chapter 17-04.

3. **Avoidance areas.** The following geographical areas may not be approved as a site for an energy conversion facility unless the applicant shows that under the circumstances there is no reasonable alternative. In determining whether an avoidance area should be designated for a facility the commission may consider, among other things, the proposed management of adverse impacts; the orderly siting of facilities; system reliability and integrity; the efficient use of resources; and alternative sites. Economic considerations alone will not justify approval of these areas. A buffer zone of a reasonable width to protect the integrity of the area must be included. Natural screening may be considered in determining the width of the buffer zone.

   a. Historical resources which are not designated as exclusion areas.

   b. Areas within the city limits of a city or the boundaries of a military installation.

   c. Areas within known floodplains as defined by the geographical boundaries of the hundred-year flood.

   d. Areas that are geologically unstable.

   e. Woodlands and wetlands.

   f. Areas of recreational significance which are not designated as exclusion areas.

4. **Additional avoidance areas for wind energy conversion facilities.** A wind energy conversion facility site must not include a geographic area where, due to operation of the facility, the sound levels within one hundred feet of an inhabited residence or a community building will exceed forty-five dBA. The sound level avoidance area criteria may be waived in writing by the owner of the occupied residence or the community building.

5. **Selection criteria.** A site may be approved in an area only when it is demonstrated to the commission by the applicant that any significant adverse effects resulting from the location, construction, and operation of the facility in that area as they relate to the following, will be at an acceptable minimum, or that those effects will be managed and maintained at an acceptable minimum. The effects to be considered include:

   a. The impact upon agriculture:

      (1) Agricultural production.

      (2) Family farms and ranches.

      (3) Land which the owner demonstrates has soil, topography, drainage, and an available water supply that cause the land to be economically suitable for irrigation.

      (4) Surface drainage patterns and ground water flow patterns.

      (5) The agricultural quality of the cropland.

   b. The impact upon the availability and adequacy of:

      (1) Law enforcement.

      (2) School systems and education programs.

(3) Governmental services and facilities.

(4) General and mental health care facilities.

(5) Recreational programs and facilities.

(6) Transportation facilities and networks.

(7) Retail service facilities.

(8) Utility services.

c. The impact upon:

(1) Local institutions.

(2) Noise-sensitive land uses.

(3) Light-sensitive land uses.

(4) Rural residences and businesses.

(5) Aquifers.

(6) Human health and safety.

(7) Animal health and safety.

(8) Plant life.

(9) Temporary and permanent housing.

(10) Temporary and permanent skilled and unskilled labor.

d. The cumulative effects of the location of the facility in relation to existing and planned facilities and other industrial development.

e. The impact upon military installations, assets, and operations.

6. **Policy criteria.** The commission may give preference to an applicant that will maximize benefits that result from the adoption of the following policies and practices, and in a proper case may require the adoption of such policies and practices. The commission may also give preference to an applicant that will maximize interstate benefits. The benefits to be considered include:

a. Recycling of the conversion byproducts and effluents.

b. Energy conservation through location, process, and design.

c. Training and utilization of available labor in this state for the general and specialized skills required.

d. Use of a primary energy source or raw material located within the state.

e. Not relocating residents.

f. The dedication of an area adjacent to the facility to land uses such as recreation, agriculture, or wildlife management.

g. Economies of construction and operation.

h. Secondary uses of appropriate associated facilities for recreation and the enhancement of wildlife.

i. Use of citizen coordinating committees.

j. A commitment of a portion of the energy produced for use in this state.

k. Labor relations.

l. The coordination of facilities.

m. Monitoring of impacts.

n. A commitment to install lighting mitigation technology for wind energy conversion facilities subject to commercial availability and federal aviation administration approval.

History: Amended effective August 1, 1979; July 1, 2006; April 1, 2013; July 1, 2017; July 1, 2018; July 1, 2019; July 1, 2020; January 1, 2022.
General Authority: NDCC 28-32-02, 49-22-18
Law Implemented: NDCC 49-22-05.1, 49-22.1-03

69-06-08-02. Transmission facility corridor and route criteria.

The following criteria must guide and govern the preparation of the inventory of exclusion and avoidance areas, and the corridor and route suitability evaluation process. Exclusion and avoidance areas may be located within a corridor, but at no given point may such an area or areas encompass more than fifty percent of the corridor width unless there is no reasonable alternative.

1. **Exclusion areas.** The following geographical areas must be excluded in the consideration of a route for a transmission facility. A buffer zone of a reasonable width to protect the integrity of the area must be included. Natural screening may be considered in determining the width of the buffer zone.

   a. Designated or registered national: parks; memorial parks; historic sites and landmarks; natural landmarks; monuments; and wilderness areas.

   b. Designated or registered state: parks; historic sites; monuments; historical markers; archaeological sites; and nature preserves.

   c. County parks and recreational areas; municipal parks; and parks owned or administered by other governmental subdivisions.

   d. Areas critical to the life stages of threatened or endangered animal or plant species.

   e. Areas where animal or plant species that are unique or rare to this state would be irreversibly damaged.

   f. Areas within one thousand two hundred feet of the geographic center of an intercontinental ballistic missile (ICBM) launch or launch control facility.

   g. Areas within thirty feet on either side of a direct line between an intercontinental ballistic missile (ICBM) launch facility and a missile alert or launch control facilities to avoid microwave interference. This restriction only applies to aboveground structures, not to surface features, such as roads, or belowground infrastructure.

2. **Avoidance areas.** The following geographical areas may not be considered in the routing of a transmission facility unless the applicant shows that under the circumstances there is no reasonable alternative. In determining whether an avoidance area should be designated for a

facility, the commission may consider, among other things, the proposed management of adverse impacts; the orderly siting of facilities; system reliability and integrity; the efficient use of resources; and alternative routes. Economic considerations alone will not justify approval of these areas. A buffer zone of a reasonable width to protect the integrity of the area will be included unless a distance is specified in the criteria. Natural screening may be considered in determining the width of the buffer zone.

a. Designated or registered national: historic districts; wildlife areas; wild, scenic, or recreational rivers; wildlife refuges; and grasslands.

b. Designated or registered state: wild, scenic, or recreational rivers; game refuges; game management areas; management areas; forests; forest management lands; and grasslands.

c. Historical resources which are not specifically designated as exclusion or avoidance areas.

d. Areas which are geologically unstable.

e. Within five hundred feet [152.4 meters] of a residence, school, or place of business. This criterion shall not apply to a water pipeline transmission facility. This avoidance area may be waived by the owner.

f. Reservoirs and municipal water supplies.

g. Water sources for organized rural water districts.

h. Irrigated land. This criterion shall not apply to an underground transmission facility.

i. Areas of recreational significance which are not designated as exclusion areas.

3. **Selection criteria.** A corridor or route shall be designated only when it is demonstrated to the commission by the applicant that any significant adverse effects which will result from the location, construction, and maintenance of the facility as they relate to the following, will be at an acceptable minimum, or that those effects will be managed and maintained at an acceptable minimum. The effects to be considered include:

a. The impact upon agriculture:

(1) Agricultural production.

(2) Family farms and ranches.

(3) Land which the owner can demonstrate has soil, topography, drainage, and an available water supply that cause the land to be economically suitable for irrigation.

(4) Surface drainage patterns and ground water flow patterns.

b. The impact upon:

(1) Sound-sensitive land uses.

(2) The visual effect on the adjacent area.

(3) Extractive and storage resources.

(4) Wetlands, woodlands, and wooded areas.

(5) Radio and television reception, and other communication or electronic control facilities.

(6) Human health and safety.

(7) Animal health and safety.

(8) Plant life.

4. **Policy criteria.** The commission may give preference to an applicant that will maximize benefits that result from the adoption of the following policies and practices, and in a proper case may require the adoption of such policies and practices. The commission may also give preference to an applicant that will maximize interstate benefits. The benefits to be considered include:

   a. Location and design.

   b. Training and utilization of available labor in this state for the general and specialized skills required.

   c. Economies of construction and operation.

   d. Use of citizen coordinating committees.

   e. A commitment of a portion of the transmitted product for use in this state.

   f. Labor relations.

   g. The coordination of facilities.

   h. Monitoring of impacts.

   i. Utilization of existing and proposed rights of way and corridors.

   j. Other existing or proposed transmission facilities.

History: Amended effective August 1, 1979; January 1, 1982; February 1, 1995; July 1, 2006; April 1, 2013; July 1, 2020; January 1, 2022.
General Authority: NDCC 49-22-18
Law Implemented: NDCC 49-22-05.1

ARTICLE 69-09
PUBLIC UTILITY DIVISION

CHAPTER 69-09-02

69-09-02-06. Continuity of service.

1. An electric public utility is responsible for ensuring reliable service.

2. Each utility shall make every reasonable effort to prevent interruptions of service, and when such interruptions occur shall endeavor to reestablish service within the shortest possible time. Whenever the service is necessarily interrupted or curtailed for the purpose of working on equipment, it shall be done at a time which, if at all practicable, will cause the least inconvenience to customers, except in cases of emergency.

~~2.~~3. Each utility shall keep a record of all interruptions to service affecting the entire distribution system of any single community or an important division of a community, and include in the record the date and time of interruption, the date and time service was restored, and, if known, the cause of each interruption. Service interruption records shall be kept for a period of six years.

4. If an electric public utility fails to meet its obligation to provide reliable service to customers, the commission may require action, assess disallowances or fines, or provide a penalty. A penalty, disallowance or fine, or action must take into consideration the nature, circumstances, and gravity of the violation, degree of culpability, history of prior service interruptions, and good faith attempts to ensure reliability.

5. By May first each year, each electric public utility shall file with the commission the records required by this section. The commission, at any time, upon notice to the electric public utility, may require a filing of the records required by this section for a specified time period or specific interruption.

6. Each electric public utility shall include in its annual May first filing, reliability statistics for the previous calendar year, including institute of electrical and electronics engineers standard 1366 indices system average interruption frequency index, system average interruption duration index, customer average interruption duration index. Each utility shall include with this filing the datapoints used to calculate each of the above indices and a detailed breakdown of each major event day. These statistics must be compiled by each electric public utility for its North Dakota distribution system.

History: Amended effective January 1, 2022.

General Authority: NDCC 49-02-11
Law Implemented: NDCC 49-02-11

CHAPTER 69-09-11
COMMON PIPELINE CARRIERS

69-09-11-01. Pipeline carrier tariffs.

A common pipeline carrier shall maintain its tariffs and have them available for production upon commission request.

History: Effective January 1, 2022.
General Authority: NDCC 28-32-02, 49-19-17
Law Implemented: NDCC 49-19-17

TITLE 72

SECRETARY OF STATE

JANUARY 2022

CHAPTER 72-06-01
CERTIFYING AND DECERTIFYING ELECTRONIC VOTING SYSTEMS

72-06-01-04. Criteria for approving direct recording electronic voting systems.

Repealed effective January 1, 2022.

~~Before the secretary of state grants a certificate of approval, the following capabilities or features of a direct recording electronic voting system must be demonstrated to the secretary of state or the secretary of state's designee upon such official's request. As used in this section, the term system means direct recording electronic voting system. The secretary of state may grant a certificate of approval for a system if the system fulfills the requirements of North Dakota Century Code section 16.1-06-14 and is approved or certified by the EAC. The secretary of state may also require that one or more of the following capabilities or features also be included in a system prior to its approval:~~

1. ~~Presents the entire ballot to the voter in a series of sequential screens that include methods to ensure the voter sees all ballot options on all screens before completing the vote and allows the voter to review all ballot choices before casting a ballot;~~

2. ~~Alerts the voter on the screen if the voter attempts to over vote or cross-party vote and provides information on how to correct the over vote or cross-party vote;~~

3. ~~Is an electronic computer-controlled voting system that provides for direct recording and tabulating of votes cast;~~

4. ~~Has a battery backup system that, at a minimum, allows voting to continue uninterrupted for two hours without external power;~~

5. Along with any activating and vote recording devices and components, has a unique embedded internal serial number for audit purposes;

6. Is designed to accommodate multiple ballot styles in each election precinct and multiple precincts;

7. Has a real-time clock capable of recording and documenting the total time polls are open in a precinct and capable of documenting the opening and closing of polls;

8. Complies with the disability voting requirements of the Help America Vote Act [Pub. L. 107-252; 42 U.S.C. 15301-15545];

9. For security purposes, along with each associated activating and recording device and component, employs a unique, electronically implanted election-specific internal security code such that the absence of the security code prevents substitution of any unauthorized system or related component;

10. Has a color touch-screen that is at least fifteen inches [38.1 centimeters] in diagonal measure;

11. Has an option to accommodate a wheelchair voter without intervention of the poll worker other than a minor adjustment such as the angle of the display, and the voter must be able to vote in a face-first position so that privacy is maintained with the ballot surface adjusted to a vertical position;

12. Has wheels so that the system may be easily rolled by one person on rough pavement and rolled through a standard thirty-inch [76.2-centimeter] doorframe if the net weight of the system, or aggregate of voting device parts, is over twenty pounds [9.07 kilograms];

13. Has a smart card-type device to activate the system for each individual voter. The election worker or voters shall be able to activate the card at the poll table with an activation device and hand the card to the voter to use on any open voting system. The card shall be rendered unusable by the voting system after the voter has cast a ballot and after a period of time has expired. There shall be a manual solution available in the event the smart card activation device or the smart card reading unit on the machine fails;

14. Prints an alphanumeric printout of the contest, candidates, position numbers, and vote totals when the polls are open so that the election workers may verify that the counters for each candidate are on zero. These printouts shall contain the system serial number and the counter total. The election worker must be able to request as many copies as needed. The system shall include a feature to allow reports to be sent to a printer or to an excel-compatible file;

15. The system central processing unit is designed so that no executable code may be launched from random access memory. If the operating system is open or widely used, it must be an embedded system;

16. Provides an electronic, redundant storage of both the vote totals and the randomized individual ballot images. These randomized images must be able to be printed after the polls close;

17. Allows a comparison of the multiple locations of totals and ballot images to detect any errors or discrepancies. In the event of a data discrepancy, an appropriate error message shall be displayed in a text format, in order to either correct the data error or prohibit voting from continuing;

18. Has a programmable memory device that plugs into the system. This programmable memory device shall contain the ballot control information, the summary vote totals, maintenance log, operator log, and the randomized ballot images;

~~19. Maintains all vote totals, counter totals, audit trail ballot images, and the internal clock time in both the main memory and the removable programmable memory devices in the event the main power and battery backup power fail;~~

~~20. Has a self-contained, internal backup battery that powers all components of the system that are powered by alternating current power. In the event of a power outage in the precinct, the self-contained, internal backup battery power shall engage with no disruption of operation or loss of data. The system shall maintain all vote totals, counter totals, audit trail ballot images, and the internal clock time in both the main memory and the removable programmable memory devices in the event the main power and battery backup fail;~~

~~21. Has software that is able to run in a networked or stand-alone environment and supports early voting;~~

~~22. Has a standard or as an option, software and hardware provisions for remote transmission of election results to a central location;~~

~~23. Has internal operating system software or firmware that:~~

~~a. Is specifically designed and engineered for the election application;~~

~~b. Is contained within each touch-screen voting device;~~

~~c. Is stored in a nonvolatile memory within each terminal;~~

~~d. Includes internal quality checks such as purity or error detection and correction codes; and~~

~~e. Includes comprehensive diagnostics to ensure that failures do not go undetected;~~

~~24. Has a mandatory preelection testing of the ballot control logic and accuracy. The logic and accuracy test results must be stored into the memory of the main processor (central processing unit) and into the same programmable memory device that is used on election day for future reference. The test results must be stored by vote total summaries and by each individual ballot image randomly. The system must be capable of printing a zero-results printout prior to these tests and results printout after the tests; and~~

~~25. Stores tabulation of votes, ballot by ballot, in two or more memory locations on separate integrated circuit chips and shall be electronically compared throughout the election. Any differences between votes tabulated and votes stored in multiple storage locations shall be detected immediately and generate an error message defining required maintenance on the electronic voting system before the system continues to be used in the election.~~

~~**History:** Effective March 1, 2004; amended effective July 1, 2006.~~
~~**General Authority:** NDCC 16.1-06-26~~
~~**Law Implemented:** NDCC 16.1-06-14, 16.1-06-26~~

72-06-01-05. Defining a vote on ~~optical~~digital scan ballots used as a part of an electronic voting system.

A voting mark that touches the oval on ~~an optical~~a digital scan ballot used as a part of an electronic voting system shall be counted as if it were in the oval. ~~Except as provided in North Dakota Century Code section 16.1-13-25, if the voting mark does not touch the oval and is not in the oval, the vote may not be counted.~~A name of an individual who is eligible to be elected which is written or entered by a voter on the space provided for write-in votes must be counted as a vote whether or not the oval is darkened and provided there exist no other marks made by the voter for that contest which would make it impossible to determine the intent of the voter.

History: Effective March 1, 2004; amended effective July 1, 2006; January 1, 2022.
General Authority: NDCC 16.1-06-26
Law Implemented: NDCC 16.1-06-26

72-06-01-06. Defining a vote on direct recording electronic voting systems.

Repealed effective January 1, 2022.

~~A vote on a direct recording electronic voting system is one that is directly recorded and tabulated on an electronic computer-controlled voting system by a method that ensures a voter sees all ballot options on all screens before completing the vote and allows the voter to review all ballot choices before casting a ballot.~~

~~**History:** Effective March 1, 2004.~~
~~**General Authority:** NDCC 16.1-06-26~~
~~**Law Implemented:** NDCC 16.1-06-26~~

72-06-01-07. Temporarily defining a vote on new electronic voting system, not otherwise addressed in this chapter.

After certifying a new electronic voting system according to section 72-06-01-01 which is not otherwise addressed in this chapter, and within sixty days following the issue of a certificate of approval by the secretary of state, the secretary of state shall temporarily define and publicize what constitutes a vote on the newly certified ~~electronic~~ voting system, which will govern until a permanent definition is adopted by rule.

History: Effective March 1, 2004; amended effective July 1, 2006; January 1, 2022.
General Authority: NDCC 16.1-06-26
Law Implemented: NDCC 16.1-06-26

72-06-01-08. Criteria for approving ballot marking devices.

Before the secretary of state grants a certificate of approval, the following capabilities or features of a ballot marking device must be demonstrated to the secretary of state or the secretary of state's designee upon such official's request. As used in this section, the term "device" means ballot marking device. The secretary of state may grant a certificate of approval for a device if the device fulfills the applicable subsection requirements of North Dakota Century Code section 16.1-06-14 and is approved or certified by the EAC. The secretary of state may also require that one or more of the following capabilities or features also be included in a system prior to its approval:

1. Presents the entire ballot to the voter in a series of sequential screens that include methods to ensure the voter sees all ballot options on all screens before completing the vote and allows the voter to review all ballot choices before casting a ballot;

2. ~~Alerts~~Does not allow the voter ~~on the screen if the voter attempts~~ to over vote or cross-party vote and ~~provides information on how to correct the over vote or cross-party vote~~informs the voter if a contest has been under voted;

3. Is an electronic computer-controlled voting system that provides for direct marking of the voter's choices on a paper ballot without tabulation of votes cast;

4. Has a battery backup system that, at a minimum, allows voting to continue uninterrupted for two hours without external power;

5. Is designed to accommodate multiple ballot styles in each election precinct and multiple precincts;

6. Has a real-time clock capable of recording and documenting the total time polls are open in a precinct and capable of documenting the opening and closing of polls;

7. Complies with the disability voting requirements of the Help America Vote Act [Pub. L. 107-252; 42 U.S.C. 15301-15545];

8. For security purposes, along with each associated activating and recording device and component, employs a unique, electronically implanted election-specific internal security code such that the absence of the security code prevents ~~substitution of any unauthorized system or related component~~operation;

9. Has a color ~~touch-screen~~touchscreen that is at least fifteen inches [38.1 centimeters] in diagonal measure;

10. Has an option to accommodate a wheelchair voter without intervention of the poll worker other than a minor adjustment such as the angle of the display, and the voter must be able to vote in a face-first position so that privacy is maintained with the ballot surface adjusted to a vertical position;

11. Has wheels so that the system may be easily rolled by one person on rough pavement and rolled through a standard thirty-inch [76.2-centimeter] doorframe if the net weight of the system, or aggregate of voting device parts, is over twenty pounds [9.07 kilograms];

12. Is activated by an official election ballot;

13. Upon activation is able to detect any premarked votes, and if votes are present, the device will not allow the voter to mark any additional votes with the device;

14. Has the capability to display, both visually and through voice files, the marked votes on a paper ballot for the benefit of a person who is not able to read or see the marks on the ballot and who desires an independent verification of marked votes prior to casting and tabulation of the votes;

15. The system central processing unit is designed so that no executable code may be launched from random access memory. If the operating system is open or widely used, it must be an embedded system;

16. Has a programmable memory card that plugs into the system. This programmable memory card shall contain the ballot definitions;

17. Has a self-contained, internal backup battery that powers all components of the system that are powered by alternating current power. In the event of a power outage, the self-contained, internal backup battery power shall engage with no disruption of operation or loss of ballot definitions;

18. Has the capability to support early voting; and

19. Has internal operating system software or ~~firmer~~firmware that:

    a. Is specifically designed and engineered for the election application;

    b. Is contained within each ballot marking device;

    c. Is stored in a nonvolatile memory within each terminal;

    d. Includes internal quality checks such as purity or error detection and correction codes; and

e. Includes comprehensive diagnostics to ensure that failures do not go undetected.

History: Effective July 1, 2006; amended effective January 1, 2022.
General Authority: NDCC 16.1-06-26
Law Implemented: NDCC 16.1-06-14, 16.1-06-26

TITLE 75

DEPARTMENT OF HUMAN SERVICES

JANUARY 2022

CHAPTER 75-02-02
MEDICAL SERVICES

75-02-02-08. Amount, duration, and scope of 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 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.

x. Interpreter services. "Interpreter services" means services that assist clients with sign or oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited English proficiency or who has hearing loss and uses interpreter services.

2. The following limitations apply to medical and remedial care and services covered or provided under the 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 50-24.1-15, 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 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; January 1, 2022.
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

75-02-02-09.4. General limitations on amount, duration, and scope.

1. Covered medical or remedial services or supplies are medically necessary when determined so by the medical provider unless the department has:

a. Denied a prior treatment authorization request to provide the service;

b. Imposed a limit that has been exceeded;

c. Imposed a condition that has not been met;

d. Upon review under North Dakota Century Code chapter 50-24.1, determined that the service or supplies are not medically necessary.

2. Limitations on payment for occupational therapy, physical therapy, and speech therapy.

a. No payment will be made for an occupational therapy evaluation except one per calendar year or for occupational therapy provided to individuals twenty-one years of age and older except for ~~twenty~~thirty visits per individual per calendar year unless the provider

requests and receives prior authorization from the department. This limit applies in combination with services delivered by independent occupational therapists and in outpatient hospital settings.

b. No payment will be made for a physical therapy evaluation except one per calendar year or for physical therapy provided to individuals twenty-one years of age and older except for ~~fifteen~~thirty visits per individual per calendar year unless the provider requests and receives prior authorization from the department. This limit applies in combination with services delivered by independent physical therapists and in outpatient hospital settings.

c. No payment will be made for a speech therapy evaluation except one per calendar year or for speech therapy provided to individuals twenty-one years of age and older except for thirty visits per individual per calendar year unless the provider requests and receives prior authorization from the department. This limit applies in combination with services delivered by independent speech therapists and in outpatient hospital settings.

3. Limitation on payment for eye services.

a. No payment will be made for eyeglasses for individuals twenty-one years of age and older except for one pair of eyeglasses no more often than once every two years. No payment will be made for the repair or replacement of eyeglasses during the two-year period unless the provider has secured the prior approval of the department and the department has found that the repair or replacement is medically necessary.

b. No payment will be made for refractive examinations for individuals twenty-one years of age and older except for one refractive examination no more often than every two years after an initial examination paid by the department unless the provider has secured the prior approval of the department.

4. Limitation on chiropractic services.

a. No payment will be made for spinal manipulation treatment services except for ~~twelve~~twenty spinal manipulation treatment services per individual per calendar year unless the provider requests and receives the prior approval of the department.

b. No payment will be made for radiologic examinations performed by a chiropractor except for two radiologic examinations per individual per year unless the provider requests and receives the prior approval of the department.

~~5. Limitation on behavioral health services.~~

~~a. No payment will be made for psychological therapy visits except for forty visits per individual per calendar year.~~

~~b. No payment will be made for psychological evaluations except for one per calendar year.~~

~~c. No payment will be made for psychological testing except for ten units per calendar year.~~

~~Limitations in this subsection apply for services rendered by practitioners described in subsection 1 of section 75-02-02-03.2 with the exception of physicians, clinical nurse specialists, physician assistants, or nurse practitioners. Services in excess of the limits are not eligible for Medicaid payment unless the additional services are medically necessary and the provider requests and receives the prior approval of the department.~~

History: Effective September 1, 2003; amended effective July 1, 2006; July 1, 2009; October 1, 2012; April 1, 2016; January 1, 2017; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04

75-02-02-09.5. Limitations on personal care services.

1. No payment for personal care services may be made unless an assessment of the recipient is made by the department or the department's designee and the recipient is determined to be impaired in at least one of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring or in at least three of the instrumental activities of daily living of medication assistance, laundry, housekeeping, and meal preparation.

2. No payment may be made for personal care services unless prior authorization has been granted by the department.

3. Payment for personal care services may only be made to an enrolled qualified service provider who meets the standards described in chapter 75-03-23 or to a basic care assistance provider that qualifies for a rate under chapter 75-02-07.1.

4. No payment may be made for personal care services provided in excess of the services, hours, or time frame authorized by the department in the recipient's approved service plan.

5. Personal care services may not include skilled health care services performed by persons with professional training.

6. An inpatient or resident of a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, a psychiatric residential treatment facility, or an institution for mental diseases may not receive personal care services.

7. Personal care services may not include home-delivered meals, services performed primarily as housekeeping tasks, transportation, social activities, or services or tasks not directly related to the needs of the recipient such as doing laundry for family members, cleaning of areas not occupied by the recipient, shopping for items not used by the recipient, or for tasks when they are completed for the benefit of both the client and the provider.

8. Payment for the tasks of laundry, shopping, ~~housekeeping,~~ meal preparation, money management, and communication ~~cannot~~may be made to a provider ~~who lives with the client and is a relative listed under the definition of family home care under subsection 4 of North Dakota Century Code section 50-06.2-02 or is a former spouse~~if the activity benefits the client. The department may pay a provider for housekeeping activities involving the client's personal private space and if the client is living with an adult, the client's share of common living space.

9. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housekeeping tasks when provided as personal care services must be incidental to the provision of other personal care tasks and cannot exceed thirty percent of the total time authorized for the provision of all personal care tasks. Personal care service tasks of laundry, shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community-based services funding sources.

10. No payment may be made for personal care services provided to a recipient by the recipient's spouse, parent of a minor child, or legal guardian.

11. No payment may be made for care needs of a recipient which are outside the scope of personal care services.

12. Authorized personal care services may only be approved for:

    a. Up to one hundred twenty hours per month;

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.

13. Personal care services may ~~only~~ be provided ~~when the needs of the~~to a recipient ~~exceed the abilities of the recipient's spouse or parent of a minor child to provide those services. Personal care services may not be substituted when a spouse or parent of a minor child refuses or chooses not to perform the service for a recipient. Personal care services may be provided during periods when a spouse or parent of a minor child is gainfully employed if the services cannot be delayed until the spouse or parent is able to perform them~~who has natural supports. For purposes of this subsection, "natural supports" means an informal, unpaid caregiver that provides care to an applicant or client.

14. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages of development.

15. The authorization for personal care services may be terminated if the services are not used within sixty days, or if services lapse for at least sixty days, after the issuance of the authorization to provide personal care services.

16. The department may deny or terminate personal care services when service to the client presents an immediate threat to the health or safety of the client, the provider of services, or others, or when services that are available are not adequate to prevent a threat to the health or safety of the client, the provider of services, or others.

17. Decisions regarding personal care services for an incapacitated client are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.

18. The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

19. Payment for personal care services may not be made unless the client has been determined eligible to receive Medicaid benefits.

20. A daily rate for personal care may be authorized, at the discretion of the department, when determined necessary to maintain a recipient in the least restrictive setting.

History: Effective July 1, 2006; amended effective January 1, 2010; July 1, 2012; October 1, 2012; April 1, 2016; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-24.1-18
Law Implemented: NDCC 50-24.1-18; 42 CFR Part 440.167

75-02-02-10.1. Limitations on inpatient psychiatric services.

Repealed effective January 1, 2022.

~~No payment may be made for inpatient psychiatric services provided to a recipient, other than those described in section 75-02-02-10, in a distinct part unit of a hospital except for the first~~

~~twenty-one days of each admission and not to exceed forty-five days per calendar year per recipient.~~

~~**History:** Effective November 1, 2001; amended effective October 1, 2012; April 1, 2018.~~
~~**General Authority:** NDCC 50-24.1-04; 42 CFR456.1; 42 CFR 456.3~~
~~**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~~substance use disorder.

1. For purposes of this section:

   a. ~~"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.1" means services for treatment of addiction as prescribed in article 75-09.1.~~

   ~~c. "American Society of Addiction Medicine II.5" means services for treatment of addiction as prescribed in article 75-09.1.~~

   ~~d. "American Society of Addiction Medicine III.1" means 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.~~"Clinically managed high-intensity residential care" means services for treatment of substance use disorder as prescribed in chapters 75-09.1-03 and 75-09.1-03.1.

   b. "Clinically managed low-intensity residential care" means services for treatment of substance use disorder as prescribed in chapters 75-09.1-02 and 75-09.1-02.1.

   c. "Clinically managed residential withdrawal" means services for treatment of substance use disorder as prescribed in chapter 75-09.1-08.

   d. "Intensive outpatient treatment" means services for treatment of substance use disorder as prescribed in chapters 75-09.1-06 and 75-09.1-06.1.

   e. "Medically monitored intensive inpatient treatment" means services for treatment of substance use disorder as prescribed in chapters 75-09.1-04 and 75-09.1-04.1.

   f. "Outpatient services" means services for treatment of substance use disorder as prescribed in chapters 75-09.1-07 and 75-09.1-07.1.

   g. "Partial hospitalization" means services for treatment of substance use disorder as prescribed in chapters 75-09.1-05 and 75-09.1-05.1.

   ~~f.~~h. "Services for treatment of ~~addiction~~substance use disorder" means ~~ambulatory~~ services provided to an individual with an impairment resulting from ~~an addictive~~a substance use 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~~substance use disorder may be hospital-based or nonhospital-based.

2. Limitations.

   ~~a. Payment may not be made for American Society of Addiction Medicine II.1 services exceeding thirty days per calendar year per recipient.~~

~~b. Payment may not be made for American Society of Addiction Medicine II.5 services exceeding forty-five days per calendar year per recipient.~~

~~c. Payment may not be made for American Society of Addiction Medicine III.5 services exceeding forty-five days per calendar year per recipient.~~

~~d. The department may authorize additional days per calendar year per recipient if determined to be medically necessary.~~

~~e.~~ Payment may not be made for ~~American Society of Addiction Medicine III.1~~clinically managed low-intensity residential care services, unless the recipient is concurrently receiving ~~American Society of Addiction Medicine II.1~~intensive outpatient treatment or ~~II.5~~partial hospitalization services.

3. Licensed addiction counselors, operating within their scope of practice, performing ~~American Society of Addiction Medicine I~~outpatient services, 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~~outpatient 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; January 1, 2022.
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~~Partial hospitalization psychiatric services.

1. For purposes of this section:

   a. "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.

   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 level A or level B 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. ~~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 authorize additional days per calendar year per recipient if determined to be medically necessary~~only be made for partial hospitalization psychiatric services that are hospital based.

History: Effective April 1, 2018; amended effective April 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 431.54

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 Medicaid program or children's health insurance program recipient meets predetermined criteria for coverage by the 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.

10. The department may require prior authorization for any medication that is a line extension drug in any of the excluded medication classes under subsection 3 of North Dakota Century Code section 50-24.6-04 if the line extension drug's net cost is higher than the original medication due to federal drug rebate offset differences.

History: Effective September 1, 2003; amended effective July 26, 2004; July 1, 2006; October 1, 2012; April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.6-04, 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 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 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 fifty-seven 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.

o. An individual age nineteen or twenty eligible under Medicaid expansion, as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], and implementing regulations.

3. A physician, advanced practice registered nurse with the role of nurse practitioner, ~~or~~ physician assistant, or certified nurse midwife 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;

   h. A federally qualified health center; or

   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. The department may not limit a recipient's disenrollment from a primary care provider. 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~~at any time upon request by the recipient.

History: Effective October 1, 2012; amended effective July 1, 2014; April 1, 2016; January 1, 2017; April 1, 2018; April 1, 2020; January 1, 2022.
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

75-02-02.1-02. Application and redetermination.

1. **Application.**

   a. All individuals wishing to make application for Medicaid must have the opportunity to do so, without delay.

   b. An application is a written request made by an individual desiring assistance under the Medicaid program, or by an individual seeking such assistance on behalf of another individual, to a county agency, the department, a disproportionate share hospital, as defined in section 1923(a)(1)(A) of the Act [42 U.S.C. 1396r-4(a)(1)(A)], or a federally qualified health center, as described in section 1905(l)(2)(B) of the Act [42 U.S.C. 1396d(l)(2)(B)].

   c. A prescribed application form must be signed by the applicant or by someone acting responsibly for an incapacitated applicant.

   d. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipients must be furnished to all who require it.

   e. A relative or other interested party may file an application ~~in~~on behalf of a deceased individual to cover medical costs incurred prior to the deceased individual's death.

   f. The date of application is the date an application, signed by an appropriate individual, is received at a county agency, the department, a disproportionate share hospital, or a federally qualified health center.

2. **Redetermination.** A redetermination must be completed within thirty days after a county agency has received information indicating a possible change in eligibility status, when eligibility is lost under a category, and in any event, no less than annually. A recipient has the same responsibility to furnish information during a redetermination as an applicant has during an application.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; May 1, 2006; January 1, 2022.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-10. Eligibility - Current and retroactive.

1. Current eligibility may be established from the first day of the month in which the application was received. This subsection does not apply to qualified Medicare beneficiaries.

2. Retroactive eligibility may be established for as many as three calendar months prior to the month in which the application was received. Eligibility can be established in each of those months for which benefits are sought and if all factors of eligibility are met during each such month. If a previous application has been taken and denied in the same month, eligibility for that entire month may be established based on the current application. Retroactive eligibility may be established even if there is no eligibility in the month of application. This subsection does not apply to qualified Medicare beneficiaries.

3. An individual determined eligible for part of a month is eligible for the entire calendar month unless a specific factor prevents eligibility during part of that month. Specific factors include:

a. An individual is born in the month, in which case the date of birth is the first date of eligibility;

b. An individual who is not receiving Medicaid benefits from another state enters the state, in which case the earliest date of eligibility is the date the individual entered the state;

c. An individual who is receiving Medicaid benefits from another state enters the state, in which case the later of the date of entry or the day after the last day of eligibility under the other state's Medicaid program is the first date of eligibility; and

d. An individual is discharged from a public institution, in which case the date of eligibility is the date of discharge.

4. Eligibility for qualified Medicare beneficiaries begins in the month following the month in which the ~~eligibility determination is made~~individual is determined eligible.

5. An individual cannot be eligible as a qualifying individual and be eligible under any other Medicaid coverage for the same period of time.

6. A child cannot be eligible for Medicaid for the same period of time the child is covered under the children's health insurance program.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-14.1. Eligibility for medically frail Medicaid expansion enrollees.

1. For the purpose of this section, "medically frail" means an individual who is eligible for or enrolled with Medicaid expansion and has been deemed to meet the status of medically frail which upon a review and determination may include an individual with any of the following: serious or complex medical conditions; disabling mental disorders; chronic substance use disorders; or physical, intellectual, or developmental disability that significantly impairs one's ability to perform one or more activities of daily living.

2. A Medicaid expansion enrollee interested in applying for a medically frail determination shall complete a self-assessment and return the completed form to the department.

3. In any instance in which a determination is to be made as to whether any individual is medically frail, documentation that validates the diagnosis or medical condition along with any other supporting documentation must be submitted to the department. The self-assessment form and documentation submitted shall be reviewed by a medical professional with professional training and pertinent experience, and who shall determine if the applicant meets medically frail eligibility requirements.

4. If the Medicaid expansion enrollee is approved for eligibility as medically frail, the enrollee may choose coverage through a managed care organization or through the Medicaid state plan services, except for individuals ages nineteen and twenty as their coverage will be determined under the Medicaid state plan services.

5. Coverage of an enrollee as medically frail may begin no earlier than the first of the month in which the self-assessment was received by the department.

History: Effective January 1, 2014; amended effective April 1, 2018; January 1, 2022.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37; 42 CFR 440.315(f)

75-02-02.1-18. Citizenship and alienage.

1. An applicant or recipient must be a United States citizen or an alien lawfully admitted for permanent residence. Acceptable documents to establish United States citizenship and naturalized citizen status are defined in 42 CFR 435.407.

2. For purposes of qualifying as a United States citizen, the United States includes the fifty states, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for purposes of Medicaid.

3. American Indians born in Canada, who may freely enter and reside in the United States, are considered to be lawfully admitted for permanent residence if at least one-half American Indian blood. A spouse or child of such an Indian, or a noncitizen individual whose membership in an Indian tribe or family is created by adoption, may not be considered to be lawfully admitted under this subsection unless the individual is of at least one-half American Indian blood by birth.

4. The following categories of aliens, while lawfully admitted for a temporary or specified period of time, are not eligible for Medicaid, except for emergency services, because of the temporary nature of their admission status:

   a. Foreign government representatives on official business and their families and servants;

   b. Visitors for business or pleasure, including exchange visitors;

   c. Aliens in travel status while traveling directly through the United States;

   d. Crewmen on shore leave;

   e. Treaty traders and investors and their families;

   f. Foreign students;

   g. International organization representatives and personnel and their families and servants;

   h. Temporary workers, including agricultural contract workers; and

   i. Members of foreign press, radio, film, or other information media and their families.

5. Except for aliens identified in subsection 4, aliens who are not lawfully admitted for permanent residence in the United States are not eligible for Medicaid, except for emergency services.

6. ~~Aliens~~Individuals from the compact of free associated states, including the Federated States of Micronesia, the Republic of Marshall Islands, ~~or~~and the Republic of Palau~~ are lawfully admitted as permanent nonimmigrants and are not eligible for Medicaid, except for emergency services~~, pursuant to section 208 of division CC of the Consolidated Appropriations Act of 2021 [Pub. L. 116-260], are eligible for Medicaid benefits without the five-year, forty-quarter ban.

7. Aliens who lawfully entered the United States for permanent residence before August 22, 1996, and who meet all other Medicaid criteria may be eligible for Medicaid.

8. The following categories of aliens who entered the United States for permanent residence on or after August 22, 1996, and who meet all other Medicaid criteria may be eligible for Medicaid as qualified aliens:

a. Honorably discharged veterans, aliens on active duty in the United States armed forces, and the spouse or unmarried dependent children of such individuals;

b. Refugees and asylees;

c. Aliens whose deportation was withheld under section 243(h) of the Immigration and Naturalization Act;

d. Cuban and Haitian entrants;

e. Aliens admitted as Amerasian immigrants;

f. Victims of a severe form of trafficking;

g. Iraqi and Afghan aliens and family members who are admitted under section 101(a)(27) of the Immigration and Naturalization Act;

h. For the period paroled, aliens paroled into the United States for at least one year under section 212(d)(5) of the Immigration and Nationality Act;

i. Aliens granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act in effect prior to April 1, 1980;

j. Aliens granted nonimmigrant status under section 101(a)(15)(T) of the Immigration and Nationality Act or who have a pending application that sets forth a prima facie case for eligibility for that nonimmigrant status;

k. Certain battered aliens and their children who have been approved or have a petition pending which sets forth a prima facie case as identified in 8 U.S.C. 1641(c), but only if the department determines there is a substantial connection between the battery and the need for the benefits to be provided; and

l. All other aliens, other than for emergency services, only after five years from the date they entered the United States, and then only if the individual is a lawful permanent resident who has been credited with forty qualifying quarters of social security coverage.

9. An alien who is not eligible for Medicaid because of the time limitations or lack of forty qualifying quarters of social security coverage may be eligible to receive emergency services that are not related to an organ transplant procedure if:

a. The alien has a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing health in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part;

b. The alien meets all other eligibility requirements for Medicaid except the requirements concerning furnishing social security numbers and verification of alien status; and

c. The alien's need for the emergency service continues.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; January 1, 2010; January 1, 2011; January 1, 2014; January 1, 2022.
General Authority: NDCC 50-06-16, 50-24.1-04

Law Implemented: NDCC 50-24.1-01, 50-24.1-37

75-02-02.1-22. Medicare savings programs.

1. Qualified Medicare beneficiaries are entitled only to Medicare cost-sharing benefits described in subsection 19 of section 75-02-02.1-01, beginning in the month following the month in which the ~~eligibility determination is made~~individual is determined eligible.

2. Special low-income Medicare beneficiaries are entitled only to Medicare cost-sharing benefits described in paragraph 2 of subdivision a of subsection 19 of section 75-02-02.1-01. Eligibility may be established for as many as three calendar months prior to the month in which the application was received.

3. Qualifying individuals are entitled only to Medicare cost-sharing benefits described in paragraph 2 of subdivision a of subsection 19 of section 75-02-02.1-01. Eligibility may be established for as many as three calendar months prior to the month in which the application was received unless the individual was in receipt of any other Medicaid benefits for the same period. Eligibility shall be established on a first-come, first-served basis to the extent of funding allocated for coverage of this group under section 1933 of the Act [42 U.S.C. 1396u-3].

4. All medically needy technical eligibility factors apply to the Medicare savings programs except as identified in this section.

5. No person may be found eligible for the Medicare savings programs unless the total value of all nonexcluded assets does not exceed:

   a. For periods of eligibility prior to January 1, 2010:

      (1) Four thousand dollars for a one-person unit; or

      (2) Six thousand dollars for a two-person unit.

   b. For periods of eligibility on or after January 1, 2010, the asset limit described in 42 U.S.C. 1396d(p)(1)(C).

6. Provisions of this chapter governing asset considerations at section 75-02-02.1-25, valuation of assets at section 75-02-02.1-32, excluded assets at section 75-02-02.1-28.1, and forms of asset ownership at section 75-02-02.1-29 apply to eligibility determinations for Medicare savings programs except:

   a. Half of a liquid asset held in common with another Medicare savings program is presumed available;

   b. Assets owned by a child, under age twenty-one, in the unit are not considered available in determining eligibility for the child's parent, except that all liquid assets held in common by the child and the parent are considered available to the parent; and

   c. Assets owned by a spouse who is not residing with an applicant or recipient are not considered available unless the assets are liquid assets held in common.

7. a. Income calculations must consider income in the manner provided for in section 75-02-02.1-34, income considerations; section 75-02-02.1-37, unearned income; section 75-02-02.1-38, earned income; section 75-02-02.1-38.2, disregarded income; and section 75-02-02.1-39, income deductions; except:

      (1) Married individuals living separate and apart from a spouse are treated as single individuals.

(2) Income disregards in section 75-02-02.1-38.2 are allowed regardless of the individual's living arrangement.

(3) The earned income of any blind or disabled student under age twenty-two is disregarded.

(4) The deductions described in subsections 2, 3, 5, 8, and 9 of section 75-02-02.1-39, income deductions, are not allowed.

(5) The deductions described in subsection 10 and subdivision e of subsection 11 of section 75-02-02.1-39, income deductions, are allowed regardless of the individual's living arrangement.

(6) Annual title II cost of living allowances effective in January shall be disregarded when determining eligibility for Medicare savings programs for January, February, and March.

b. A qualified Medicare beneficiary is eligible if countable income is equal to or less than one hundred percent of the poverty level applicable to a family of the size involved, and if the individual meets all of the requirements described in this section.

c. A special low-income Medicare beneficiary is eligible if countable income is more than one hundred percent but equal to or less than one hundred twenty percent of the poverty level applicable to a family of the size involved, and if the individual meets all of the requirements described in this section.

d. A qualifying individual is income eligible if countable income is more than one hundred twenty percent, but equal to or less than one hundred thirty-five percent of the poverty level applicable to a family of the size involved, and if the individual meets all of the requirements described in this section.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; May 1, 2006; January 1, 2010; January 1, 2022.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-24. Spousal impoverishment prevention.

1. For purposes of this section:

a. "Community spouse" means the spouse of an institutionalized spouse or the spouse of a home and community-based services spouse.

b. "Family member" means only minor or dependent children, dependent parents, or dependent siblings of the institutionalized spouse, home and community-based services spouse, or community spouse who are residing with the community spouse. For purposes of applying this definition, a family member is dependent only if that family member is, and may properly be, claimed as a dependent on the federal income tax return filed by the institutionalized spouse or home and community-based services spouse, or the community spouse, or filed jointly by both.

c. "Home and community-based services spouse" means an individual who:

(1) Requires care of the type provided in a nursing facility, but chooses to receive home and community-based services in the community; and

(2) Is married to a spouse who resides in the community at least one day of each month.

d. "Institutionalized spouse" means an individual who:

(1) Requires care in a medical institution, a nursing facility, a swing bed, or the state hospital and, at the beginning of the individual's institutionalization, was likely to be in the facility for at least thirty consecutive days even though the individual does not actually remain in the facility for thirty consecutive days; and

(2) Is married to a spouse who resides in the community at least one day of each month.

e. "Monthly maintenance needs allowance" means for a community spouse, the greater of the amount authorized by the legislative assembly per month or the minimum amount permitted under section 1924(d)(3) of the Act [42 U.S.C. 1396r-5(d)(3)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)].

2. a. At the request of an institutionalized spouse, a home and community-based services spouse, or a community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse, or the beginning of the first continuous period of receipt of home and community-based services by a home and community-based services spouse, and upon receipt of relevant documentation of assets, the total value described in subdivision b shall be assessed and documented.

b. There shall be computed, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse, or as of the beginning of the first continuous period of receipt of home and community-based services by a home and community-based services spouse:

(1) The total value of the countable assets to the extent either the institutionalized spouse or the community spouse, or the home and community-based services spouse and the community spouse, has an ownership interest; and

(2) A spousal share, which is equal to one-half of all countable assets, but not less than the minimum amount permitted under section 1924(f)(2)(A)(i) of the Act [42 U.S.C. 1396r-5(f)(2)(A)(i)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)], and not more than the maximum amount permitted under section 1924(f)(2)(A)(ii)(II) of the Act [42 U.S.C. 1396r-5(f)(2)(A)(ii)(II)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)].

c. In determining the assets of the institutionalized spouse at the time of application, all countable assets held by the institutionalized spouse, the community spouse, or both, must be considered available to the institutionalized spouse to the extent they exceed the community spouse countable asset allowance.

d. In determining the assets of the home and community-based services spouse at the time of application, all countable assets held by the home and community-based services spouse, the community spouse, or both, must be considered available to the home and community-based services spouse to the extent they exceed the community spouse asset allowance.

e. During the continuous period in which the spouse is in an institution or receiving home and community-based services, and after the month in which an institutionalized spouse or a home and community-based services spouse is determined to be eligible for benefits under this chapter, no countable assets of the community spouse may be deemed available to the institutionalized spouse or home and community-based services spouse.

Assets owned by the community spouse are not considered available to the institutionalized spouse or home and community-based services spouse during this continuous period of eligibility. A transfer of assets or income by the community spouse for less than fair market value is governed by section 75-02-02.1-33.1 and shall be considered in determining continuing eligibility of the institutionalized spouse or home and community-based services spouse.

f. The institutionalized spouse or home and community-based services spouse is not ineligible by reason of assets determined under subdivision c or d to be available for the cost of care if:

(1) The institutionalized spouse or the home and community-based services spouse has assigned to the state any rights to support from the community spouse; or

(2) It is determined that a denial of eligibility would work an undue hardship because the presumption described in subsection 3 of section 75-02-02.1-25 has been rebutted.

g. An institutionalized spouse or home and community-based services spouse is allowed the medically needy asset limit of three thousand dollars.

h. An institutionalized spouse or a home and community-based services spouse is asset eligible if the total value of all countable assets owned by both spouses is less than the total of the community spouse countable asset allowance and the institutionalized spouse asset limit or home and community-based services asset limit, as applicable. The assets may be owned by either spouse provided that the requirements of subdivision i are complied with.

i. An institutionalized spouse or a home and community-based services spouse may transfer an amount equal to the community spouse countable asset allowance, but only to the extent the assets of the institutionalized spouse or home and community-based services spouse are transferred to, or for the sole benefit of, the community spouse. Such transfers, when made by an individual who has otherwise qualified for Medicaid benefits, must be completed before the next regularly scheduled redetermination of eligibility. During this period, such assets are not counted as available to the institutionalized spouse even though the assets are not yet transferred.

(1) When an eligible institutionalized spouse or home and community-based services spouse exceeds the asset limits due to an increase in the value of assets or the receipt of assets not previously owned, the institutionalized spouse or home and community-based services spouse may transfer additional assets to the community spouse equal to no more than the current community spouse countable asset allowance less the total value of assets owned by the community spouse, previously transferred to, or for the sole benefit of, the community spouse under this subdivision.

(2) If a transfer made under this subdivision causes the total value of all assets owned by the community spouse immediately prior to the transfer, plus the value of all assets transferred at any time under this subdivision, to equal or exceed the current community spouse asset allowance, no further transfer may be made under paragraph 1.

(3) If a court has entered an order against an institutionalized spouse for the support of a community spouse, assets required by such order to be transferred, by the institutionalized spouse to the community spouse, may not be counted as available to the institutionalized spouse even though the assets are not yet transferred.

3. A community spouse may retain or receive assets, which do not exceed the community spouse countable asset allowance, for purposes of determining the Medicaid eligibility of the institutionalized spouse. The community spouse countable asset allowance means the spousal share determined under paragraph 2 of subdivision b of subsection 2, as adjusted pursuant to section 1924(g) of the Act [Pub. L. 105-33; 111 Stat. 549; 42 U.S.C. 1396r-5(g)] plus:

   a. Any additional amount transferred under a court order in the manner and for the purpose described in paragraph 4 of subdivision i of subsection 2; or

   b. Any additional amount established through a fair hearing conducted under subsection 6.

4. Countable assets include all assets that are not specifically excluded. The provisions of section 75-02-02.1-28.1 governing asset exclusions apply to this section.

5. Income calculations must consider income in the manner provided for in section 75-02-02.1-34, income considerations, section 75-02-02.1-37, unearned income, section 75-02-02.1-38, earned income, section 75-02-02.1-38.1, ~~posteligibility~~post-eligibility treatment of income, section 75-02-02.1-38.2, disregarded income, section 75-02-02.1-39, income deductions, and section 75-02-02.1-40, income levels, except:

   a. No income of the community spouse may be deemed available to an institutionalized spouse during any month in which an institutionalized spouse is in the institution, or to a home and community-based services spouse during any month in which that spouse receives home and community-based services; and

   b. No institutionalized spouse may be income eligible for Medicaid in any month in which that spouse's income, after all income disregards and deductions other than the deduction of amounts provided to a spouse or family member, exceed an amount equal to that individual's current monthly medical expenses, not covered by a third party, plus the medically needy income level for one.

6. The provisions of this section describing the treatment of income and assets for the community spouse do not describe that treatment for the purposes of determining Medicaid eligibility for the community spouse or for children of the community spouse.

7. a. Notice must be provided of the amount of the community spouse income allowance, of the amount of any family allowances, of the method of computing the amount of the community spouse countable asset allowance, and of the right to a fair hearing respecting ownership or availability of income and assets, and the determination of the community spouse monthly income or countable asset allowance. The notice must be provided, upon a determination of Medicaid eligibility of an institutionalized spouse, to both spouses, and upon a subsequent request by either spouse or a representative acting on behalf of either spouse, to the spouse making the request.

   b. A community spouse, or an institutionalized spouse or a home and community-based services spouse, is entitled to a fair hearing under chapter 75-01-03 if application for Medicaid has been made on behalf of the institutionalized spouse or home and community-based services spouse and either spouse is dissatisfied with a determination of:

      (1) The community spouse monthly income allowance;

      (2) The amount of monthly income otherwise available to the community spouse as determined in calculating the community spouse monthly income allowance;

      (3) The computation of the spousal share of countable assets;

(4) The attribution of countable assets; or

(5) The determination of the community spouse countable asset allowance.

c. Any hearing respecting the determination of the community spouse countable asset allowance must be held within thirty days of the request for the hearing.

d. If either spouse establishes that the community spouse needs income, above the level provided by the monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs allowance for that spouse must be increased to an amount adequate to provide necessary additional income.

e. (1) If either spouse establishes that the assets included within the community spouse countable asset allowance generate an amount of income inadequate to raise the community spouse's income to the monthly maintenance needs allowance, to the extent that total assets permit, the community spouse countable asset allowance for that spouse must be increased to an amount adequate to provide such a monthly maintenance needs allowance. For purposes of calculations made under this subdivision, all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, must be treated as having been made available before an additional amount of assets may be allocated to the community spouse under this subdivision.

(2) To establish a need for an increased asset allowance under this subdivision, the applicant, recipient, or the community spouse must provide verification of all income and assets of the community spouse.

(3) The amount of assets adequate to provide a monthly maintenance needs allowance for the community spouse must be based on the cost of a single premium lifetime annuity selected by the department that provides monthly payments equal to the difference between the monthly maintenance needs allowance and other income of both spouses not generated by either spouse's countable assets.

(4) The monthly maintenance needs allowance amount upon which calculations under this subdivision are made must be the amount in effect upon filing of the appeal.

(5) The estimate of the cost of an annuity described in paragraph 3 must be substituted for the amount of assets attributed to the community spouse if the amount of assets previously determined is less than the estimate. If the amount of assets attributed to the community spouse prior to the hearing is greater than the estimate of the cost of an annuity described in paragraph 3, the attribution of assets to the community spouse made prior to the hearing must be affirmed.

(6) No applicant, recipient, or community spouse is required to purchase an annuity as a condition of the applicant or recipient's eligibility for Medicaid benefits.

8. Any transfer of an asset or income is a disqualifying transfer under section 75-02-02.1-33.1 or 75-02-02.1-33.2, whether made by a community spouse, a home and community-based services spouse, or an institutionalized spouse, unless specifically authorized by this section. The income that may be received by or deemed provided to an ineligible community spouse, and the asset amounts that an ineligible community spouse may retain, are intended to allow that community spouse to avoid impoverishment. They are not intended to allow the community spouse to make transfers of assets or income, for less than adequate consideration, which would disqualify the institutionalized spouse or home and

community-based services spouse, if made by the institutionalized spouse or home and community-based services spouse.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; October 1, 1993; July 1, 2003; June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2011; April 1, 2016; January 1, 2022.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396r-5

75-02-02.1-24.2. Eligibility for workers with disabilities.

1. An individual shall be enrolled as a member of the workers with disabilities coverage if that individual:

   a. Is gainfully employed;

   b. Is at least sixteen, but less than sixty-five, years of age;

   c. Is disabled as determined by the social security administration or the state review team;

   d. Meets the requirements of this section; and

   e. Is not in receipt of any other Medicaid benefits under this chapter other than coverage as a qualified Medicare beneficiary or a special low-income Medicare beneficiary.

2. An individual may be regarded as gainfully employed only if, taking all factors into consideration, the individual shows that the activity asserted as employment:

   a. Produces a product or service that someone would ordinarily be employed to produce and for which payment is received;

   b. Reflects a relationship of employer and employee or producer and customer;

   c. Requires the individual's physical effort for completion of job tasks, or, if the individual has the skills and knowledge to direct the activity of others, reflects the outcome of that direction; and

   d. The employment setting is not primarily an evaluative or experiential activity.

3. Asset considerations provided under section 75-02-02.1-25, asset limits provided under section 75-02-02.1-26, and excluded assets provided under section 75-02-02.1-28.1 are applicable to the workers with disabilities coverage except that each individual enrolled as a member of the workers with disabilities coverage group is allowed an additional ten thousand dollars in assets.

4. Except for Indians who are exempt from cost-sharing under federal law, an individual who has not paid a one-time enrollment fee of one hundred dollars may not be enrolled.

5. Any individual who fails to pay the premium established under this section for three months shall be disenrolled and may not be reenrolled thereafter without first reestablishing eligibility under this section and paying all outstanding enrollment fees and premiums. Any month in which no premium is due shall not be counted as a month in which the individual failed to pay a premium.

6. Payments received by the department from an individual claiming eligibility under this section shall be credited first to unpaid enrollment fees and then to the oldest unpaid premium. The department shall credit payments on the day received, provided that credit for any payment made by an instrument that is not honored shall be reversed. The department may require any

individual who has attempted payment by a dishonored instrument to make subsequent payments in a specified manner.

7. A monthly premium is due on the tenth day of each month for which coverage is sought and shall be equal to five percent of the individual's gross countable income. This requirement does not apply to Indians who are exempt from cost-sharing under federal law.

8. No individual may be found eligible under this section if the individual and the individual's family have total net income equaling or exceeding two hundred twenty-five percent of the poverty level.

9. This section becomes effective on the effective date of approved amendments to the Medicaid state plan sufficient to secure federal financial participation in the cost of services provided to individuals found eligible under this section, remains effective as long as federal financial participation continues to be available and state law authorizes such coverage, and is thereafter ineffective.

10. The department may not require the payment of a premium or disenroll an individual for failure to pay a premium or enrollment fee for workers with disabilities coverage during a federally declared emergency if collection of the premium or enrollment fee may impact the receipt of federal funds.

History: Effective June 1, 2004; amended effective August 1, 2005; April 1, 2008; January 1, 2011; April 1, 2012; January 1, 2022.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02.7, 50-24.1-18.1

75-02-02.1-24.3. Eligibility for children with disabilities.

1. A child must be enrolled as a member of the children with disabilities coverage if that child:

   a. Is under age nineteen, including the month the child turns age nineteen;

   b. Is disabled;

   c. Meets the requirements of this section; and

   d. Is not in receipt of any other Medicaid benefits under this chapter.

2. As a condition of eligibility, a child must be enrolled in a health insurance policy if:

   a. The child's family has an employer-based health insurance plan available to them; and

   b. The employer pays at least fifty percent of the premium.

3. A monthly premium is due on the tenth day of each month for which coverage is sought and is equal to five percent of the family's gross countable income. This premium may be offset by any other health insurance premium the family pays for a health insurance plan that provides coverage for the individual claiming eligibility under this section. This subsection does not apply to Indians who are exempt from cost-sharing under federal law.

4. If the premium established for an individual's coverage under this section is not paid for three months, the individual will be disenrolled and may not be reenrolled without first reestablishing eligibility under this section and paying all outstanding premiums. Any month in which no payment is due may not be counted as a month in which the individual's premium failed to be paid.

5. Payments received by the department from or on behalf of an individual claiming eligibility under this section will be credited first to the oldest unpaid premium. The department will credit payments on the day received, provided that credit for any payment made by an instrument that is not honored will be reversed. The department may require any individual who has attempted payment by a dishonored instrument to make subsequent payments in a specified manner.

6. No individual may be found eligible under this section if the individual and the individual's family have total net income in excess of two hundred fifty percent of the poverty level.

7. This section becomes effective March 1, 2008, remains effective as long as federal financial participation continues to be available and state law authorizes such coverage, and is thereafter ineffective.

8. For purposes of this section, "family" means any member of the Medicaid unit who is a spouse, parent, financially responsible caretaker relative, sibling, or child of the individual requesting benefits under this section.

9. The department may not require the payment of a premium or disenroll an individual for failure to pay a premium for families of children with disabilities coverage during a federally declared emergency if collection of the premium may impact the receipt of federal funds.

History: Effective April 1, 2008; amended effective January 1, 2011; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-31

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 75-02-05-07. 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 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 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 original claims received by the department later than ~~twelve months following~~one hundred eighty days from the date ~~the~~of service ~~was provided~~. ~~Claim~~Final claim adjustments must be submitted within ~~twelve months of the most recent processed claim shall be considered timely~~three hundred sixty-five days from the date of service. The department may grant a variance to extend the deadline for a provider to submit a final claim adjustment. A refusal to grant a variance is not subject to a request for review or an appeal.

7. The department will process claims ~~six months past the Medicare explanation of benefits date~~within one hundred eighty days from the date on the Medicare explanation of benefits 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; January 1, 2022.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: 42 CFR 431.107

CHAPTER 75-02-06
RATESETTING FOR NURSING HOME CARE

75-02-06-01. Definitions.

In this chapter, unless the context or subject matter requires otherwise:

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

2. "Actual rate" means the facility rate for each cost category calculated using allowable historical operating costs and adjustment factors.

3. "Adjustment factor" means the ~~inflation rate for nursing home services used to develop the legislative appropriation for the department for the applicable rate year~~centers for Medicare and Medicaid services skilled nursing facility market basket index four-quarter moving average percent change for quarter two of the applicable rate year from the current market basket data file publicly available as of August thirty-first of the year preceding the rate year. The adjustment factor also shall include any legislatively approved inflation increase for nursing facilities.

4. "Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.

5. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by medical assistance regulations.

6. "Bona fide sale" means the purchase of a facility's capital assets with cash or debt in an arm's-length transaction. It does not include:

   a. A purchase of shares in a corporation that owns, operates, or controls a facility except as provided under subsection 3 of section 75-02-06-07;

   b. A sale and leaseback to the same licensee;

   c. A transfer of an interest to a trust;

   d. Gifts or other transfers for nominal or no consideration;

   e. A merger of two or more related organizations;

   f. A change in the legal form of doing business;

   g. The addition or deletion of a partner, owner, or shareholder; or

   h. A sale, merger, reorganization, or any other transfer of interest between related organizations.

7. "Building" means the physical plant, including building components and building services equipment, licensed as a facility, and used directly for resident care, and auxiliary buildings including sheds, garages, and storage buildings located on the site used directly for resident care.

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 directly for resident care.

9. "Certified nurse aide" means:

   a. An individual who has satisfactorily completed a nurse aide training and competency evaluation program approved by the state as meeting the requirements of 42 CFR 483.151 through 483.154 and is registered on a state-established registry of nurse aides as required by 42 CFR 483.156; or who has been deemed or determined competent as provided in 42 CFR 483.151(a) and (b) and is registered on a state-established registry of nurse aides as required by 42 CFR 483.156; or

   b. An individual who has worked less than four months as a nurse aide and is enrolled in a training and evaluation program approved by the state as meeting the requirements of 42 CFR 483.151 through 483.154.

10. "Chain organization" means a group of two or more health care facilities owned, leased, or, through any other device, controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

11. "Close relative" means an individual whose relationship by blood, marriage, or adoption to an individual who is directly or indirectly affiliated with, controls, or is controlled by a facility is within the third degree of kinship.

12. "Community contribution" means a contribution to a civic organization or sponsorship of community activities. It does not include a donation to a charity.

13. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, the determination of cost limitations, and determination of rates.

14. "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 facility are divided for purposes of cost assignment and allocations.

15. "Cost rate" means the rate calculated using historical operating costs and adjustment factors up to the limit rate for direct care, other direct care, and indirect care. The cost rate shall include an efficiency incentive and operating margin.

16. "Cost report" means the department approved form for reporting costs, statistical data, and other relevant information of the facility.

~~16.~~17. "Department" means the department of human services.

~~17.~~18. "Depreciable asset" means a capital asset for which the cost must be capitalized for ratesetting purposes.

~~18.~~19. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

~~19.~~20. "Depreciation guidelines" means the American hospital association's guidelines as published by American hospital publishing, inc., in "Estimated Useful Lives of Depreciable Hospital Assets", revised 2018 edition.

~~20.~~21. "Desk audit rate" means the rate established by the department based upon a review of the cost report submission prior to an audit of the cost report.

~~21.~~22. "Direct care costs" means the cost category for allowable nursing and therapy costs.

~~22.~~23. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

~~23.~~24. "Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the nursing facility premises.

~~24.~~25. "Employment benefits" means fringe benefits, other employee benefits including vision insurance, disability insurance, long-term care insurance, employee assistance programs, employee child care benefits, and payroll taxes.

~~25.~~26. "Established rate" means the rate paid for services.

~~26.~~27. "Facility" means a nursing facility not owned or administered by state government or a nursing facility, owned or administered by state government, which agrees to accept a rate established

under this chapter. It does not mean an intermediate care facility for individuals with intellectual disabilities.

~~27.~~28. "Fair market value" means value at which an asset could be sold in the open market in a transaction between informed, unrelated parties.

~~28.~~29. "Final decision rate" means the amount, if any, determined on a per day basis, by which a rate otherwise set under this chapter is increased as a result of a request for reconsideration, a request for an administrative appeal, or a request for judicial appeal taken from a decision on an administrative appeal.

~~29.~~30. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.

~~30.~~31. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

~~31.~~32. "Freestanding facility" means a nursing facility which does not share basic services with a hospital-based provider.

~~32.~~33. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, uniform allowances, and medical services furnished at nursing facility expense.

~~33.~~34. "Highest market-driven compensation" means the highest compensation given to an employee of a freestanding facility who is not an owner of the facility or is not a member of the governing board of the facility.

~~34.~~35. "Historical operating costs" means the allowable operating costs incurred by the facility during the report year immediately preceding the rate year for which the established rate becomes effective.

~~35.~~36. "Hospice general inpatient care" means short-term inpatient care necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. It does not mean care provided to an individual residing in a nursing facility.

~~36.~~37. "Hospice inpatient respite care" means short-term inpatient care provided to an individual when necessary to relieve family members or other persons caring for the individual at home. Care may be provided for no more than five consecutive days. For purposes of the definition, home does not include nursing facility.

~~37.~~38. "Hospital leave day" means any day that a resident is not in the facility, but is in an acute care setting as an inpatient or has been identified in a resident assessment instrument as "discharged anticipated to return".

~~38.~~39. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.

~~39.~~40. "In-house resident day" for nursing facilities means a day that a resident was actually residing in the facility and was not on therapeutic leave or in the hospital. "In-house resident day" for hospitals means an inpatient day.

~~40.~~41. "Institutional leave day" means any day that a resident is not in the facility, but is in another nursing facility, swing-bed facility, transitional care unit, subacute care unit, or intermediate care facility for individuals with intellectual disabilities.

~~41.~~42. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

~~42.~~43. "Limit rate" means the rate established as the maximum allowable rate for a cost category.

~~43.~~44. "Lobbyist" means any person who in any manner, directly or indirectly, attempts to secure the passage, amendment, defeat, approval, or veto of any legislation, attempts to influence decisions made by the legislative council, and is required to register as a lobbyist.

~~44.~~45. "Managed care organization" means a Medicaid managed care organization as that term is defined in section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)].

~~45.~~46. "Margin cap" means a percentage of the price rate limit which represents the maximum per diem amount a facility may receive if the facility has historical operating costs, including adjustment factors, below the price rate.

47. "Medical assistance program" means the program which pays the cost of health care provided to eligible recipients pursuant to North Dakota Century Code chapter 50-24.1.

~~46.~~48. "Medical records costs" means costs associated with the determination that medical record standards are met and with the maintenance of records for individuals who have been discharged from the facility. It does not include maintenance of medical records for in-house residents.

~~47.~~49. "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.

~~48.~~50. "Noncovered day" means a resident day that is not payable by medical assistance but is counted as a resident day.

~~49.~~51. "Other direct care costs" means the cost category for allowable activities, social services, laundry, and food costs.

~~50.~~52. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act (FICA) taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

~~51.~~53. "Peer group" means the grouping of facilities based on their licensed bed capacity available for occupancy as of June thirtieth of the report year to determine the indirect care cost category price rate. The large peer group must be facilities with licensed bed capacity greater than fifty-five beds. The small peer group must be facilities with licensed bed capacity of fifty-five beds or fewer.

54. "Pending decision rate" means the amount, determined on a per day basis, by which a rate otherwise set under this chapter would increase if a facility prevails on a request for reconsideration, on a request for an administrative appeal, or on a request for a judicial appeal taken from a decision on an administrative appeal; however, the amount may not cause any component of the rate to exceed rate limits established under this chapter.

~~52.~~55. "Price rate" means the rate calculated using historical operating costs and adjustment factors up to the limit rate for the direct care, other direct care, and indirect care cost categories.

56. "Private-pay resident" means a nursing facility resident on whose behalf the facility is not receiving medical assistance payments and whose payment rate is not established by any governmental entity with ratesetting authority, including veterans' administration or Medicare,

or whose payment rate is not negotiated by any managed care organization contracting with a facility to provide services to the resident.

~~53.~~57. "Private room" means a room equipped for use by only one resident.

~~54.~~58. "Property costs" means the cost category for allowable real property costs and other costs which are passed through.

~~55.~~59. "Provider" means the organization or individual who has executed a provider agreement with the department.

~~56.~~60. "Rate adjustment percentage" means the percentage used to determine the minimum adjustment threshold to the rate weight of one for all facilities. The percentage is thirty-sixth hundredths of one percent effective with the June 30, 2019, cost reporting period.

~~57.~~61. "Rate year" means the calendar year from January first through December thirty-first.

~~58.~~62. "Reasonable resident-related 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. Reasonable resident-related cost takes into account that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or services.

~~59.~~63. "Related organization" means a close relative or person or an organization which a provider 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. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.

~~60.~~64. "Report year" means the fiscal year from July first through June thirtieth of the year immediately preceding the rate year.

~~61.~~65. "Resident" means a person who has been admitted to the facility, but not discharged.

~~62.~~66. "Resident day" in a nursing facility means all days for which service is provided or for which payment is ordinarily sought, including hospital leave days and therapeutic leave days. The day of admission and the day of death are resident days. The day of discharge is not a resident day. "Resident day" in a hospital means all inpatient days for which payment is ordinarily sought.

~~63.~~67. "Respite care" means short-term care provided to an individual when necessary to relieve family members or other persons caring for the individual at home.

~~64.~~68. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting, and setting.

~~65.~~69. "Significant capacity increase" means an increase of fifty percent or more in the number of licensed beds or an increase of twenty beds, whichever is greater; but does not mean an increase by a facility which reduces the number of its licensed beds and thereafter relicenses those beds, and does not mean an increase in a nursing facility's licensed capacity resulting from converting beds formerly licensed as basic care beds.

~~66.~~70. "Standardized resident day" means a resident day times the classification weight for the resident.

~~67.~~71. "Therapeutic leave day" means any day that a resident is not in the facility, another nursing facility, swing-bed facility, transitional care unit, subacute unit, an intermediate care facility for

individuals with intellectual disabilities, or an acute care setting, or, if not in an institutional setting, is not receiving home- and community-based waivered services.

~~68.~~72. "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.

~~69.~~73. "Working capital debt" means debt incurred to finance nursing facility operating costs, but does not include debt incurred to acquire or refinance a capital asset or to refund or refinance debt associated with acquiring a capital asset.

History: Effective September 1, 1980; amended effective December 1, 1983; June 1, 1985; September 1, 1987; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; July 1, 1996; January 1, 1998; January 1, 1999; January 1, 2000; July 2, 2002; July 2, 2003; December 1, 2005; October 1, 2010; July 1, 2012; January 1, 2014; July 1, 2016; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-16. Rate determinations for cost.

1. This section is applicable for establishing a cost rate for direct care, other direct care, and indirect care for the June 30, 2021, report year.

2. For each cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection ~~4~~5 divided by standardized resident days for the direct care cost category and resident days for other direct care, indirect care, and property cost categories. The actual rate as calculated is compared to the limit rate for each cost category to determine the lesser of the actual rate or the limit rate. The lesser rate is given the rate weight of one. The rate weight of one for direct care is then multiplied times the weight for each classification in subsection 5 of section 75-02-06-17 to establish the direct care rate for that classification. The lesser of the actual rate or the limit rate for other direct care, indirect care, and property costs, and the adjustments provided for in ~~subsection 2~~subsections 3 and ~~3~~4 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

~~2.~~3. a. For a facility with an actual rate below the limit rate for indirect care costs, an incentive amount equal to seventy percent times the difference between the actual rate, exclusive of the adjustment factor, and the limit rate in effect at the end of the year immediately preceding the rate year, up to a maximum of two dollars and sixty cents or the difference between the actual rate, inclusive of the adjustment factor and the limit rate for indirect care costs, whichever is less, must be included as part of the indirect care cost rate.

b. A facility shall receive an operating margin of four and four-tenths percent, effective January 1, 2020, through ~~June 30~~December 31, 2021, and ~~three~~four and four-tenths percent effective ~~July 1, 2021~~January 1, 2022, through December 31, 2023, based on the lesser of the actual direct care and other direct care rates, exclusive of the adjustment factor, or the limit rate in effect at the end of the year immediately preceding the rate year. The operating margin must be added to the rate for the direct care and other direct care cost categories.

~~3.~~4. Limitations.

a. The department shall accumulate and analyze statistics on costs incurred by facilities. Statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. Limitations and incentives may be

established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. The department may implement ceilings at any time based upon information available.

b. The department shall review, on an ongoing basis, aggregate payments to facilities 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. All facilities except those nongeriatric facilities for individuals with physical disabilities or units within a nursing facility providing geropsychiatric services described in North Dakota Century Code section 50-24.4-13 must be used to establish a limit rate for the direct care, other direct care, and indirect care cost categories. The base year is the report year ended June 30, ~~2014~~2021. The limit rates for the direct care, other direct care, and indirect care cost categories must be established using the June 30, 2021, base year. Base year costs may not be adjusted in any manner or for any reason not provided for in this subsection.

d. The limit rate for each of the cost categories must be established as follows:

(1) Historical costs for the report year ended June 30, ~~2014~~2020, as adjusted, must be used to establish rates for all facilities in the direct care, other direct care, and indirect care cost categories. The rates as established must be ranked from low to high for each cost category.

(2) For the rate year beginning ~~June 1, 2017~~January 1, 2021, the limit rate for each cost category is:

(a) For the direct care cost category, ~~one hundred seventy-eight dollars and eighteen~~two hundred four dollars and eighty-four cents;

(b) For the other direct care cost category, ~~twenty-eight dollars and fifteen~~twenty-nine dollars and eighty-four cents; and

(c) For the indirect care cost category, ~~seventy-seven dollars and twenty-nine~~eighty-four dollars and fifty-one cents.

e. A facility with an actual rate that exceeds the limit rate for a cost category shall receive the limit rate.

f. The cost rate for the January 1, 2023, rate year must be the previous rate year's cost rate increased by the adjustment factor.

g. The actual rate for indirect care costs and property costs must be the lesser of the rate established using:

(1) Actual census for the report year; or

(2) Ninety percent of licensed bed capacity available for occupancy as of June thirtieth of the report year:

(a) Multiplied times three hundred sixty-five; and

(b) Reduced by the number of affected beds, for each day any bed is not in service during the report year, due to a remodeling, renovation, or construction project.

~~g.~~h. The department may waive or reduce the application of subdivision ~~f~~g if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:

(1) The facility has reduced licensed capacity; or

(2) The facility's governing board has approved a capacity decrease to occur no later than the end of the rate year which would be affected by subdivision ~~f~~g.

~~h.~~i. The department may waive the application of paragraph 2 of subdivision ~~f~~g for nongeriatric facilities for individuals with disabilities or geropsychiatric facilities or units if occupancy below ninety percent is due to lack of department-approved referrals or admissions.

~~4.~~5. An adjustment factor shall be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care under subsection ~~1~~2 and for purposes of adjusting the limit rates for direct care costs, other direct care costs, and indirect care costs under subsection ~~3~~4, but may not be used to adjust property costs under either subsection ~~1~~2 or ~~3~~4. The adjustment factor for the January 1, 2023, rates must be reduced by one-half percent.

~~5.~~6. Rate adjustments.

a. Desk audit rate.

(1) The cost report must be reviewed taking into consideration the prior year's adjustments. The facility must be notified by electronic mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department shall review the information and make appropriate adjustments.

(2) The desk audit rate must be effective January first of each rate year unless the department specifically identifies an alternative effective date and must continue in effect until a final rate is established.

(3) Until a final rate is effective, pursuant to paragraph 3 of subdivision b, private-pay rates may not exceed the desk audit rate except as provided for in section 75-02-06-22 or subdivision c.

(4) The facility may request a reconsideration of the desk rate for purposes of establishing a pending decision rate. The request for reconsideration must be filed with the department's medical services division within thirty days of the date of the rate notification and must contain the information required in subsection 1 of section 75-02-06-26. No decision on the request for reconsideration of the desk rate may be made by the department unless, after the facility has been notified that the desk rate is the final rate, the facility requests, in writing within thirty days of the rate notification, the department to issue a decision on that request for reconsideration.

(5) The desk rate may be adjusted for special rates or one-time adjustments provided for in this section.

(6) The desk rate may be adjusted to reflect errors, adjustments, or omissions for the report year that result in a change of at least the rate adjustment percentage per day.

b. Final rate.

(1) The cost report may be field audited to establish a final rate. If no field audit is performed, the desk audit rate must become the final rate upon notification from the department. The final rate is effective January first of each rate year unless the department specifically identifies an alternative effective date.

(2) The final rate must include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk audit rate of at least the rate adjustment percentage per day that are found during a field audit or are reported by the facility within twelve months of the rate yearend.

(3) The private-pay rate must be adjusted to the final rate no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive except as provided for in subdivision c.

(4) The final rate may be revised at any time for special rates or one-time adjustments provided for in this section.

(5) If adjustments, errors, or omissions are found after a final rate has been established, the following procedures must be used:

(a) Adjustments, errors, or omissions found within twelve months of establishment of the final rate, not including subsequent revisions, resulting in a change of at least the rate adjustment percentage per day must result in a change to the final rate. The change must be applied retroactively as provided for in this section.

(b) Adjustments, errors, or omissions found later than twelve months after the establishment of the final rate, not including subsequent revisions, that would have resulted in a change of at least the rate adjustment percentage per day had they been included, must be included as an adjustment in the report year that the adjustment, error, or omission was found.

(c) The two report years immediately preceding the report year to which the adjustments, errors, or omissions apply may also be reviewed for similar adjustments, errors, or omissions.

c. Pending decision rates for private-pay residents.

(1) If a facility has made a request for reconsideration, taken an administrative appeal, or taken a judicial appeal from a decision on an administrative appeal, and has provided information sufficient to allow the department to accurately calculate, on a per day basis, the effect of each of the disputed issues on the facility's rate, the department shall determine and issue a pending decision rate within thirty days of receipt of the request for reconsideration, administrative appeal, or judicial appeal. If the information furnished is insufficient to determine a pending decision rate, the department, within thirty days of receipt of the request for reconsideration, shall inform the facility of the insufficiency and may identify information that would correct the insufficiency.

(2) The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding North Dakota Century Code section

50-24.4-19, the total must be the rate chargeable to private-pay residents until a final decision on the request for reconsideration or appeal is made and is no longer subject to further appeal. The pending decision rate is subject to any rate limitation that may apply.

(3) The facility shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-pay resident from the date the facility charges a private-pay resident the pending decision rate.

(4) If the pending decision rate paid by a private-pay resident exceeds the final decision rate, the facility shall refund the difference, plus interest accrued at the legal rate from the date of notification of the pending decision rate, within sixty days after the final decision is no longer subject to appeal. If a facility fails to provide a timely refund to a living resident or former resident, the facility shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the facility shall pay the refund to a person lawfully administering the estate of the deceased former resident or lawfully acting as successor to the deceased former resident. If no person is lawfully administering the estate or lawfully acting as a successor, the facility may make any disposition of the refund permitted by law. Interest paid under this subsection is not an allowable cost.

d. The final rate as established must be retroactive to the effective date of the desk rate, except with respect to rates paid by private-pay residents. A rate paid by a private-pay resident must be retroactively adjusted and the difference refunded to the resident, if the rate paid by the private-pay resident exceeds the final rate by at least one dollar per day, except that a pending decision rate is not subject to adjustment or refund until a decision on the disputed amount is made.

~~6.~~7. Rate payments.

a. The rate as established must be considered as payment for all accommodations and includes all items designated as routinely provided. No payments may be solicited or received from the resident or any other person to supplement the rate as established.

b. The rate as established must be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate must be the maximum chargeable to the department for the same bed type, i.e., hospital or leave days.

c. If the established rate exceeds the rate charged to a private-pay resident, on any given date, the facility shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment. The refund must be the difference between the established rate and the rate charged the private-pay resident times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision also applies to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

d. Peer groupings, limitations, or adjustments based upon data received from or relating to more than one facility are effective for a rate period. Any change in the data used to establish peer groupings, limitations, or adjustments may not be used to change such peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

e. The established rate is paid based on a prospective ratesetting procedure. No retroactive settlements for actual costs incurred during the rate year that exceed the established rate may be made unless specifically provided for in this section.

~~7.~~8. Partial year.

a. Rates for a facility changing ownership during the rate period are set under this subdivision.

(1) The rates established for direct care, other direct care, indirect care, operating margins, and incentives for the previous owner must be retained through the end of the rate period and the rates for the next rate period following the change in ownership must be established:

(a) For a facility with ~~four~~six or more months of operation under the new ownership during the report year, through use of a cost report for the period;

(b) For a facility with less than ~~four~~six months of operation under the new ownership during the report year, by indexing the rates established for the previous owner forward using the adjustment factor in subsection ~~4~~5; or

(c) If the change of ownership occurred after the report year end, but prior to the beginning of the next rate year, and the previous owner submits and allows audit of a cost report, by establishing a rate based on the previous owner's cost report.

(2) Unless a facility elects to have a property rate established under paragraph 3, the rate established for property for the previous owner must be retained through the end of the rate period and the property rate for the next rate period following the change in ownership must be established:

(a) For a facility with ~~four~~six or more months of operation under the new ownership during the report year, through use of a cost report for the period;

(b) For a facility with less than ~~four~~six months of operation under the new ownership during the report year, by using the rate established for the previous owner for the previous rate year; or

(c) If the change of ownership occurred after the report year end, but prior to the beginning of the next rate year, and the previous owner submits and allows audit of a cost report, by establishing a rate based on the previous owner's cost report.

(3) A facility may choose to have a property rate established, during the remainder of the rate year and the subsequent rate year, based on interest and principal payments on the allowable portion of debt to be expended during the rate years. The property rate must go into effect on the first of the month following notification by the department. The difference between a property rate established based on the facility's election and a property rate established based on paragraph 2, multiplied by actual census for the period, must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using this paragraph, may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

b. For a new facility, the department shall establish ~~an interim~~a rate equal to the limit rates for direct care, other direct care, and indirect care in effect for the rate year in which the facility begins operation, plus the property rate. The property rate must be calculated

using projected property costs and projected census. The ~~interim~~ rate must be in effect for no less than ten months and no more than eighteen months. ~~Costs for the period in which the interim rate is effective must be used to establish a final rate. If the final rates for direct care, other direct care, and indirect care costs are less than the interim rates for those costs, a retroactive adjustment as provided for in subsection 5 must be made.~~ A retroactive adjustment to the property rate must be made to adjust projected property costs to actual property costs. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for property and indirect care costs must be the greater of actual census, projected census, or census imputed at ninety-five percent of licensed beds.

(1) If the effective date of the ~~interim~~ rate is on or after ~~March~~January first and on or before June thirtieth, the ~~interim~~ rate must be effective for the remainder of that rate year and must continue through June thirtieth of the subsequent rate year. The facility shall file by March first ~~an interim~~a cost report for the period ending December thirty-first of the year in which the facility first provides services. The ~~interim~~ cost report is used to establish the actual rate effective July first of the subsequent rate year. The partial year rate established based on the ~~interim~~ cost report must include applicable incentives, margins, phase-ins, and adjustment factors and may not be subject to any cost settle-up. ~~The cost reports for the report year ending June thirtieth of the current and subsequent rate years must be used to determine the final rate for the periods that the interim rate was in effect.~~

(2) If the effective date of the ~~interim~~ rate is on or after July first and on or before December thirty-first, the ~~interim~~ rate must remain in effect through the end of the subsequent rate year. The facility shall file a cost report for the partial report year ending June thirtieth of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year. The facility shall file by March first ~~an interim~~a cost report for the period July first through December thirty-first of the subsequent rate year. ~~The interim cost report is used, along with the report year cost report, to determine the final rate for the periods the interim rate was in effect.~~

(3) ~~If the effective date of the interim rate is on or after January first and on or before February twenty-ninth, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. The facility shall file a cost report for the period ending June thirtieth of the current rate year. This cost report must be used to establish the rate for the subsequent rate year. The facility shall file by March first an interim cost report for the period July first through December thirty-first of the current rate year. The interim cost report is used, along with the report year cost report, to determine the final rate for the period that the interim rate was in effect.~~

~~(4)~~ The final rate for direct care, other direct care, and indirect care costs established under this subdivision must be limited to the lesser of the limit rate for the current rate year or the actual rate.

c. For a facility with renovations or replacements in excess of one hundred thousand dollars, and without a significant capacity increase, the rate established for direct care, other direct care, indirect care, operating margins, and incentive based on the last report year, plus a property rate calculated based on projected property costs and imputed census, must be applied to all licensed beds. The projected property rate must be effective on the first day of the month beginning after the date the project is completed and placed into service or the first day of the month beginning after the date the request for a projected property rate is received by the department, whichever is later. The property rate for the subsequent rate year must be based on projected property costs

and imputed census, rather than on property costs actually incurred in the report year. Imputed census is based on the greater of actual census of all licensed beds existing before the renovation or ninety percent of the available licensed beds existing prior to renovation, plus ninety-five percent of the increase in licensed bed capacity and unavailable licensed beds existing prior to the renovation. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

d. For a facility with a significant capacity increase, the rate established for direct care, other direct care, indirect care, operating margins, and incentive based on the last report year, must be applied to all licensed beds. A projected property rate must be established based on projected property costs and projected census. The projected property rate must be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the state department of health or the first day of the month beginning after the date when the request for a projected property rate is made to the department, whichever is later, through the end of the rate year. The property rate for the subsequent rate year must be based on projected property costs and census imputed as ninety-five percent of licensed beds, rather than on property costs actually incurred during the report year; and may not be subject to retroactive cost settle-up. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

e. For a facility with no significant capacity increase and no renovations or replacements in excess of one hundred thousand dollars, the established rate based on the report year must be applied throughout the rate year for all licensed beds.

f. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

g. At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using subdivision c or d and the property rate that would otherwise be established based on historical costs must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using subdivision c or d may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

~~8.~~9. One-time adjustments.

a. Adjustments to meet certification standards.

(1) The department may provide for an increase in the established rate for additional costs incurred to meet certification standards. The survey conducted by the state department of health must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary and other costs that must be increased to correct the deficiencies cited in the survey process.

(2) The facility shall submit a written request to the medical services division within thirty days of submitting the plan of correction to the state department of health. The request must:

(a) Include a statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health's certification survey;

(b) Identify the number of new staff or additional staff hours and the associated costs required to meet the certification standards; and

(c) Provide a detailed list of any other costs necessary to meet survey standards.

(3) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted to an amount not to exceed the limit rate.

(4) Any additional funds provided must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection ~~5~~6.

b. Adjustments for unforeseeable expenses.

(1) The department may provide for an increase in the established rate for additional costs incurred to meet major unforeseeable expenses. The expenses must be resident related and must be beyond the control of those responsible for the management of the facility.

(2) Within sixty days after first incurring the unforeseeable expense, the facility shall submit a written request to the medical services division containing the following information:

(a) An explanation as to why the facility believes the expense was unforeseeable;

(b) An explanation as to why the facility believes the expense was beyond the managerial control of the facility; and

(c) A detailed breakdown of the unforeseeable expenses by expense line item.

(3) The department shall base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management based on its background and knowledge of nursing care industry and business trends.

(4) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted upward not to exceed the limit rate.

(5) Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection ~~5~~6.

c. Adjustment to historical operating costs.

(1) A facility may receive a one-time adjustment to historical operating costs when the facility has been found to be significantly below care-related minimum standards described in subparagraph a of paragraph 2 and when it has been determined the

facility cannot meet the minimum standards through reallocation of costs and efficiency incentives.

(2) The following conditions must be met before a facility can receive the adjustment:

(a) The facility shall document, based on nursing hours and standardized resident days, the facility cannot provide a minimum of one and two-tenths nursing hours per standardized resident day;

(b) The facility shall document all available resources, including efficiency incentives, if used to increase nursing hours, are not sufficient to meet the minimum standards; and

(c) The facility shall submit a written plan describing how the facility will meet the minimum standard if the adjustment is received, including the number and type of staff to be added to the current staff and the projected cost for salary and fringe benefits for the additional staff.

(3) The adjustment must be calculated based on the costs necessary to increase nursing hours to the minimum standards less any operating margins and incentives included when calculating the established rate. The net increase must be divided by standardized resident days and the amount calculated must be added to the rate. This rate is subject to any rate limitations that may apply.

(4) If the facility fails to implement the plan to increase nursing hours to one and two-tenths hours per standardized resident day, the amount included as the adjustment must be adjusted in accordance with the methodologies set forth in subsection ~~5~~6.

(5) If the cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement may be made.

d. Adjustments for disaster recovery costs when evacuation of residents occurs.

(1) A facility may incur certain costs when recovering from a disaster such as a flood, tornado, or fire. If evacuation of residents was necessary because of the disaster, actual recovery costs during the evacuation period, net of insurance recoveries, may be considered as deferred charges and allocated over a number of periods that benefit from the costs.

(2) When a facility has evacuated residents and capitalizes recovery costs as a deferred charge, the recovery costs must be recognized as allowable costs amortized over sixty consecutive months beginning with the sixth month after the first resident is readmitted to the facility.

(3) Recovery costs must be identified as startup costs and included as passthrough costs for report purposes. Recovery costs are not subject to any limitations except as provided in paragraph 4.

(4) If a facility evacuates residents, the ninety percent occupancy limitation may not be applied during the recovery period or for the first six months following the month the facility readmits the first resident.

(5) Insurance recoveries relating to the disaster recovery period must be reported as a reduction of recovery costs. Insurance recoveries received after the first month of the sixty-month amortization period must be included as a reduction of deferred

charges not yet amortized, except that the reduction for insurance recoveries may occur only at the beginning of a rate year.

~~9.~~10. Under no circumstances, including an appeal or judicial decision to the effect a rate was erroneously established, may a rate adjustment be made to any rate established under this chapter, unless the cumulative impact of all adjustments not already included in the established rate equals or exceeds the rate adjustment percentage per day.

History: Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; July 1, 1984; September 1, 1987; January 1, 1990; April 1, 1991; January 1, 1992; November 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998; January 1, 1999; January 1, 2000; January 1, 2002; July 2, 2003; December 1, 2005; January 1, 2010; July 1, 2010; January 1, 2012; January 1, 2014; July 1, 2016; April 1, 2018; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-16.2. One-time adjustments for legislatively approved cost increases.

1. The department shall increase rates otherwise established by this chapter for supplemental payments or one-time adjustments to historical costs approved by the legislative assembly.

2. Any additional funds made available by the supplemental payments or one-time adjustments must be used for the legislatively prescribed purpose and are subject to audit. If the department determines that the funds were not used for the appropriate purpose, an adjustment must be made in accordance with subsection ~~5~~6 of section 75-02-06-16.

History: Effective July 1, 2009; amended effective January 1, 2022.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4

75-02-06-16.3. Rate determinations for price.

1. For each cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 3 divided by standardized resident days for the direct care cost category and resident days for other direct care, indirect care, and property cost categories. The actual rate must include the margin cap. The actual rate as calculated is compared to the price rate for each cost category, excluding property, to determine the lesser of the actual rate or the price rate. The lesser rate is given the rate weight of one. The rate weight of one for direct care is then multiplied times the weight for each classification in subsection 5 of section 75-02-06-17 to establish the direct care rate for that classification. The lesser of the actual rate or the price rate for other direct care and indirect care, property costs, and the adjustments provided for in subsection 2 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

2. Limitations.

   a. The department shall accumulate and analyze statistics on costs incurred by facilities. Statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. Limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. The department may implement ceilings at any time based upon information available.

   b. The department shall review, on an ongoing basis, aggregate payments to facilities 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. All facilities, except those nongeriatric facilities for individuals with physical disabilities or units within a nursing facility providing geropsychiatric services described in North Dakota Century Code section 50-24.4-13, must be used to establish a price rate for the direct care and other direct care cost categories. The base year is the report year ended June 30, 2021. A new base year will be established using the report year ended June 30, 2023. Base year costs may not be adjusted in any manner or for any reason not provided for in this subsection or subsection 3.

d. All facilities must be grouped into peer groups based on the licensed bed capacity available for occupancy as of June thirtieth of the report year. Facilities in each peer group must be used to establish a price rate for the indirect care cost category for that peer group. The base year is the report year ended June 30, 2021. A new base year will be established using the report year ended June 30, 2023. Base year costs may not be adjusted in any manner or for any reason not provided for in this subsection or subsection 3.

e. The price rate for each of the cost categories must be established using historical operating costs for the base year. The price rate will be established using the same percentage of the median used to establish the limit rates for the January 1, 2021, rate year.

f. A facility with an actual rate that exceeds the price rate for a cost category shall receive the price rate.

g. The price rate for each of the cost categories for the January 1, 2023, rate year must be the price rate for the previous rate year increased by the adjustment factor.

h. The price rate for each of the cost categories for the January 1, 2025, rate year must be the price rate for the previous rate year increased by the adjustment factor.

i. The actual rate for indirect care costs and property costs must be the lesser of the rate established using:

(1) Actual census for the report year; or

(2) Ninety percent of licensed bed capacity available for occupancy as of June thirtieth of the report year:

(a) Multiplied times three hundred sixty-five; and

(b) Reduced by the number of affected beds, for each day any bed is not in service during the report year, due to a remodeling, renovation, or construction project.

j. The department may waive or reduce the application of subdivision i if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:

(1) The facility has reduced licensed capacity; or

(2) The facility's governing board has approved a capacity decrease to occur no later than the end of the rate year that would be affected by subdivision i.

k. The department may waive the application of subdivision i for nongeriatric facilities for individuals with disabilities or geropsychiatric facilities or units if occupancy below ninety percent is due to lack of department-approved referrals or admissions.

3 An adjustment factor must be used for purposes of adjusting historical operating costs for direct care, other direct care, and indirect care under subsection 1 and for purposes of adjusting the price rate for direct care costs, other direct care costs, and indirect care costs under subsection 2, but may not be used to adjust property costs under either subsection 1 or 2.

4. Rate adjustments.

a. Desk audit rate.

(1) The cost report must be reviewed taking into consideration the prior year's adjustments. The facility must be notified by electronic mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department shall review the information and make appropriate adjustments.

(2) The desk audit rate must be effective January first of each rate year unless the department specifically identifies an alternative effective date and must continue in effect until a final rate is established.

(3) Until a final rate is effective, pursuant to paragraph 3 of subdivision b, private-pay rates may not exceed the desk audit rate, except as provided for in section 75-02-06-22 or subdivision c.

(4) The facility may request a reconsideration of the desk rate for purposes of establishing a pending decision rate. The request for reconsideration must be filed with the department's medical services division within thirty days of the date of the rate notification and must contain the information required in subsection 1 of section 75-02-06-26. A decision on the request for reconsideration of the desk rate may not be made by the department unless, after the facility has been notified that the desk rate is the final rate, the facility requests, in writing within thirty days of the rate notification, the department to issue a decision on that request for reconsideration.

(5) The desk rate may be adjusted for special rates or one-time adjustments provided for in this section.

(6) The desk rate may be adjusted to reflect errors, adjustments, or omissions for the report year which result in a change of at least the rate adjustment percentage per day.

b. Final rate.

(1) The cost report may be field audited to establish a final rate. If a field audit is not performed, the desk audit rate must become the final rate upon notification from the department. The final rate is effective January first of each rate year, unless the department specifically identifies an alternative effective date.

(2) The final rate must include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk audit rate of at least the rate

adjustment percentage per day which are found during a field audit or are reported by the facility within twelve months of the rate year end.

(3) The private-pay rate must be adjusted to the final rate no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive, except as provided for in subdivision c.

(4) The final rate may be revised at any time for special rates or one-time adjustments provided for in this section.

(5) If adjustments, errors, or omissions are found after a final rate has been established, the following procedures must be used:

(a) Adjustments, errors, or omissions found within twelve months of establishment of the final rate, not including subsequent revisions, resulting in a change of at least the rate adjustment percentage per day must result in a change to the final rate. The change must be applied retroactively as provided for in this section.

(b) Adjustments, errors, or omissions found later than twelve months after the establishment of the final rate, not including subsequent revisions, which would have resulted in a change of at least the rate adjustment percentage per day had they been included, must be included as an adjustment in the report year that the adjustment, error, or omission was found.

(c) The two report years immediately preceding the report year to which the adjustments, errors, or omissions apply may also be reviewed for similar adjustments, errors, or omissions.

c. Pending decision rates for private-pay residents.

(1) If a facility has made a request for reconsideration, taken an administrative appeal, or taken a judicial appeal from a decision on an administrative appeal, and has provided information sufficient to allow the department to accurately calculate, on a per-day basis, the effect of each of the disputed issues on the facility's rate, the department shall determine and issue a pending decision rate within thirty days of receipt of the request for reconsideration, administrative appeal, or judicial appeal. If the information furnished is insufficient to determine a pending decision rate, the department, within thirty days of receipt of the request for reconsideration, shall inform the facility of the insufficiency and may identify information that would correct the insufficiency.

(2) The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding North Dakota Century Code section 50-24.4-19, the total must be the rate chargeable to private-pay residents until a final decision on the request for reconsideration or appeal is made and is no longer subject to further appeal. The pending decision rate is subject to any rate limitation that may apply.

(3) The facility shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-pay resident from the date the facility charges a private-pay resident the pending decision rate.

(4) If the pending decision rate paid by a private-pay resident exceeds the final decision rate, the facility shall refund the difference, plus interest accrued at the legal rate from the date of notification of the pending decision rate, within sixty days after the final decision is no longer subject to appeal. If a facility fails to provide a timely

refund to a living resident or former resident, the facility shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the facility shall pay the refund to a person lawfully administering the estate of the deceased former resident or lawfully acting as successor to the deceased former resident. If no person is lawfully administering the estate or lawfully acting as a successor, the facility may make any disposition of the refund permitted by law. Interest paid under this subsection is not an allowable cost.

d. The final rate as established must be retroactive to the effective date of the desk rate, except with respect to rates paid by private-pay residents. A rate paid by a private-pay resident must be retroactively adjusted and the difference refunded to the resident, if the rate paid by the private-pay resident exceeds the final rate by at least one dollar per day, except that a pending decision rate is not subject to adjustment or refund until a decision on the disputed amount is made.

5. Rate payments.

a. The rate as established must be considered as payment for all accommodations and includes all items designated as routinely provided. Payments may not be solicited or received from the resident or any other person to supplement the rate as established.

b. The rate as established must be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate must be the maximum chargeable to the department for the same bed type, i.e., hospital or leave days.

c. If the established rate exceeds the rate charged to a private-pay resident, on any given date, the facility immediately shall report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, within thirty days, the facility shall refund the overpayment. The refund must be the difference between the established rate and the rate charged the private-pay resident times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision also applies to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

d. Peer groupings, limitations, or adjustments based upon data received from or relating to more than one facility are effective for a rate period. Any change in the data used to establish peer groupings, limitations, or adjustments may not be used to change such peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

e. The established rate is paid based on a prospective ratesetting procedure. No retroactive settlements for actual costs incurred during the rate year which exceed the established rate may be made unless specifically provided for in this section.

6. Partial year.

a. Rates for a facility changing ownership during the rate period are set under this subdivision.

(1) The rates established for direct care, other direct care, and indirect care for the previous owner must be retained through the end of the rate period and the rates for the next rate period following the change in ownership must be established:

(a) For a facility with six or more months of operation under the new ownership during the report year, through use of a cost report for the period;

(b) For a facility with less than six months of operation under the new ownership during the report year, by indexing the rates established for the previous owner forward using the adjustment factor in subsection 4; or

(c) If the change of ownership occurred after the report year end, but before the beginning of the next rate year, and the previous owner submits and allows audit of a cost report, by establishing a rate based on the previous owner's cost report.

(2) Unless a facility elects to have a property rate established under paragraph 3, the rate established for property for the previous owner must be retained through the end of the rate period and the property rate for the next rate period following the change in ownership must be established:

(a) For a facility with six or more months of operation under the new ownership during the report year, through use of a cost report for the period;

(b) For a facility with less than six months of operation under the new ownership during the report year, by using the rate established for the previous owner for the previous rate year; or

(c) If the change of ownership occurred after the report year end, but before the beginning of the next rate year, and the previous owner submits and allows audit of a cost report, by establishing a rate based on the previous owner's cost report.

(3) A facility may choose to have a property rate established, during the remainder of the rate year and the subsequent rate year, based on interest and principal payments on the allowable portion of debt to be expended during the rate years. The property rate must go into effect on the first of the month following notification by the department. The difference between a property rate established based on the facility's election and a property rate established based on paragraph 2, multiplied by actual census for the period, must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using this paragraph, may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

b. For a new facility, the department shall establish a rate equal to the price rate for direct care, other direct care, and indirect care in effect for the rate year in which the facility begins operation, plus the property rate. The property rate must be calculated using projected property costs and projected census. A retroactive adjustment to the property rate must be made to adjust projected property costs to actual property costs. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for property and indirect care costs must be the greater of actual census, projected census, or census imputed at ninety-five percent of licensed beds.

(1) If the effective date of the rate is on or after January first and on or before June thirtieth, the rate must be effective for the remainder of that rate year and must continue through June thirtieth of the subsequent rate year. The facility shall file by March first a cost report for the period ending December thirty-first of the year in which the facility first provides services. The cost report is used to establish the actual rate effective July first of the subsequent rate year. The partial year rate

established based on this cost report must include applicable margins and adjustment factors and may not be subject to any cost settle-up.

(2) If the effective date of the rate is on or after July first and on or before December thirty-first, the rate must remain in effect through the end of the subsequent rate year. The facility shall file a cost report for the partial report year ending June thirtieth of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year.

c. For a facility with renovations or replacements in excess of one hundred thousand dollars, and without a significant capacity increase, the rate established for direct care, other direct care, and indirect care based on the last report year, plus a property rate calculated based on projected property costs and imputed census, must be applied to all licensed beds. The projected property rate must be effective on the first day of the month beginning after the date the project is completed and placed into service or the first day of the month beginning after the date the request for a projected property rate is received by the department, whichever is later. The property rate for the subsequent rate year must be based on projected property costs and imputed census, rather than on property costs actually incurred in the report year. Imputed census is based on the greater of actual census of all licensed beds existing before the renovation or ninety percent of the available licensed beds existing before renovation, plus ninety-five percent of the increase in licensed bed capacity and unavailable licensed beds existing before the renovation. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

d. For a facility with a significant capacity increase, the rate established for direct care, other direct care, and indirect care based on the last report year, must be applied to all licensed beds. A projected property rate must be established based on projected property costs and projected census. The projected property rate must be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the state department of health or the first day of the month beginning after the date when the request for a projected property rate is made to the department, whichever is later, through the end of the rate year. The property rate for the subsequent rate year must be based on projected property costs and census imputed as ninety-five percent of licensed beds, rather than on property costs actually incurred during the report year; and may not be subject to retroactive cost settle-up. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

e. For a facility with no significant capacity increase and no renovations or replacements in excess of one hundred thousand dollars, the established rate based on the report year must be applied throughout the rate year for all licensed beds.

f. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

g. At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using subdivision c or d and the property rate that would otherwise be established based on historical costs must be determined. The property rate paid in each of the twelve years, beginning with the first

rate year following the use of a property rate established using subdivision c or d may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

7. One-time adjustments.

a. Adjustments to meet certification standards.

(1) The department may provide for an increase in the established rate for additional costs incurred to meet certification standards. The survey conducted by the state department of health must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary and other costs that must be increased to correct the deficiencies cited in the survey process.

(2) The facility shall submit a written request to the medical services division within thirty days of submitting the plan of correction to the state department of health. The request must:

(a) Include a statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health's certification survey;

(b) Identify the number of new staff or additional staff hours and the associated costs required to meet the certification standards; and

(c) Provide a detailed list of any other costs necessary to meet survey standards.

(3) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted to an amount not to exceed the price rate.

(4) Any additional funds provided must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection 4.

b. Adjustments for unforeseeable expenses.

(1) The department may provide for an increase in the established rate for additional costs incurred to meet major unforeseeable expenses. The expenses must be resident related and must be beyond the control of those responsible for the management of the facility.

(2) Within sixty days after first incurring the unforeseeable expense, the facility shall submit a written request to the medical services division containing the following information:

(a) An explanation as to why the facility believes the expense was unforeseeable;

(b) An explanation as to why the facility believes the expense was beyond the managerial control of the facility; and

(c) A detailed breakdown of the unforeseeable expenses by expense line item.

(3) The department shall base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management

based on its background and knowledge of nursing care industry and business trends.

(4) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted upward, not to exceed the price rate.

(5) Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection 4.

c. Adjustment to historical operating costs.

(1) A facility may receive a one-time adjustment to historical operating costs when the facility has been found to be significantly below care-related minimum standards described in subparagraph a of paragraph 2 and when it has been determined the facility cannot meet the minimum standards through reallocation of costs and use of margin cap.

(2) The following conditions must be met before a facility can receive the adjustment:

(a) The facility shall document, based on nursing hours and standardized resident days, the facility cannot provide a minimum of one and two-tenths nursing hours per standardized resident day;

(b) The facility shall document all available resources, including margin cap, if used to increase nursing hours, are not sufficient to meet the minimum standards; and

(c) The facility shall submit a written plan describing how the facility will meet the minimum standard if the adjustment is received, including the number and type of staff to be added to the current staff and the projected cost for salary and fringe benefits for the additional staff.

(3) The adjustment must be calculated based on the costs necessary to increase nursing hours to the minimum standards less any margin cap included when calculating the established rate. The net increase must be divided by standardized resident days and the amount calculated must be added to the rate. This rate is subject to any price rate limitations that may apply.

(4) If the facility fails to implement the plan to increase nursing hours to one and two-tenths hours per standardized resident day, the amount included as the adjustment must be adjusted in accordance with the methodologies set forth in subsection 4.

(5) If the cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement may be made.

d. Adjustments for disaster recovery costs when evacuation of residents occurs.

(1) A facility may incur certain costs when recovering from a disaster, such as a flood, tornado, or fire. If evacuation of residents was necessary because of the disaster, actual recovery costs during the evacuation period, net of insurance recoveries, may be considered as deferred charges and allocated over a number of periods that benefit from the costs.

(2) When a facility has evacuated residents and capitalizes recovery costs as a deferred charge, the recovery costs must be recognized as allowable costs amortized over sixty consecutive months beginning with the sixth month after the first resident is readmitted to the facility.

(3) Recovery costs must be identified as startup costs and included as passthrough costs for report purposes. Recovery costs are not subject to any limitations except as provided in paragraph 4.

(4) If a facility evacuates residents, the ninety percent occupancy limitation may not be applied during the recovery period or for the first six months following the month the facility readmits the first resident.

(5) Insurance recoveries relating to the disaster recovery period must be reported as a reduction of recovery costs. Insurance recoveries received after the first month of the sixty-month amortization period must be included as a reduction of deferred charges not yet amortized, except that the reduction for insurance recoveries may occur only at the beginning of a rate year.

e. Adjustments for a significant reduction in census.

(1) A facility may request a revised desk rate if the facility has a significant reduction in census. The reduction in census cannot be due to renovation.

(2) For purposes of this section a significant reduction in census is defined as:

(a) At least ten percent of licensed bed capacity for a facility in the large peer group; and

(b) At least five percent of licensed bed capacity for a facility in the small peer group.

(3) The licensed bed capacity will be based on the licensed beds used to establish the peer groups.

(4) The revised desk rate must be calculated using:

(a) The facility's allowable historical operating costs from the most recent base year increased by the adjustment factors, if any, up to the current report year.

(b) The facility's allowable property costs from the most recent report year.

(c) The standardized resident days and resident days from the most recent report year.

(d) The revised desk rate must be limited to the price rate for direct care, other direct care, and indirect cost categories.

(5) A facility that receives a revised desk rate under this section may not increase licensed bed capacity during the rate year.

8. Under no circumstances, including an appeal or judicial decision to the effect a rate was erroneously established, may a rate adjustment be made to any rate established under this chapter, unless the cumulative impact of all adjustments not already included in the established rate equals or exceeds the rate adjustment percentage per day.

History: Effective January 1, 2022.
General Authority: NDCC 50-24.1-04, 50-24.4-02

Law Implemented: NDCC 50-24.4

75-02-06-24. Exclusions.

1. A facility that exclusively provides residential services for nongeriatric individuals with physical disabilities or a unit within a facility which exclusively provides geropsychiatric services shall not be included in the calculation of the rate limitations ~~and its rate must not be limited by such limitations~~.

2. The ~~facility rate or the~~ rate for a unit within a facility which exclusively provides geropsychiatric services must be established using the actual allowable historical costs adjusted by the indices under subsection ~~4~~5 of section 75-02-06-16. Actual allowable historical costs must be determined using the applicable sections of the policies and procedures. An operating margin and incentive determined under subsection ~~2~~3 of section 75-02-06-16 must be included in the ~~facility~~facility's cost rate.

~~2.~~3. The direct care rate for a unit within a facility that exclusively provides geropsychiatric services must be established using the allowable historical operating costs and adjustment factors under subsection 3 of section 75-02-06-16.3. The margin cap for direct care must be included in the facility's direct care rate.

4. The direct care rate for a facility that exclusively provides residential services for nongeriatric individuals with physical disabilities must be established using the allowable historical operating costs and adjustment factors under subsection 3 of section 75-02-06-16.3. The margin cap for direct care must be included in the facility's direct care rate.

5. A facility may establish a rate for respite care, hospice inpatient respite care, or hospice general inpatient care services.

History: Effective January 1, 1996; amended effective July 1, 1999; January 1, 2022.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-25. Notification of rates.

1. The department shall notify each facility of the desk audit rate on or before November ~~twenty-second~~twenty-fourth of the year preceding the rate year, except a facility that has requested and received a cost reporting deadline extension of fifteen days or less shall be notified on or before November thirtieth of the year preceding the rate year, and a facility that has requested and received a cost reporting deadline extension in excess of fifteen days shall be notified on or before December fifteenth of the year preceding the rate year.

2. The department shall notify each facility of the cost rate and the price rate for the 2022 and 2023 rate years.

3. The facility shall notify the department on or before November 29, 2021, if the facility accepts the cost rate as the established rate for the 2022 rate year.

4. The facility shall notify the department on or before November 28, 2022, if the facility accepts the cost rate as the established rate for the 2023 rate year. The facility does not have the option to choose the cost rate for the 2023 rate year if the facility's 2022 rate was the price rate.

5. The facility shall provide to all private-pay residents a thirty-day written notification of any increase in the rates for each classification. An increase in rates is not effective unless the facility has notified private-pay residents that the rate increase is effective by the first day of the second month following the date of notification by the department. If the facility does not

notify private-pay residents by the first day of the first month following notification by the department, the established rate in effect at the time of notification by the department must remain in effect until the date the rate is payable by private-pay residents. No retroactive adjustment may be made to an established rate that remains in effect because the facility did not promptly notify private-pay residents unless the adjustment would result in a decrease of at least the rate adjustment percentage per day. A facility may make a rate change without giving a thirty-day written notice when the purpose of the rate change is to reflect a necessary change in the case-mix classification of a resident.

~~3.~~6. If the department fails to notify the facility of the desk rate, as provided in subsection 1, the time required for giving written notice, as provided for in subsection ~~2~~5, must be decreased by the number of days by which the department was late in setting the rate.

History: Effective January 1, 1996; amended effective January 1, 2000; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

ARTICLE 75-03
COMMUNITY SERVICES

CHAPTER 75-03-07

75-03-07-04. In-home registration and standards.

1. An application for a registration document must be submitted to the department ~~of~~or its authorized agent wherein the applicant proposes to provide in-home services. Application must be made in the form and manner prescribed by the department.

2. An applicant for an in-home registration document shall be directly responsible for the care, supervision, and guidance of the child or children in the child or children's home and shall comply with the following standards, certifying in the application that the applicant:

   a. Is at least eighteen years of age.

   b. Is physically, cognitively, socially, and emotionally healthy and will use mature judgment when making decisions impacting the quality of child care.

   c. Shall devote adequate time and attention to the children in the applicant's care and provide an environment that is physically and socially adequate for children.

   d. Shall participate in specialized training related to child care if provided by or approved by the department.

   e. Shall complete one hour of department-approved training annually on sudden infant death prevention prior to in-home provider having unsupervised access to infants.

   f. Shall provide food of sufficient quantity and nutritious quality in accordance with the United States department of agriculture standards which satisfies the dietary needs of the children while in the applicant's care.

   g. Shall provide proper care, supervision, and protection for children in the applicant's care. Supervision means the provider being within sight or hearing range of an infant, toddler, or preschooler at all times so the provider is capable of intervening to protect the health and safety of the child. For the school-age child, it means a provider being available for assistance and care so that the child's health and safety are protected.

   h. Shall provide for a safe and sanitary environment while children are in care.

   i. May not use or be under the influence of any illegal drugs or alcoholic beverages while children are in care.

   j. May not leave children without supervision.

   k. Shall ensure that discipline is constructive or educational in nature and may include diversion, separation from the problem situation, talking with the child about the situation, praising appropriate behavior, or gentle physical restraint, such as holding. A child may not be subjected to physical harm, fear, or humiliation. Disregard of any of the following disciplinary rules or any disciplinary measure resulting in physical or emotional injury, or

neglect or abuse, to any child is grounds for denial or revocation of an in-home registration.

(1) Authority to discipline may not be delegated to children nor may discipline be administered by children.

(2) Separation, when used as discipline, must be appropriate to the child's development and circumstances. The child must be in a safe, lighted, well-ventilated room within sight or hearing range of the in-home provider. An in-home provider may not isolate a child in a locked room or closet.

(3) A child may not be punished for lapses in toilet training.

(4) An in-home provider may not use verbal abuse or make derogatory remarks about a child, or a child's family, race, or religion when addressing the child or in the presence of a child.

(5) An in-home provider may not use profane, threatening, unduly loud, or abusive language in the presence of a child.

(6) An in-home provider may not force-feed a child or coerce a child to eat, unless medically prescribed and administered under a medical provider's care.

(7) An in-home provider may not use deprivation of meals or snacks as a form of discipline or punishment.

(8) An in-home provider may not kick, punch, spank, shake, pinch, bite, roughly handle, strike, mechanically restrain, or physically maltreat a child.

(9) An in-home provider may not force a child to ingest substances that would cause pain or discomfort, for example, placing soap in a child's mouth to deter the child from biting other children.

(10) An in-home provider may not withhold active play from a child as a form of discipline or punishment, beyond a brief period of separation.

l. Shall discuss methods of discipline and child management with the parent or parents.

3. If the physical or mental, cognitive, social, or emotional health capabilities of an in-home applicant or provider appear to be questionable, the department may require the individual to present evidence of the individual's ability to provide the required care based on a formal evaluation. The department is not responsible for costs of any required evaluation.

4. In-home providers shall ensure safe care for the children receiving services in their care. If a ~~services-required~~confirmed decision made under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists, indicating that a child has been abused or neglected by the applicant or in-home provider, that decision has a direct bearing on the applicant's or in-home provider's ability to serve the public in a capacity involving the provision of child care and the application or in-home registration may be denied or revoked. If a ~~services-required~~confirmed determination under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists indicating that any child has been abused or neglected by the applicant or in-home provider, the applicant or in-home provider shall furnish information, satisfactory to the department, from which the department can determine the applicant's or in-home provider's ability to provide care that is free of abuse or neglect. The department shall furnish the determination of current ability to the applicant or

in-home provider. Each applicant shall complete a department-approved authorization for background check form no later than the first day of employment.

5. An in-home provider may provide early childhood services in a private residence for up to five children through the age of eleven, of which no more than three may be under the age of twenty-four months.

History: Effective December 1, 1981; amended effective January 1, 1987; January 1, 2011; April 1, 2016; April 1, 2018; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-02, 50-11.1-06, 50-11.1-07, 50-11.1-08

75-03-07-06. Denial or revocation of in-home registration.

1. The right to provide early childhood services is dependent upon the applicant's or provider's continuing compliance with the terms of the registration as listed in section 75-03-07-04.

2. A fraudulent or untrue representation is grounds for revocation or denial.

3. a. The applicant or in-home provider may not have been found guilty of, pled guilty to, or pled no contest to:

   (1) An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2 sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-17-01, simple assault; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing a police officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; or 14-09-22, abuse of child; or 14-09-22.1, neglect of child;

   (2) An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in paragraph 1; or

   (3) An offense, other than an offense identified in paragraph 1 or 2, if the department determines that the individual has not been sufficiently rehabilitated. An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.

   b. The department has determined that the offenses enumerated in paragraphs 1 and 2 of subdivision a have a direct bearing on the applicant's or provider's ability to serve the public in a capacity as a provider.

   c. In the case of a misdemeanor offense described in North Dakota Century Code sections 12.1-17-01, simple assault; 12.1-17-03, reckless endangerment; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; in the case of a class B misdemeanor offense described in North Dakota Century Code section 12.1-17-01.2, domestic violence; or equivalent conduct in another jurisdiction which requires proof of

substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction.

4. An in-home provider shall submit an application for a fingerprint-based criminal history record check at the time of application and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department ~~may conduct~~shall submit a request to the bureau of criminal investigation for a nationwide name-based criminal history record ~~investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background~~ check.

5. Review of fingerprint-based criminal history record check results.

   a. If an individual disputes the results of the criminal history record check required under this chapter, the individual may request a review of the results by submitting a written request for review to the department within thirty calendar days of the date of the department's memo outlining the results. The individual's request for review must include a statement of each disputed item and the reason for the dispute.

   b. The department shall assign the individual's request for review to a department review panel. An individual who has requested a review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.

   c. The department shall notify the individual of the department's final decision in writing within sixty calendar days of receipt of the individual's request for review.

History: Effective January 1, 2011; amended effective April 1, 2014; April 1, 2016; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-06, 50-11.1-06.1, 50-11.1-06.2, 50-11.1-07, 50-11.1-08

CHAPTER 75-03-07.1

75-03-07.1-00.1. Definitions.

The terms used in this chapter have the same meanings as in North Dakota Century Code section 50-11.1-02. In addition, as used in this chapter:

1. "Application" means all forms the department requires when applying or reapplying for a self-declaration.

2. "Aquatic activity" means an activity in or on a body of water, either natural or manmade, including rivers, lakes, streams, swimming pools, and water slides.

~~2.~~3. "Attendance" means the total number of children present at any one time.

~~3.~~4. "Child with special needs" means a child whose medical providers have determined that the child has or is at risk for chronic physical, developmental, behavioral, or emotional conditions.

~~4.~~5. "Emergency designee" means an individual designated by a provider to be a backup staff member for emergency assistance or to provide substitute care.

~~5.~~6. "Infant" means a child who is less than twelve months of age.

~~6.~~7. "Provider" means the holder of a self-declaration document.

~~7.~~8. "Supervision" means a provider or emergency designee responsible for caring for or teaching children being within sight or hearing range of an infant, toddler, or preschooler at all times so that the provider or emergency designee is capable of intervening to protect the health and safety of the child. For the school-age child, it means a provider or emergency designee responsible for caring for or teaching children being available for assistance and care so that the child's health and safety is protected.

History: Effective January 1, 2011; amended effective April 1, 2016; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02, 50-11.1-08, 50-11.1-17

75-03-07.1-02. Self-declaration standards - Application.

1. An applicant for a self-declaration document shall submit the application to the department or its authorized agent in which the applicant proposes to provide early childhood services. An application, including a department-approved authorization for background check for household members age twelve and older, an emergency designee, and an applicant, and an application for a fingerprint-based criminal history record check for the applicant and emergency designee, must be made in the form and manner prescribed by the department.

2. The current self-declaration document must be displayed prominently in the premises to which it applies.

3. A provisional self-declaration document may be issued:

   a. The department may issue a provisional self-declaration document although the applicant or provider fails to, or is unable to, comply with all applicable standards and rules of the department.

   b. A provisional self-declaration document must:

      (1) State that the provider has failed to comply with all applicable standards and rules of the department;

(2) State the items of noncompliance;

(3) Expire at a set date, not to exceed six months from the date of issuance; and

(4) Be exchanged for an unrestricted self-declaration document, which bears an expiration date of one year from the date of issuance of the provisional self-declaration document, after the applicant or operator demonstrates compliance, satisfactory to the department, with all applicable standards and rules.

c. The department may issue a provisional self-declaration document only to an applicant or provider who has waived, in writing:

(1) The right to a written statement of charges as to the reasons for the denial of an unrestricted self-declaration document; and

(2) The right to an administrative hearing, in the manner provided in North Dakota Century Code chapter 28-32, concerning the nonissuance of an unrestricted self-declaration document, either at the time of application or during the period of operation under a provisional self-declaration document.

d. Any provisional self-declaration document issued must be accompanied by a written statement of violations signed by the department and must be acknowledged in writing by the provider.

e. Subject to the exceptions contained in this section, a provisional self-declaration document entitles the provider to all rights and privileges afforded the provider of an unrestricted self-declaration document.

f. The provider shall display prominently the provisional self-declaration document and agreement.

g. The provider shall provide parents written notice that the provider is operating on a provisional self-declaration document and the basis for the provisional self-declaration document.

~~3.~~4. The provider shall be directly responsible for the care, supervision, and guidance of the children.

a. The provider:

(1) Must be at least eighteen years of age;

(2) Shall provide an environment that is physically and socially adequate for the children; and that the provider is of good physical, cognitive, social, and emotional health and shall use mature judgment when making decisions impacting the quality of child care;

(3) Shall devote adequate time and attention to the children in the provider's care;

(4) Shall provide food of sufficient quantity and nutritious quality in accordance with the United States department of agriculture standards which satisfies the dietary needs of the children while in the provider's care;

(5) Shall provide proper care and protection for children in the provider's care;

(6) May not use or be under the influence of, and will not allow any household member or emergency designee to use or be under the influence of any illegal drugs or alcoholic beverages while caring for children;

(7) May not leave children without supervision;

(8) Shall verify that the child has received all immunizations appropriate for the child's age, as prescribed by the state department of health, or have on file a document stating that the child is medically exempt or exempt from immunizations based on religious, philosophical, or moral beliefs, unless the child is a drop-in or school-age child;

(9) Shall report immediately, as a mandated reporter, suspected child abuse or neglect as required by North Dakota Century Code section 50-25.1-03;

(10) Shall provide a variety of games, toys, books, crafts, and other activities and materials to enhance the child's intellectual and social development and to broaden the child's life experience. Each provider shall have enough play materials and equipment so that at any one time each child in attendance may be involved individually or as a group;

(11) Shall ensure a current health assessment or a health assessment statement completed by the parent is obtained at the time of initial enrollment of the child, which must indicate any special precautions for diet, medication, or activity. This assessment must be completed annually;

(12) Shall ensure a child information form completed by the parent is obtained at the time of initial enrollment of the child and annually thereafter;

(13) Shall certify completion of a department-approved basic child care course within ninety days of being approved as a provider;

(14) Shall be currently certified in infant and pediatric cardiopulmonary resuscitation and the use of an automated external defibrillator by the American heart association, American red cross, or other similar cardiopulmonary resuscitation and automated external defibrillator training programs that are approved by the department;

(15) Shall be currently certified in first aid by a program approved by the department;

(16) Shall complete a minimum of three hours of department-approved training annually, including one hour on sudden infant death prevention prior to provider having unsupervised access to infants. The same training courses may be counted toward self-declaration annual requirements only if at least three years has passed since the last completion date of that training course, with the exception of sudden infant death prevention annual training;

(17) Shall ensure the emergency designee is currently certified in infant and pediatric cardiopulmonary resuscitation and the use of an automated external defibrillator by the American heart association, American red cross, or other similar cardiopulmonary resuscitation and automated external defibrillator training programs that are approved by the department;

(18) Shall ensure the emergency designee is currently certified in first aid by a program approved by the department;

(19) Shall ensure the emergency designee certifies completion of a department-approved basic child care course within ninety days;

(20) Shall ensure that the emergency designee completes one hour of department-approved training on sudden infant death prevention prior to emergency designee having unsupervised access to infants; and

(21) Shall release a child only to the child's parent, legal custodian, guardian, or an individual who has been authorized by the child's parent, legal custodian, or guardian.

b. The provider shall ensure that discipline will be constructive or educational in nature and may include diversion, separation from the problem situation, talking with the child about the situation, praising appropriate behavior, or gentle physical restraint such as holding. A child may not be subjected to physical harm or humiliation. Disregard of any of the following disciplinary rules or any disciplinary measure resulting in physical or emotional injury or neglect or abuse to any child is grounds for denial or revocation of a self-declaration document.

(1) A child may not be kicked, punched, spanked, shaken, pinched, bitten, roughly handled, struck, mechanically restrained, or physically maltreated by the provider, emergency designee, household member, or any other adult in the residence.

(2) Authority to discipline may not be delegated to or be administered by children.

(3) Separation, when used as discipline, must be appropriate to the child's development and circumstances, and the child must be in a safe, lighted, well-ventilated room within sight or hearing range of an adult. A child may not be isolated in a locked room or closet.

(4) A child may not be punished for lapses in toilet training.

(5) A provider may not use verbal abuse or make derogatory remarks about the child, or the child's family, race, or religion when addressing a child or in the presence of a child.

(6) A provider may not use profane, threatening, unduly loud, or abusive language in the presence of a child.

(7) A provider may not force-feed a child or coerce a child to eat unless medically prescribed and administered under a medical provider's care.

(8) A provider may not use deprivation of snacks or meals as a form of discipline or punishment.

(9) A provider may not force a child to ingest substances that would cause pain or discomfort, for example, placing soap in a child's mouth to deter the child from biting other children.

(10) A provider may not withhold active play from a child as a form of discipline or punishment, beyond a brief period of separation.

c. The provider shall ensure that a working smoke detector is properly installed and in good working order on each floor used by children.

d. The provider shall ensure that a fire extinguisher that is inspected annually is properly installed, is in good working order, and is located in the area used for child care.

e. The provider shall ensure that a working telephone is located in the location used for child care. ~~Emergency~~Current emergency numbers for parents and first responders must be posted.

f. When transportation is provided by a provider, children must be protected by adequate supervision ~~and~~, safety precautions, and liability insurance.

(1) Drivers must be eighteen years of age or older and must comply with all relevant federal, state, and local laws, including child restraint laws.

(2) A child must not be left unattended in a vehicle.

g. Aquatic activities:

(1) The provider shall have policies that ensure the health and safety of children in care while participating in aquatic activities, including types of aquatic activities the program may participate in, staff-to-child ratios appropriate to the ages and swimming ability of the children participating in aquatic activities, and additional safety precautions to be taken.

(2) The provider may not permit any child to participate in an aquatic activity without written parental permission, which includes parent disclosure of the child's swimming ability.

~~4.~~5. Potential hazards, such as guns, household cleaning chemicals, uninsulated wires, medicines, noncovered electrical outlets, poisonous plants, and open stairways must not be accessible to children. Guns and ammunition must be kept in separate locked storage, or trigger locks must be used. Other weapons and dangerous sporting equipment, such as bows and arrows, must not be accessible to children.

~~5.~~6. If the physical, cognitive, social, or emotional health capabilities of an applicant or provider appear to be questionable, the department may require that the individual present evidence of capability to provide the required care based on a formal evaluation. The department is not responsible for costs of any required evaluation.

~~6.~~7. A self-declaration document is only effective for one year.

History: Effective June 1, 1995; amended effective January 1, 2011; January 1, 2013; April 1, 2016; April 1, 2018; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-07, 50-11.1-08, 50-11.1-16, 50-11.1-17

75-03-07.1-06. Denial or revocation of self-declaration document.

1. The right to provide early childhood services is dependent upon the applicant's or provider's continuing compliance with the terms of the application as listed in section 75-03-07.1-02.

2. A fraudulent or untrue representation is grounds for revocation or denial.

3. a. The applicant, self-declaration provider, emergency designee, and household members may not have been found guilty of, pled guilty to, or pled no contest to:

(1) An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-17-01, simple assault; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing a police officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony

under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 14-09-22, abuse of child; or 14-09-22.1, neglect of child;

(2) An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in paragraph 1; or

(3) An offense, other than an offense identified in paragraph 1 or 2, if the department determines that the individual has not been sufficiently rehabilitated. An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.

b. The department has determined that the offenses enumerated in paragraphs 1 and 2 of subdivision a have a direct bearing on the applicant's, provider's, or emergency designee's ability to serve the public in a capacity as a provider or emergency designee.

c. In the case of a misdemeanor offense described in North Dakota Century Code sections 12.1-17-01, simple assault; 12.1-17-03, reckless endangerment; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; in the case of a class B misdemeanor offense described North Dakota Century Code section 12.1-17-01.2, domestic violence; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction.

4. A provider shall submit an application for a fingerprint-based criminal history record check at the time of application and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The provider shall ensure that each emergency designee submits an application for a fingerprint-based criminal history record check upon hire and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department ~~may conduct~~shall submit a request to the bureau of criminal investigation for a nationwide name-based criminal history record ~~investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background~~ check.

5. Review of fingerprint-based criminal history record check results.

a. If an individual disputes the results of the criminal history record check required under this chapter, the individual may request a review of the results by submitting a written request for review to the department within thirty calendar days of the date of the department's memo outlining the results. The individual's request for review must include a statement of each disputed item and the reason for the dispute.

b. The department shall assign the individual's request for review to a department review panel. An individual who has requested a review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.

c. The department shall notify the individual of the department's final decision in writing within sixty calendar days of receipt of the individual's request for review.

6. A provider shall ensure safe care for the children receiving services in the provider's residence. If a ~~services-required~~confirmed decision made under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists indicating that a child has been abused or neglected by an applicant, provider, emergency designee, or household member, that decision has a direct bearing on the applicant's or provider's ability to serve the public in a capacity involving the provision of child care, and the application or self-declaration document may be denied or revoked.

   a. If a ~~services-required~~confirmed determination under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists indicating that any child has been abused or neglected by the applicant, provider, emergency designee, or household member, the applicant or provider shall furnish information to the department, from which the department can determine the applicant's, provider's, or emergency designee's ability to provide care that is free of abuse or neglect. The department shall furnish the determination of ability to the applicant or provider.

   b. Each applicant, provider, and emergency designee shall complete, and the provider shall submit to the department or its authorized agent, a department-approved authorization for background check form no later than the first day of employment.

   c. Household members over the age of twelve shall complete, and the provider shall submit to the department or its authorized agent, a department-approved authorization for background check form at the time of application or upon obtaining residence at the location of the child care.

History: Effective June 1, 1995; amended effective January 1, 2011; January 1, 2013; April 1, 2014; April 1, 2016; April 1, 2018; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08, 50-11.1-09
Law Implemented: NDCC 50-11.1-06.2, 50-11.1-08, 50-11.1-09, 50-11.1-16, 50-11.1-17

75-03-07.1-10. Correction of violations.

1. A provider shall correct violations noted in a correction order within the following times:

   a. For a violation of subsection 24 of North Dakota Century Code section 50-11.1-02, North Dakota Century Code section 50-11.1-02.2, paragraph 5 or 7 of subdivision a of subsection 3 of section 75-03-07.1-02, subdivision b of subsection 3 of section 75-03-07.1-02, or subsection 4 of section 75-03-07.1-02, or section 75-03-07.1-08, within twenty-four hours.

   b. For a violation of subdivision g or h of subsection 1 of North Dakota Century Code section 50-11.1-17 or all other deficiencies of chapter 75-03-07.1, within twenty days.

2. All periods of correction begin on the date of the receipt of the correction order by the provider.

3. The department may grant an extension of additional time to correct violations, up to a period of one-half the original allowable time allotted. An extension may be granted upon application by the provider and a showing that the need for the extension is created by unforeseeable circumstances and the provider has diligently pursued the correction of the violation.

4. The provider shall furnish a written notice to the department or its authorized agent upon completion of the required corrective action. The correction order remains in effect until the department or its authorized agent confirms the corrections have been made.

5. The provider shall notify the parent of each child receiving care at the residence and each emergency designee how to report a complaint or suspected rule violation.

6. Within three business days of the receipt of the correction order, the provider shall notify the parents of each child receiving care by this provider that a correction order has been issued. In addition to providing notice to the parent of each child, the provider also must post the correction order in a conspicuous location within the residence until the violation has been corrected or five days, whichever is longer.

7. A provider who has been issued a correction order must be reinspected at the end of the period allowed for correction. If, upon reinspection, it is determined that the provider has not corrected a violation identified in the correction order, a notice of noncompliance with the correction order must be mailed by certified mail to the provider. The notice must specify the violations not corrected and the penalties assessed in accordance with North Dakota Century Code section 50-11.1-07.5.

8. Refutation process for a correction order:

   a. A self-declared provider may refute a correction order by submitting a refutation request in writing on the form provided by the department within five calendar days of receiving the correction order.

   b. The department shall respond to written refutations within five business days of receipt.

History: Effective January 1, 2011; amended effective January 1, 2013; April 1, 2014; April 1, 2016; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-07, 50-11.1-07.1, 50-11.1-07.2, 50-11.1-08

75-03-07.1-13. Minimum emergency disaster plans.

1. Each self-declared provider shall establish and post an emergency disaster plan for the safety of the children in care. Written disaster plans must be developed in cooperation with local emergency management agencies. The plan must include:

   a. Emergency procedures, including the availability of emergency food, water, and first aid supplies;

   b. ~~What will be done if parents are unable to pick up their child as a result of the emergency; and~~Procedures for evacuation, relocation, shelter-in-place, and lockdown;

   c. ~~What will be done if the self-declared provider has to be relocated or must close as a result of the emergency~~Communications and reunification with families;

   d. Continuity of operations; and

   e. Accommodations for infants, toddlers, children with disabilities, and children with chronic medical conditions.

2. Fire and emergency evacuation drills must be performed monthly.

History: Effective April 1, 2018; amended effective January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-17

CHAPTER 75-03-08

75-03-08-03. Definitions.

The terms used in this chapter have the same meanings as in North Dakota Century Code section 50-11.1-02. In addition, as used in this chapter, unless the context or subject matter otherwise requires:

1. "Application" means all forms the department requires when applying or reapplying for a license.

2. "Aquatic activity" means an activity in or on a body of water, either natural or manmade, including rivers, lakes, streams, swimming pools, and water slides.

~~2.~~3. "Attendance" means the total number of children present at any one time at the family child care.

~~3.~~4. "Child with special needs" means a child determined by a medical provider to have or to be at risk for chronic physical, developmental, behavioral, or emotional conditions.

~~4.~~5. "Emergency designee" means an individual designated by the provider to be a backup staff member for emergency assistance or to provide substitute care.

~~5.~~6. "Infant" means a child who is younger than twelve months of age.

~~6.~~7. "Medication" is defined as any drug or remedy which is taken internally or orally, inhaled, or applied topically.

~~7.~~8. "Provider" means owner or operator of a family child care.

~~8.~~9. "Substitute staff" means paid or unpaid staff who work less than thirty-two hours per month and are not regularly scheduled for work.

~~9.~~10. "Volunteer" means an individual who visits or provides an unpaid service, including a firefighter for fire safety week, a practicum student, or a foster grandparent.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2016; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02

75-03-08-09. Staffing requirements.

1. Staffing requirements are established by the number of children physically in care at the family child care at any given time, rather than total enrollment.

2. If a child with special needs is admitted to the program, the child's developmental age level must be used in determining the number of children for which care may be provided.

~~3. Children using the family child care for a McGruff safe house, a block house, or a certified safe house program during an emergency are not counted under this section.~~

History: Effective January 1, 1999; amended effective January 1, 2011; January 1, 2013; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02.1, 50-11.1-04, 50-11.1-08

75-03-08-15. Minimum standards for provision of transportation.

1. Prior to licensure, the provider shall establish a written policy governing the transportation of children to and from the family child care, if the family child care provides transportation. This policy must specify who is to provide transportation and how parental permission is to be obtained for activities which occur outside the family child care. If the family child care provides transportation, the provider shall inform the parents of any insurance coverage on the vehicles. Any vehicle used for transporting children must be in safe operating condition and in compliance with state and local laws.

2. When transportation is provided by a family child care, children must be protected by adequate staff supervision ~~and~~, safety precautions, and liability insurance.

   a. Staffing requirements must be maintained to assure the safety of children while being transported.

   b. A child may not be left unattended in a vehicle.

3. Children must be instructed in safe transportation conduct appropriate to their age and stage of development.

4. The driver shall be eighteen years of age or older and shall comply with all relevant federal, state, and local laws, including child restraint system laws.

History: Effective January 1, 1999; amended effective January 1, 2011; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-08

75-03-08-16. Minimum emergency evacuation and disaster plan.

1. Each provider shall establish and post an emergency disaster plan for the safety of the children in care. Written disaster plans must be developed in cooperation with local emergency management agencies. The plan must include:

   a. Emergency procedures, including the availability of emergency food, water, and first-aid supplies;

   b. ~~What will be done if parents are unable to pick up their child as a result of the emergency; and~~Procedures for evacuation, relocation, shelter-in-place, and lockdown;

   c. ~~What will be done if the family child care has to be relocated or must close as a result of the emergency~~Communications and reunification with families;

   d. Continuity of operations; and

   e. Accommodations for infants, toddlers, children with disabilities, and children with chronic medical conditions.

2. Fire and emergency evacuation drills must be performed monthly.

History: Effective January 1, 2011; amended effective January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-08

75-03-08-22. Records.

1. A copy of this chapter must be kept on the premises and available to staff members at all times.

2. The provider shall maintain the following records:

   a. The child's full name, birth date, current home address, legal names of the child's parents, and ~~the~~current business and personal telephone numbers where they can be reached;

   b. A written statement from the parents or legal guardian authorizing emergency medical care;

   c. Names and telephone numbers of individuals authorized to take the child from the family child care;

   d. Verification that the child has received all immunizations appropriate for the child's age, as prescribed by the state department of health, or have on file a document citing that the child is medically exempt or exempt from immunizations based on religious, philosophical, or moral beliefs, unless the child is a drop-in or school-age child; and

   e. A current health assessment or a health assessment statement completed by the parent, obtained at the time of initial enrollment of the child, that must indicate any special precautions for diet, medication, or activity. This assessment shall be completed annually.

3. The provider shall ensure that all records, photographs, and information maintained with respect to children receiving child care services are kept confidential, and that access is limited to staff members, the parents of each child, and to the following, unless otherwise protected by law:

   a. Authorized agent and department representatives;

   b. Individuals having a definite interest in the well-being of the child concerned and who, in the judgment of the department, are in a position to serve the child's interests should that be necessary; and

   c. Individuals who possess written authorization from the child's parent. The family child care shall have a release of information form available and shall have the form signed prior to the release of information.

History: Effective January 1, 1999; amended effective January 1, 2011; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-08-27. Effect of conviction on licensure and employment.

1. An applicant or provider may not be, and a family child care may not employ or allow, in any capacity that involves or permits contact between the emergency designee, staff member, or household member and any child cared for by the family child care, a provider, emergency designee, staff member, or household member who has been found guilty of, pled guilty to, or pled no contest to:

   a. An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-17-01, simple assault; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing a police officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors;

12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 14-09-22, abuse of child; or 14-09-22.1, neglect of child;

b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or

c. An offense, other than an offense identified in subdivision a or b, if the department in the case of an applicant, provider, or household member, or the provider in the case of a staff member or emergency designee, determines that the individual has not been sufficiently rehabilitated. An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.

2. The department has determined that the offenses enumerated in subdivision a or b of subsection 1 have a direct bearing on the applicant's, provider's, emergency designee's, or staff member's ability to serve the public in a capacity as a provider, emergency designee, or staff member.

3. In the case of a misdemeanor offense described in North Dakota Century Code sections 12.1-17-01, simple assault; 12.1-17-03, reckless endangerment; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; in the case of a class B misdemeanor offense described in North Dakota Century Code section 12.1-17-01.2, domestic violence; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction.

4. The provider shall establish written policies and engage in practices that conform to those policies to effectively implement this section before the hiring of any staff members.

5. A provider shall submit an application for a fingerprint-based criminal history record check at the time of application and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The provider shall ensure that each staff member submits an application for a fingerprint-based criminal history record check upon hire and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department ~~may conduct~~shall submit a request to the bureau of criminal investigation for a nationwide name-based criminal history record ~~investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background~~ check.

6. Review of fingerprint-based criminal history record check results.

a. If an individual disputes the results of the criminal history record check required under this chapter, the individual may request a review of the results by submitting a written request for review to the department within thirty calendar days of the date of the department's memo outlining the results. The individual's request for review must include a statement of each disputed item and the reason for the dispute.

b. The department shall assign the individual's request for review to a department review panel. An individual who has requested a review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.

c. The department shall notify the individual of the department's final decision in writing within sixty calendar days of receipt of the individual's request for review.

History: Effective January 1, 1999; amended effective January 1, 2011; April 1, 2014; April 1, 2016; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-06.1, 50-11.1-06.2, 50-11.1-07, 50-11.1-08, 50-11.1-09

75-03-08-28. Child abuse and neglect decisions.

1. A provider shall ensure safe care for the children receiving services in the provider's family child care. If a ~~services-required~~confirmed decision made under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists, indicating that a child has been abused or neglected by an applicant, provider, emergency designee, staff member, or household member, that decision has a direct bearing on the applicant's or provider's ability to serve the public in a capacity involving the provision of child care, and the application or license may be denied or revoked. If a ~~services-required~~confirmed determination under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists, indicating that any child has been abused or neglected by the applicant, provider, emergency designee, staff member, or household member, the applicant or provider shall furnish information satisfactory to the department, from which the department can determine the applicant's, provider's, or staff member's ability to provide care that is free of abuse and neglect. The department shall furnish the determination of current ability to the applicant or provider.

2. Each applicant, provider, emergency designee, and staff member in the family child care shall complete, and the provider shall submit to the department or its authorized agent, a department-approved authorization for background check form no later than the first day of employment.

3. Household members over the age of twelve shall complete, and the provider shall submit to the department or its authorized agent, a department-approved authorization for background check form at the time of application, relicensure, or upon obtaining residence at the location of the family child care.

History: Effective January 1, 1999; amended effective January 1, 2011; January 1, 2013; April 1, 2014; April 1, 2016; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-04, 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-08-29. Correction of violations.

1. A provider shall correct violations noted in a correction order within the following times:

   a. For a violation of subsection 8 of North Dakota Century Code section 50-11.1-02, North Dakota Century Code section 50-11.1-02.2, section 75-03-08-04, subsection 4 or 11 of section 75-03-08-08.1, section 75-03-08-09, subsection 2 or 9 of section 75-03-08-14, section 75-03-08-23, or subsection 1 of section 75-03-08-24, within twenty-four hours.

b. For a violation that requires an inspection by a state fire marshal or local fire department authority pursuant to section 75-03-08-14, within sixty days.

c. For a violation that requires substantial building remodeling, construction, or change, within sixty days.

d. For all other violations, within twenty days.

2. All periods for correction begin on the date of receipt of the correction order by the provider.

3. The department may grant an extension of additional time to correct violations, up to a period of one-half the original allowable time allotted. An extension may be granted upon application by the provider and a showing that the need for the extension is created by unforeseeable circumstances and the provider has diligently pursued the correction of the violation.

4. The provider shall furnish a written notice to the department or its authorized agent upon completion of the required corrective action. The correction order remains in effect until the department or its authorized agent confirms the corrections have been made.

5. Within three business days of the receipt of the correction order, the provider shall notify the parents of each child receiving care at the family child care that a correction order has been issued. In addition to providing notice to the parent of each child, the provider also shall post the correction order in a conspicuous location within the family child care until the violation has been corrected or for five days, whichever is longer.

6. A family child care program that has been issued a correction order must be reinspected at the end of the period allowed for correction. If, upon reinspection, it is determined that the program has not corrected a violation identified in the correction order, a notice of noncompliance with the correction order must be mailed by certified mail to the program. The notice must specify the violations not corrected and the penalties assessed in accordance with North Dakota Century Code section 50-11.1-07.5.

7. If a family child care program receives more than one correction order in a single year, the provider may be referred by the department for consulting services to assist the provider in maintaining compliance and to avoid future corrective action.

8. Refutation process for a correction order:

a. A provider may refute a correction order by submitting a refutation request in writing on the form provided by the department within five calendar days of receiving the correction order.

b. The department shall respond to written refutations within five business days of receipt.

History: Effective January 1, 1999; amended effective January 1, 2011; January 1, 2013; April 1, 2014; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-07.1, 50-11.1-07.2, 50-11.1-07.3

CHAPTER 75-03-09

75-03-09-03. Definitions.

The terms used in this chapter have the same meanings as in North Dakota Century Code section 50-11.1-02. In addition, as used in this chapter, unless the context or subject matter otherwise requires:

1. "Application" means all forms the department requires when applying or reapplying for a license.

2. "Aquatic activity" means an activity in or on a body of water, either natural or manmade, including rivers, lakes, streams, swimming pools, and water slides.

~~2.~~3. "Attendance" means the total number of children present at any one time at the group child care.

~~3.~~4. "Child with special needs" means a child whose medical providers have determined that the child has or is at risk for chronic physical, developmental, behavioral, or emotional conditions.

~~4.~~5. "Emergency designee" means an individual designated by the operator to be a backup caregiver for emergency assistance or to provide substitute care.

~~5.~~6. "Group child care supervisor" means an individual responsible for overseeing the day-to-day operation of a group child care.

~~6.~~7. "Infant" means a child who is less than twelve months of age.

~~7.~~8. "Medications" means any drug or remedy which is taken internally or orally, inhaled, or applied topically.

~~8.~~9. "Operator" means the individual or governing board who has the legal responsibility and the administrative authority for the operation of a group child care.

~~9.~~10. "Provider" means the group child care owner or operator.

~~10.~~11. "Substitute staff" means paid or unpaid staff who work less than thirty-two hours per month and are not regularly scheduled for work.

~~11.~~12. "Volunteer" means an individual who visits or provides an unpaid service or visit, including a firefighter for fire safety week, a practicum student, or a foster grandparent.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2014; April 1, 2016; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02

75-03-09-07. Application for and nontransferability of group child care license.

1. An application for license must be submitted to the department or its authorized agent. Application must be made in the form and manner prescribed by the department.

2. A license issued under this chapter is nontransferable and valid only for the premises indicated on the license.

3. An application for a new license must be filed upon change of provider or location.

4. The department may not issue more than one in-home registration, self-declaration, or license per residence. A residence means real property that is typically used as a single family dwelling. ~~A provider or operator with more than one in-home registration, self-declaration, or license in a single residence or two or more providers or operators operating under in-home registrations, self-declarations, or licenses out of the same residence prior to January 1, 2011, will be exempt from this subsection until January 1, 2016, after which time all operators will be subject to this subsection.~~

History: Effective December 1, 1981; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-03, 50-11.1-04, 50-11.1-06.2, 50-11.1-07, 50-11.1-08

75-03-09-09. Staffing requirements.

1. The number of staff members and their responsibilities must reflect program requirements, individual differences in the needs of the children enrolled, and may permit flexible groupings, if necessary.

2. a. A provider may provide early childhood services for no more than seven children at any one time, which includes no more than three children under twenty-four months of age. A provider may also provide early childhood services to two additional school-age children; or

   b. A provider may elect to staff according to the following minimum ratio of staff members responsible for caring for or teaching children to children in group child care:

      (1) For children younger than eighteen months of age, a ratio of .25 in decimal form is assigned;

      (2) For children eighteen months of age to thirty-six months of age, a ratio of .20 in decimal form is assigned;

      (3) For children thirty-six months of age to four years of age, a ratio of .14 in decimal form is assigned;

      (4) For children four years of age to five years of age, a ratio of .10 in decimal form is assigned;

      (5) For children five years of age to six years of age, a ratio of .08 in decimal form is assigned;

      (6) For children six years to twelve years of age, a ratio of .05 in decimal form is assigned; and

      (7) When there is a mixed-aged group, the number of children in each age category is multiplied by the corresponding ratio number, converted to decimal form, and carried to the nearest hundredth. To determine the number of staff members responsible for caring for or teaching children necessary at any given time, numbers of staff members for all age categories are added, and any fractional staff member count is then rounded to the next highest whole number whenever the fractional staff member count amounts to thirty-five hundredths or more. If lower than thirty-five hundredths, the fractional amount is dropped. No more than four children under the age of eighteen months per staff member are allowed in any mixed-aged group.

3. A provider licensed for at least two years may apply for a waiver of the required ratio, not to exceed .25 decimal point. The department shall consider demonstration of need, health and safety of children, age of children, number of children, and licensing history of the provider in determining whether to approve the application for a waiver. The department may deny an application for waiver and may revoke a waiver granted under this subsection. The decision to deny or revoke a waiver is not an appealable decision. The department shall review each waiver granted under this subsection ~~at least every twelve months~~annually to determine if the circumstances which led to granting the waiver continue to exist.

4. The provider of a group child care shall ensure that the group child care is sufficiently staffed at all times to meet the child and staff ratios for children in attendance, and that no more children than the licensed capacity are served at one time.

5. If a child with special needs is admitted to the group child care, the child's developmental age level must be used in determining the number of children for which care can be provided.

6. The provider shall ensure that children with special needs requiring more than usual care and supervision have adequate care and supervision provided to them without adversely affecting care provided to the remaining children in the group child care.

~~7. Children using the group child care for a McGruff safe house, a block house, or a certified safe house program during an emergency are not counted under this section.~~

History: Effective December 1, 1981; amended effective July 1, 1984; January 1, 1987; January 1, 1989; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; July 1, 2013; April 1, 2014; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02.1, 50-11.1-04, 50-11.1-08

75-03-09-16. Minimum emergency evacuation and disaster plan.

1. Each provider shall establish and post an emergency disaster plan for the safety of the children in care. Written disaster plans must be developed in cooperation with local emergency management agencies. The plan must include:

   a. Emergency procedures, including the availability of emergency food, water, and first-aid supplies;

   b. ~~What will be done if parents are unable to pick up their child as a result of the emergency; and~~Procedures for evacuation, relocation, shelter-in-place, and lockdown;

   c. ~~What will be done if the group child care has to be relocated or must close as a result of the emergency~~Communications and reunification with families;

   d. Continuity of operations; and

   e. Accommodations for infants, toddlers, children with disabilities, and children with chronic medical conditions.

2. Fire and emergency evacuation drills must be performed.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-08

75-03-09-22. Records.

1. The provider shall keep a copy of this chapter on the premises of the group child care and shall make it available to staff members at all times.

2. The provider shall maintain the following records:

   a. The child's full name, birthdate, and current home address;

   b. Legal names of the child's parents, and ~~the~~current business and personal telephone numbers where they can be reached;

   c. Names and telephone numbers of individuals who may assume responsibility for the child if the individuals legally responsible for the child cannot be reached immediately in an emergency;

   d. A written statement from the parents authorizing emergency medical care;

   e. Names and telephone numbers of individuals authorized to take the child from the group child care;

   f. Verification that the child has received all immunizations appropriate for the child's age, as prescribed by the state department of health, or have on file a document citing that the child is medically exempt or exempt from immunizations based on religious, philosophical, or moral beliefs, unless the child is a drop-in or school-age child; and

   g. A current health assessment or a health assessment statement completed by the parent, obtained at the time of initial enrollment of the child which must indicate any special precautions for diet, medication, or activity. This assessment must be completed annually.

3. The provider must verify the identification of the child through official documentation such as a certified birth certificate, certified school records, passport, or any other documentary evidence the provider considers appropriate proof of identity and shall comply with North Dakota Century Code section 12-60-26.

4. The provider shall ensure that all records, photographs, and information maintained with respect to children receiving child care services are kept confidential, and that access is limited to staff members, the parents of each child, and to the following, unless otherwise protected by law:

   a. The authorized agent and department representatives;

   b. Individuals having a definite interest in the well-being of the children concerned and who, in the judgment of the department, are in a position to serve the children's interests should that be necessary; and

   c. Individuals who possess a written authorization from the child's parent. The group child care shall have a release of information form available and shall have the form signed prior to the release of information.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-09-27. Effect of conviction on licensure and employment.

1. An applicant or provider may not be, and a group child care may not employ or allow, in any capacity that involves or permits contact between the emergency designee, group child care supervisor, staff member, or household member and any child cared for by the group child care, a provider, emergency designee, group child care supervisor, staff member, or household member who has been found guilty of, pled guilty to, or pled no contest to:

   a. An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-17-01, simple assault; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing a police officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 14-09-22, abuse of child; or 14-09-22.1, neglect of child;

   b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or

   c. An offense, other than an offense identified in subdivision a or b, if the department in the case of a group child care applicant, provider, or group child care supervisor, or household member, or the provider in the case of a staff member or emergency designee, determines that the individual has not been sufficiently rehabilitated. An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.

2. The department has determined that the offenses enumerated in subdivisions a and b of subsection 1 have a direct bearing on the applicant's, provider's, emergency designee's, or staff member's ability to serve the public as a provider, emergency designee, or staff member.

3. In the case of a misdemeanor offense described in North Dakota Century Code sections 12.1-17-01, simple assault; 12.1-17-03, reckless endangerment; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; in the case of a class B misdemeanor offense described in North Dakota Century Code section 12.1-17-01.2, domestic violence; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction.

4. The provider shall establish written policies and engage in practices that conform to those policies to effectively implement this section before the hiring of any staff.

5. A provider shall submit an application for a fingerprint-based criminal history record check at the time of application and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The provider shall ensure that each staff member

submits an application for a fingerprint-based criminal history record check upon hire and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department ~~may conduct~~shall submit a request to the bureau of criminal investigation for a nationwide name-based criminal history record ~~investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background~~ check.

6. Review of fingerprint-based criminal history record check results.

   a. If an individual disputes the results of the criminal history record check required under this chapter, the individual may request a review of the results by submitting a written request for review to the department within thirty calendar days of the date of the department's memo outlining the results. The individual's request for review must include a statement of each disputed item and the reason for the dispute.

   b. The department shall assign the individual's request for review to a department review panel. An individual who has requested a review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.

   c. The department shall notify the individual of the department's final decision in writing within sixty calendar days of receipt of the individual's request for review.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2014; April 1, 2016; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-06.1, 50-11.1-06.2, 50-11.1-07, 50-11.1-08, 50-11.1-09

75-03-09-28. Child abuse and neglect decisions.

1. A provider shall ensure safe care for the children receiving services in the provider's group child care. If a ~~services-required~~confirmed decision made under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists, indicating that a child has been abused or neglected by an applicant, provider, emergency designee, staff member, or household member, that decision has a direct bearing on the applicant's or provider's ability to serve the public in a capacity involving the provision of child care and the application or license may be denied or revoked. If a ~~services-required~~confirmed determination under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists indicating that any child has been abused or neglected by the applicant, provider, emergency designee, staff member, or household member, the applicant or provider shall furnish information satisfactory to the department, from which the department can determine the applicant's, provider's, emergency designee's, or staff member's ability to provide care that is free of abuse and neglect. The department shall furnish the determination of current ability to the applicant or provider.

2. Each applicant, provider, emergency designee, and staff member in the group child care shall complete, and the provider shall submit to the department or its authorized agent, a department-approved authorization for background check form no later than the first day of employment.

3. Household members over the age of twelve shall complete, and the provider shall submit to the department or its authorized agent, a department-approved authorization for background check form at the time of application or relicensure or upon obtaining residence at the location of the group child care.

History: Effective December 1, 1981; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; April 1, 2014; April 1, 2016; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-04, 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-09-29. Correction of violations.

1. Within three business days of the receipt of the correction order, the provider shall notify the parents of each child receiving care at the group child care that a correction order has been issued. In addition to providing notice to the parent of each child, the provider shall post the correction order in a conspicuous location within the facility until the violation has been corrected or for five days, whichever is longer.

2. Violations noted in a correction order must be corrected:

   a. For a violation of North Dakota Century Code section 50-11.1-02.2; section 75-03-09-04; subdivision i of subsection 1 of section 75-03-09-08; section 75-03-09-09; subsection 4 or 8 of section 75-03-09-12; subsection 3, 6, 9, or 10 of section 75-03-09-18; section 75-03-09-23; or subsection 1 of section 75-03-09-24, within twenty-four hours;

   b. For a violation requiring the hiring of a group child care supervisor with those qualifications set forth in section 75-03-09-10, within sixty days;

   c. For a violation that requires an inspection by a state fire marshal or local fire department authority pursuant to section 75-03-09-17, within sixty days;

   d. For a violation that requires substantial building remodeling, construction, or change, within sixty days; and

   e. For all other violations, within twenty days.

3. All periods for correction begin on the date of receipt of the correction order by the provider.

4. The department may grant an extension of additional time to correct violations, up to a period of one-half the original allowable time allotted. An extension may be granted upon application by the provider and a showing that the need for the extension is created by unforeseeable circumstances and the provider has diligently pursued the correction of the violation.

5. The provider shall furnish written notice to the department or its authorized agent upon completion of the required corrective action. The correction order remains in effect until the department or its authorized agent confirms the corrections have been made.

6. At the end of the period allowed for correction, the department or its authorized agent shall reinspect a group child care that has been issued a correction order. If, upon reinspection, it is determined that the group child care has not corrected a violation identified in the correction order, the department or its authorized agent shall mail a notice of noncompliance with the correction order by certified mail to the group child care. The notice must specify the violations not corrected and the penalties assessed in accordance with North Dakota Century Code section 50-11.1-07.5.

7. If a group child care receives more than one correction order in a single year, the department or its authorized agent may refer the group child care for consulting services to assist the provider in maintaining compliance and to avoid future corrective action.

8. Refutation process for a correction order:

   a. A provider may refute a correction order by submitting a refutation request in writing on the form provided by the department within five calendar days of receiving the correction order.

   b. The department shall respond to written refutations within five business days of receipt.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; April 1, 2014; April 1, 2018; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-07.1, 50-11.1-07.2, 50-11.1-07.3

CHAPTER 75-03-10

75-03-10-03. Definitions.

The terms used in this chapter have the same meanings as in North Dakota Century Code section 50-11.1-02. In addition, as used in this chapter, unless the context or subject matter otherwise requires:

1. "Application" means all forms the department requires when applying or reapplying for a license.

2. "Aquatic activity" means an activity in or on a body of water, either natural or manmade, including rivers, lakes, streams, swimming pools, and water slides.

~~2.~~3. "Attendance" means the total number of children present at any one time at the facility.

~~3.~~4. "Child with special needs" means a child whose medical providers have determined that the child has or is at risk of chronic physical, developmental, behavioral, or emotional conditions.

~~4.~~5. "Director" means the individual responsible for overseeing the general operation and implementing the policies and procedures of the child care center.

~~5.~~6. "Emergency designee" means an individual designated by the operator to be a backup staff member for emergency assistance or to provide substitute care.

~~6.~~7. "Infant" means a child who is less than twelve months of age.

~~7.~~8. "Medication" means any drug or remedy which is taken internally or orally, inhaled, or applied topically.

~~8.~~9. "Operator" means the individual or governing board who has the legal responsibility and the administrative authority for the operation of a child care center.

~~9.~~10. "Substitute staff" means staff who work less than thirty-two hours per month and are not regularly scheduled for work.

~~10.~~11. "Supervisor" means any individual with the responsibility for organizing and supervising daily child care center activities.

~~11.~~12. "Volunteer" means an individual who visits or provides an unpaid service, including a firefighter for fire safety week, a practicum student, or a foster grandparent.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2016; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02

75-03-10-07. Application for and nontransferability of child care center license.

An application for a license must be submitted to the department or its authorized agent.

1. An applicant shall submit an application for a license to the department or its authorized agent. Application must be made in the form and manner prescribed by the department.

2. A license issued under this chapter is nontransferable and is valid only for the premises that are indicated on the license.

3. An application for a new license must be filed by the operator upon change of operator or location.

4. The department may not issue more than one in-home registration, self-declaration, or license per residence. A residence means real property that is typically used as a single family dwelling. ~~A provider or operator with more than one in-home registration, self-declaration, or license in a single residence or two or more providers or operators operating under in-home registrations, self-declarations, or licenses out of the same residence prior to January 1, 2011, will be exempt from this subsection until January 1, 2016, after which time all operators will be subject to this subsection.~~

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-03, 50-11.1-04, 50-11.1-06.2, 50-11.1-07, 50-11.1-08

75-03-10-08. Staffing and group size requirements.

1. The number of staff members and their responsibilities must reflect program requirements and individual differences in the needs of the children enrolled, and may permit mixed-age groups, if necessary. Service personnel engaged in housekeeping and food preparation may not be counted in the child to staff ratio for periods of time when they are engaged in housekeeping or food preparation.

2. a. The operator shall ensure that the center is sufficiently staffed at all times to meet the child to staff ratios for children in attendance and that no more children than the licensed capacity are served at one time. The minimum ratio of staff members responsible for caring for or teaching children to children in child care centers and maximum group size of children must be:

   (1) For children less than eighteen months of age, one staff member may care for four children, a ratio of .25 in decimal form, with a maximum group size of ten children;

   (2) For children eighteen months of age to thirty-six months of age, one staff member may care for five children, a ratio of .20 in decimal form, with a maximum group size of fifteen children;

   (3) For children three years of age to four years of age, one staff member may care for seven children, a ratio of .14 in decimal form, with a maximum group size of twenty children;

   (4) For children four years of age to five years of age, one staff member may care for ten children, a ratio of .10 in decimal form, with a maximum group size of twenty-five children;

   (5) For children five years of age to six years of age, one staff member may care for twelve children, a ratio of .08 in decimal form, with a maximum group size of thirty children; and

   (6) For children six years to twelve years of age, one staff member may care for twenty children, a ratio of .05 in decimal form, with a maximum group size of forty children.

   b. ~~The provisions in subdivision a relating to maximum group size do not apply to operators licensed prior to January 1, 1999, if those operators are otherwise qualified to operate a child care center. Any operator who discontinues operation of the child care center under a valid license or who fails to renew the operator's license upon its expiration will not be~~

~~exempt subsequently from the requirements relating to maximum group size. The exemption for operators licensed prior to January 1, 1999, will end on January 1, 2015, after which time all operators will be subject to the requirements of this subsection.~~

~~c.~~ When there are mixed-age groups in the same room, the operator shall ensure:

(1) The maximum group size is consistent with the:

(a) Age of the majority of the children; or

(b) Highest number of children in the youngest age group;

(2) When children age zero to eighteen months are in the mixed-age group, the maximum group size does not exceed ten children;

(3) The mixed-age group does not exceed the acceptable ratio pursuant to subdivision d of subsection 2 of section 75-03-10-08 and the maximum number of children per staff member pursuant to subdivision a of subsection 2 of section 75-03-10-08; and

(4) If the mixed-age group contains the maximum number of children per staff member pursuant to subdivision a of subsection 2 of section 75-03-10-08, the mixed-age group may only contain additional older children.

~~d.~~c. When there is a mixed-age group, the number of children in each age category is multiplied by the corresponding ratio number, converted to decimal form, and carried to the nearest hundredth. To determine the number of staff members responsible for caring for or teaching children necessary at any given time, numbers of staff members for all age categories are added, and any fractional staff member count is then rounded to the next highest whole number whenever the fractional staff member count amounts to thirty-five hundredths or more. If lower than thirty-five hundredths, the fractional amount is dropped.

3. If a child with special needs is admitted to the child care center, the child's developmental age level must be used to determine into which age group the child should be placed for determining child to staff ratios.

4. The operator shall ensure that a child with special needs requiring more than usual care and supervision has adequate care and supervision without adversely affecting care provided to the other children in the child care center.

5. ~~Children using the child care center for a McGruff safe house, a block house, or a certified safe house program during an emergency are not counted under this section.~~

~~6.~~ An operator licensed for at least two years may apply for a waiver of the required ratio and maximum group size, not to exceed .25 decimal point per group. The department shall consider demonstration of need, health and safety of children, age of children, number of children, and licensing history of the operator in determining whether to approve the application for a waiver. The department may deny an application for waiver and may revoke a waiver granted under this subsection. The decision to deny or revoke a waiver is not an appealable decision. The department shall review each waiver granted under this subsection ~~at least every twelve months~~annually to determine if the circumstances which led to granting the waiver continue to exist.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; July 1, 2013; April 1, 2014; January 1, 2022.

General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02.1, 50-11.1-04, 50-11.1-08

75-03-10-16. Minimum emergency evacuation and disaster plan.

1. The operator shall establish and post an emergency disaster plan for the safety of the children in care. The operator shall develop written disaster plans in cooperation with local emergency management agencies. The plan must include:

   a. Emergency procedures, including the availability of emergency food, water, and first-aid supplies;

   b. ~~What will be done if parents are unable to pick up their child as a result of the emergency; and~~Procedures for evacuation, relocation, shelter-in-place, and lockdown;

   c. ~~What will be done if the child care center has to be relocated or must close as a result of the emergency~~Communications and reunification with families;

   d. Continuity of operations; and

   e. Accommodations for infants, toddlers, children with disabilities, and children with chronic medical conditions.

2. Fire and emergency evacuation drills must be performed monthly.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-08

75-03-10-22. Records.

1. The operator shall keep a copy of this chapter on the premises of the child care center and shall make it available to staff members at all times.

2. The operator shall maintain the following records:

   a. The child's full name, birth date, and current home address;

   b. Legal names of the child's parents and ~~the~~current business and personal telephone numbers where they can be reached;

   c. Names and telephone numbers of individuals who may assume responsibility for the child if the individuals legally responsible for the child cannot be reached immediately in an emergency;

   d. A written statement from the parents authorizing emergency medical care;

   e. Names and telephone numbers of individuals authorized to take the child from the child care center;

   f. Verification that the child has received all immunizations appropriate for the child's age, as prescribed by the state department of health, or have on file a document stating that the child is medically exempt or exempt from immunizations based on religious, philosophical, or moral beliefs, unless the child is a drop-in or school-age child; and

g. A current health assessment or a health assessment statement completed by the parent, obtained at the time of initial enrollment of the child which must indicate any special precautions for diet, medication, or activity. This assessment must be completed annually.

3. The operator shall record and verify the identification of the child through official documentation such as a certified birth certificate, certified school records, passport, or any other documentary evidence the operator considers appropriate proof of identity and shall comply with North Dakota Century Code section 12-60-26.

4. The operator shall ensure that all records, photographs, and information maintained with respect to children receiving child care services are kept confidential, and that access is limited to staff members, the parents of each child, and to the following, unless otherwise protected by law:

   a. The authorized agent and department representatives;

   b. Individuals having a definite interest in the well-being of the children concerned and who, in the judgment of the department, are in a position to serve the child's interests should that be necessary; and

   c. Individuals who possess a written authorization from the child's parent. The child care center shall have a release of information form available and shall have the form signed prior to the release of information.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-10-27. Effect of conviction on licensure and employment.

1. An applicant, operator, director, or supervisor may not be, and a child care center may not employ or allow, in any capacity that involves or permits contact between the emergency designee, substitute staff member, or staff member and any child cared for by the child care center, an operator, emergency designee, substitute staff member, director, supervisor, or staff member who has been found guilty of, pled guilty to, or pled no contest to:

   a. An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-17-01, simple assault; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing a police officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 14-09-22, abuse of child; or 14-09-22.1, neglect of child;

b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or

c. An offense other than an offense identified in subdivision a or b, if the department in the case of a child care center applicant, operator, director, or supervisor, or the operator in the case of an emergency designee, substitute staff, or staff member, determines that the individual has not been sufficiently rehabilitated. An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.

2. The department has determined that the offenses enumerated in subdivisions a and b of subsection 1 have a direct bearing on the applicant's, operator's, emergency designee's, substitute staff member's, director's, supervisor's, or staff member's ability to serve the public as an operator, emergency designee, substitute staff member, director, supervisor, or staff member.

3. In the case of a misdemeanor offense described in North Dakota Century Code sections 12.1-17-01, simple assault; 12.1-17-03, reckless endangerment; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; in the case of a class B misdemeanor offense described in North Dakota Century Code section 12.1-17-01.2, domestic violence; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction.

4. The operator shall establish written policies and engage in practices that conform to those policies to effectively implement this section before hiring any staff member.

5. An operator shall submit an application for a fingerprint-based criminal history record check at the time of application and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The operator shall ensure that each staff member submits an application for a fingerprint-based criminal history record check upon hire and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department ~~may conduct~~shall submit a request to the bureau of criminal investigation for a nationwide name-based criminal history record ~~investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background~~ check.

6. Review of fingerprint-based criminal history record check results.

a. If an individual disputes the results of the criminal history record check required under this chapter, the individual may request a review of the results by submitting a written request for review to the department within thirty calendar days of the date of the department's memo outlining the results. The individual's request for review must include a statement of each disputed item and the reason for the dispute.

b. The department shall assign the individual's request for review to a department review panel. An individual who has requested a review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.

c. The department shall notify the individual of the department's final decision in writing within sixty calendar days of receipt of the individual's request for review.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2014; April 1, 2016; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-06.1, 50-11.1-06.2, 50-11.1-07, 50-11.1-08, 50-11.1-09

75-03-10-28. Child abuse and neglect decisions.

An operator shall ensure safe care for the children receiving services in the child care center.

1. If a ~~services-required~~confirmed decision made under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists, indicating that a child has been abused or neglected by an applicant, operator, director, supervisor, emergency designee, substitute staff member, or staff member, that decision has a direct bearing on the applicant's or operator's ability to serve the public in a capacity involving the provisions of child care and the application or license may be denied or revoked. If a ~~services-required~~confirmed determination under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists indicating that any child has been abused or neglected by the applicant, operator, director, supervisor, emergency designee, substitute staff member, or staff member, the applicant or operator shall furnish information satisfactory to the department, from which the department can determine the applicant's, operator's, director's, supervisor's, emergency designee's, substitute staff member's, or staff member's ability to provide care that is free of abuse and neglect. The department shall furnish the determination of current ability to the applicant or operator.

2. Each applicant, operator, director, supervisor, emergency designee, substitute staff member, and staff member shall complete, and the operator shall submit to the department or its authorized agent, a department-approved authorization for background check form no later than the first day of employment.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; April 1, 2014; April 1, 2016; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-10-29. Correction of violations.

1. Within three business days of the receipt of the correction order, the operator shall notify the parents of each child receiving care at the child care center that a correction order has been issued. In addition to providing notice to the parent of each child, the operator shall post the correction order in a conspicuous location within the child care center until the violation has been corrected or for five days, whichever is longer.

2. Violations noted in a correction order must be corrected:

   a. For a violation of North Dakota Century Code section 50-11.1-02.2; section 75-03-10-04 or 75-03-10-08; subsection 12 of section 75-03-10-09; subdivision e of subsection 1 of section 75-03-10-12; subsection 3 of section 75-03-10-12; subsection 3, 6, 9, or 10 of

section 75-03-10-18; section 75-03-10-23; or subsection 1 of section 75-03-10-24, within twenty-four hours;

b. For a violation requiring the hiring of a child care supervisor with those qualifications set forth in section 75-03-10-11.1, or a child care center director with those qualifications set forth in section 75-03-10-10, within sixty days;

c. For a violation that requires an inspection by a state fire marshal or local fire department authority pursuant to section 75-03-10-17, within sixty days;

d. For a violation that requires substantial building remodeling, construction, or change, within sixty days; and

e. For all other violations, within twenty days.

3. All periods for correction begin on the date of receipt of the correction order by the operator.

4. The department may grant an extension of additional time to correct violations, up to a period of one-half the original allowable time allotted. An extension may be granted upon application by the operator and a showing that the need for the extension is created by unforeseeable circumstances and the operator has diligently pursued the correction of the violations.

5. The operator shall furnish a written notice to the department or its authorized agent upon completion of the required corrective action. The correction order remains in effect until the department or its authorized agent confirms that the corrections have been made.

6. At the end of the period allowed for correction, the department or its authorized agent shall reinspect a child care center that has been issued a correction order. If, upon reinspection, the department or its authorized agent determines that the child care center has not corrected a violation identified in the correction order, the department or its authorized agent shall mail a notice of noncompliance with the correction order by certified mail to the child care center. The notice must specify the violations not corrected and the penalties assessed in accordance with North Dakota Century Code section 50-11.1-07.5.

7. If a child care center receives more than one correction order in a single year, the operator may be referred by the department for consulting services to assist the operator in maintaining compliance and to avoid future corrective action.

8. Refutation process for a correction order:

a. An operator may refute a correction order by submitting a refutation request in writing on the form provided by the department within five calendar days of receiving the correction order.

b. The department shall respond to written refutations within five business days of receipt.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; April 1, 2014; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-07.1, 50-11.1-07.2, 50-11.1-07.3

CHAPTER 75-03-11

75-03-11-03. Definitions.

The terms used in this chapter have the same meanings as in North Dakota Century Code section 50-11.1-02. In addition, as used in this chapter, unless the context or subject matter otherwise requires:

1. "Application" means all forms the department requires when applying or reapplying for a license.

2. "Aquatic activity" means an activity in or on a body of water, either natural or manmade, including rivers, lakes, streams, swimming pools, and water slides.

~~2.~~3. "Assistant" means any individual who works directly with children in a preschool under the supervision of a teacher or a director.

~~3.~~4. "Attendance" means the total number of children present at any one time at the facility.

~~4.~~5. "Child with special needs" means a child whose medical providers have determined that the child has or is at risk for chronic physical, developmental, behavioral, or emotional conditions.

~~5.~~6. "Director" means an individual responsible for supervising and organizing program activities in a preschool.

~~6.~~7. "Emergency designee" means an individual designated by the operator to be a backup staff member for emergency assistance or to provide substitute care.

~~7.~~8. "Medication" means any drug or remedy which is taken internally or orally, inhaled, or applied topically.

~~8.~~9. "Operator" means the individual or governing board who has the legal responsibility and the administrative authority for the operation of a preschool.

~~9.~~10. "Preschool" means a program licensed to provide early childhood services which follows a preschool curriculum and course of study designed primarily to enhance the educational development of the children enrolled and which serves no child for more than three hours per day.

~~10.~~11. "Substitute staff" means staff who work less than thirty-two hours per month, and are not regularly scheduled for work.

~~11.~~12. "Teacher" means an individual with the responsibility of implementing program activities, either as the director or under the supervision of the director.

~~12.~~13. "Volunteer" means an individual who visits or provides an unpaid service or visit, including a firefighter for fire safety week, a practicum student, or a foster grandparent.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2016; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02

75-03-11-07. Application for and nontransferability of preschool license.

1. An applicant shall submit an application for a license to the department or its authorized agent. Application must be made in the form and manner prescribed by the department.

2. A license issued under this chapter is nontransferable and valid only for the premises indicated on the license. An application for a new license must be filed upon change of operator or location.

3. The department may not issue more than one in-home registration, self-declaration, or license per residence. A residence means real property that is typically used as a single family dwelling. ~~A provider or operator with more than one in-home registration, self-declaration, or license in a single residence or two or more providers or operators operating under in-home registrations, self-declarations, or licenses out of the same residence prior to January 1, 2011, will be exempt from this subsection until January 1, 2016, after which time all operators will be subject to this subsection.~~

History: Effective December 1, 1981; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-03, 50-11.1-04, 50-11.1-06.2, 50-11.1-07, 50-11.1-08

75-03-11-09. Staffing requirements.

1. The number of staff members and their responsibilities must reflect program requirements and individual differences in the needs of the children enrolled, and may permit mixed-age groups, if necessary. Service personnel engaged in housekeeping and food preparations may not be counted in the child to staff member ratio for periods of time when they are engaged in housekeeping or food preparation.

2. The minimum ratio of staff members responsible for caring for or teaching children to children in preschool must be:

   a. If all children in care are children two years of age to three years of age, one staff member may care for six children, a ratio of .167 in decimal form.

   b. If all children in care are children three years of age to four years of age, one staff member may care for eleven children, a ratio of .09 in decimal form.

   c. If all children in care are children four years of age to five years of age, one staff member may care for thirteen children, a ratio of .077 in decimal form.

   d. If all children in care are children five years of age to six years of age, one staff member may care for sixteen children, a ratio of .063 in decimal form.

   e. There must be at least one director or teacher, in addition to at least one staff member responsible for caring for or teaching children, per group of ten children, if the group includes children two years old.

   f. There must be at least one director or teacher, in addition to at least one staff member responsible for caring for or teaching children, per group of twenty children, if the group includes children three years old.

   g. There must be at least one director or teacher, in addition to at least one staff member responsible for caring for or teaching children, per group of twenty-four children, ages four to six.

3. When there are mixed-age groups, the number of children in each category is multiplied by the corresponding ratio number, converted to decimal form, and carried to the nearest hundredth. To determine the number of staff members responsible for caring for or teaching children necessary at any given time, numbers of staff members for all age categories are

added, and any fractional staff member count is then rounded to the next highest whole number whenever the fractional staff member count amounts to thirty-five hundredths or more. If lower than thirty-five hundredths, the fractional amount is dropped.

4. If a child with special needs is admitted to the preschool, the child's developmental age level must be used in determining the child to staff ratios.

5. The operator shall ensure that a child with special needs requiring more than usual care and supervision has adequate care and supervision without adversely affecting care provided to the other children in the preschool.

~~6. Children using the preschool for a McGruff safe house, a block house, or a certified safe house program during an emergency are not counted under this section.~~

History: Effective December 1, 1981; amended effective July 1, 1984; January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02.1, 50-11.1-04, 50-11.1-08

75-03-11-16. Minimum emergency evacuation and disaster plan.

1. Each operator shall establish and post an emergency disaster plan for the safety of the children in care. Written disaster plans must be developed in cooperation with local emergency management agencies. The plan must include:

   a. Emergency procedures, including the availability of emergency food, water, and first-aid supplies;

   b. ~~What will be done if parents are unable to pick up their child as a result of the emergency; and~~Procedures for evacuation, relocation, shelter-in-place, and lockdown;

   c. ~~What will be done if the preschool has to be relocated or must close as a result of the emergency.~~Communications and reunification with families;

   d. Continuity of operations; and

   e. Accommodations for infants, toddlers, children with disabilities, and children with chronic medical conditions.

2. Fire and emergency evacuation drills must be performed monthly.

History: Effective January 1, 2011; amended effective April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-08

75-03-11-19. Minimum requirements regarding space.

1. Each preschool shall provide adequate indoor and outdoor space for the daily activities of all children for the licensed capacity of the preschool.

2. Adequate space must include a minimum of thirty-five square feet [3.25 square meters] of indoor space per child. Indoor space considered must exclude bathrooms, pantries, passageways leading to outdoor exits, areas occupied by furniture or appliances that children should not play on or under, and space children are not permitted to occupy.

3. There must be a minimum of seventy-five square feet [6.97 square meters] of appropriate outdoor play space per child for the preschool. If available outdoor play space does not

accommodate the licensed capacity of the preschool at one time, the total appropriate outdoor play space available must be no less than the number of children in the largest class or group of the preschool multiplied by seventy-five square feet [6.97 square meters]. Operators who provide seventy-five square feet [6.97 square meters] of separate indoor recreation space per child for the largest class or group are exempt from the outdoor space requirement. The operator shall prepare a written schedule of outdoor or separate indoor recreation space playtime which limits the use of the play area to its capacity, giving each class or group an opportunity to play daily.

4. An operator holding a current license under this chapter on or before January 1, 2022, is exempt from subsection 3 unless the operator's license lapses for more than six months.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-11-22. Records.

1. The operator shall keep a copy of this chapter on the premises of the preschool and shall make it available to staff members at all times.

2. The operator shall maintain the following records:

   a. The child's full name, birth date, current home address, legal names of the child's parents, and ~~the~~current business and personal telephone numbers where they can be reached;

   b. A written statement from the parents authorizing emergency medical care;

   c. Names and telephone numbers of individuals who may assume responsibility for the child if the individuals legally responsible for the child cannot be reached immediately in an emergency;

   d. Names and telephone numbers of individuals authorized to take the child from the preschool;

   e. Verification that the child has received all immunizations appropriate for the child's age, as prescribed by the state department of health, or have on file a document citing that the child is medically exempt or exempt from immunizations based on religious, philosophical, or moral beliefs, unless the child is a drop-in child; and

   f. A current health assessment or a health assessment statement completed by the parent, obtained at the time of initial enrollment of the child which must indicate any special precautions for diet, medication, or activity. This assessment must be completed annually.

3. The operator shall verify the identification of the child through official documentation such as a certified birth certificate, certified school records, passport, or any other documentary evidence the provider considers appropriate proof of identity and shall comply with North Dakota Century Code section 12-60-26.

4. The operator shall ensure that all records, photographs, and information maintained with respect to children receiving child care services are kept confidential, and that access is limited to staff members, the parents, and to the following, unless otherwise protected by law:

a. The authorized agent and department representatives;

b. Individuals having a definite interest in the well-being of the child concerned and who, in the judgment of the department, are in a position to serve the child's interests should that be necessary; and

c. Individuals who possess written authorization from the child's parent. The preschool shall have a release of information form available and shall have the form signed prior to the release of information.

History: Effective December 1, 1981; amended effective January 1, 1987; July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-11-27. Effect of conviction on licensure and employment.

1. An applicant, operator, or director may not be, and a preschool may not employ or allow, in any capacity that involves or permits contact between the teacher, assistant, emergency designee, or staff member and any child cared for by the preschool, an operator, director, staff member, teacher, assistant, or emergency designee, who has been found guilty of, pled guilty to, or pled no contest to:

   a. An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-17-01, simple assault; 12.1-17-01.2, domestic violence; 12.1-17-01.1, assault; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing a police officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 14-09-22, abuse of child; or 14-09-22.1, neglect of child;

   b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or

   c. An offense, other than an offense identified in subdivision a or b, if the department in the case of an applicant, operator, or director, or the operator in the case of a staff member, teacher, assistant, substitute staff member, or emergency designee, determines that the individual has not been sufficiently rehabilitated. An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.

2. The department has determined that the offenses enumerated in subdivision a or b of subsection 1 have a direct bearing on the applicant's, operator's, director's, teacher's, assistant's, substitute staff member's, emergency designee's, or a staff member's ability to serve the public as an operator, director, teacher, assistant, emergency designee, or a staff member.

3. In the case of a misdemeanor offense described in North Dakota Century Code sections 12.1-17-01, simple assault; 12.1-17-03, reckless endangerment; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; in the case of a class B misdemeanor offense described in North Dakota Century Code section 12.1-17-01.2, domestic violence; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction.

4. The operator shall establish written policies and engage in practices that conform to those policies to effectively implement this section, before hiring any directors, staff members, teachers, assistants, substitute staff members, or emergency designees.

5. An operator shall submit an application for a fingerprint-based criminal history record check at the time of application and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The operator shall ensure that each staff member submits an application for a fingerprint-based criminal history record check upon hire and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department ~~may conduct~~shall submit a request to the bureau of criminal investigation for a nationwide name-based criminal history record ~~investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background~~ check.

6. Review of fingerprint-based criminal history record check results.

   a. If an individual disputes the results of the criminal history record check required under this chapter, the individual may request a review of the results by submitting a written request for review to the department within thirty calendar days of the date of the department's memo outlining the results. The individual's request for review must include a statement of each disputed item and the reason for the dispute.

   b. The department shall assign the individual's request for review to a department review panel. An individual who has requested a review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.

   c. The department shall notify the individual of the department's final decision in writing within sixty calendar days of receipt of the individual's request for review.

History: Effective January 1, 1999; amended effective January 2, 2011; April 1, 2014; April 1, 2016; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-06.1, 50-11.1-06.2, 50-11.1-07, 50-11.1-08, 50-11.1-09

75-03-11-28. Child abuse and neglect determinations.

An operator shall ensure safe care for the children receiving services in the preschool.

1. If a ~~services required~~confirmed decision made under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists, indicating that a child has been abused or neglected by any applicant, operator, director, teacher, assistant, staff member, substitute staff member, or emergency

designee, it has a direct bearing on the applicant's or operator's ability to serve the public in a capacity involving the provision of child care and the application or license may be denied or revoked. If a ~~services required~~confirmed determination under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists indicating that any child has been abused or neglected by the applicant, operator, director, teacher, assistant, staff member, substitute staff member, or emergency designee, the applicant or operator shall furnish information satisfactory to the department, from which the department can determine the applicant's, operator's, director's, teacher's, assistant's, staff member's, substitute staff member's, or emergency designee's ability to provide care that is free of abuse and neglect. The department shall furnish the determination of current ability to the applicant or operator.

2. Each applicant, operator, director, teacher, assistant, staff member, substitute staff member, and emergency designee shall complete, and the operator shall submit to the department or its authorized agent, a department-approved authorization for background check form no later than the first day of employment.

History: Effective January 1, 1999; amended effective January 2, 2011; January 1, 2013; April 1, 2014; April 1, 2016; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-04, 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-11-29. Correction of violations.

1. Within three business days of receipt of the correction order, the operator shall notify the parents of each child enrolled in the preschool that a correction order has been issued. In addition to providing notice to the parent of each child, the operator shall post the correction order in a conspicuous location within the preschool until the violation has been corrected or for five days, whichever is longer.

2. Violations noted in a correction order must be corrected:

   a. For a violation of North Dakota Century Code section 50-11.1-02.2; section 75-03-11-04; subsection 13 of section 75-03-11-08; section 75-03-11-09; subsection 4 of section 75-03-11-10; subsection 3 of section 75-03-11-13; subsection 2, 7, or 8 of section 75-03-11-18; or section 75-03-11-23, within twenty-four hours;

   b. For a violation requiring the hiring of a director with those qualifications set forth in section 75-03-11-08.1 or a teacher with those qualifications as set forth in section 75-03-11-08.2, within sixty days;

   c. For a violation that requires an inspection by a state fire marshal or local fire department authority pursuant to section 75-03-11-17, within sixty days;

   d. For a violation that requires substantial building remodeling, construction, or change, within sixty days; and

   e. For all other violations, within twenty days.

3. All periods for correction begin on the date of receipt of the correction order by the operator.

4. The department may grant an extension of additional time to correct violations, up to a period of one-half the original allowable time allotted. An extension may be granted upon application by the operator and a showing that the need for the extension is created by unforeseeable circumstances and the operator has diligently pursued the correction of the violation.

5. The operator shall furnish written notice to the department or its authorized agent upon completion of the required corrective action. The correction order remains in effect until the department or its authorized agent confirms that the corrections have been made.

6. At the end of the period allowed for correction, the department or its authorized agent shall reinspect a preschool that has been issued a correction order. If, upon reinspection, the department or its authorized agent determines that the preschool has not corrected a violation identified in the correction order, the department or its authorized agent shall mail a notice of noncompliance with the correction order by certified mail to the preschool. The notice must specify the violations not corrected and the penalties assessed in accordance with North Dakota Century Code section 50-11.1-07.5.

7. If a preschool receives more than one correction order in a single year, the operator may be referred by the department for consulting services. The consulting services will be offered to assist the operator in maintaining compliance and to avoid future corrective action.

8. Refutation process for a correction order:

   a. An operator may refute a correction order by submitting a refutation request in writing on the form provided by the department within five calendar days of receiving the correction orders.

   b. The department shall respond to written refutations within five business days of receipt.

History: Effective January 1, 1999; amended effective January 2, 2011; January 1, 2013; April 1, 2014; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-07.1, 50-11.1-07.2, 50-11.1-07.3

CHAPTER 75-03-11.1

75-03-11.1-03. Definitions.

The terms used in this chapter have the same meanings as in North Dakota Century Code section 50-11.1-02. In addition, as used in this chapter, unless the context or subject matter otherwise requires:

1. "Application" means all forms the department requires when applying or reapplying for a license.

2. "Aquatic activity" means an activity in or on a body of water, either natural or manmade, including rivers, lakes, streams, swimming pools, and water slides.

~~2.~~3. "Attendance" means the total number of children present at any one time at the facility.

~~3.~~4. "Child with special needs" means a child whose medical providers have determined that the child has or is at risk of chronic physical, developmental, behavioral, or emotional conditions.

~~4.~~5. "Director" means an individual responsible for overseeing the general operation of, and implementing the policies and procedures of, the school-age child care program.

~~5.~~6. "Emergency designee" means an individual designated by the school-age child care program to be a backup staff member for emergency assistance or to provide substitute care.

~~6.~~7. "Medication" means any drug or remedy which is taken internally or orally, inhaled, or applied topically.

~~7.~~8. "Operator" means the individual or governing board who has the legal responsibility and the administrative authority for the operations of a school-age child care program.

~~8. "School-age child care program satellite" means a location used by a licensed school-age child care program other than the building or location listed as the main location on the license.~~

9. "School-age child care program" or "program" means a program licensed to provide early childhood services exclusively to school-age children before and after school, during school holidays, and during summer vacation.

10. "Substitute staff" means staff who work less than thirty-two hours per month and are not regularly scheduled for work.

11. "Supervisor" means any person with the responsibility for organizing and supervising daily program activities.

12. "Volunteer" means an individual who visits or provides an unpaid service or visit, including a firefighter for fire safety week, a practicum student, or a foster grandparent.

History: Effective June 1, 1995; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2016; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02

75-03-11.1-04. Effect of licensing and display of license.

1. The issuance of a license to operate a school-age child care program is evidence of compliance with the standards contained in this chapter and North Dakota Century Code chapter 50-11.1 at the time of licensure.

2. The current license must be displayed prominently in the premises to which it applies.

3. The license must specify the maximum number of children for whom the school-age child care program~~, including any satellite locations,~~ may provide care. The school-age child care program~~, including satellite locations,~~ may not admit a greater number of children than the license allows.

History: Effective June 1, 1995; amended effective January 1, 1999; January 1, 2011; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-03, 50-11.1-04

75-03-11.1-07. Application for and nontransferability of school-age child care program license.

1. An applicant shall submit an application for a license to the department or its authorized agent. Application must be made in the form and manner prescribed by the department.

2. A license issued under this chapter is nontransferable and is valid only for the premises indicated on the license.

3. An application for a new license must be filed upon change of operator or location.

4. The department may not issue more than one in-home registration, self-declaration, or license per residence. A residence means real property that is typically used as a single family dwelling. ~~A provider or operator with more than one in-home registration, self-declaration, or license in a single residence or two or more providers or operators operating under in-home registrations, self-declarations, or licenses out of the same residence prior to January 1, 2011, will be exempt from this subsection until January 1, 2016, after which time all operators will be subject to this subsection.~~

History: Effective June 1, 1995; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-03, 50-11.1-04, 50-11.1-06.2, 50-11.1-07, 50-11.1-08

75-03-11.1-08. Duties of school-age child care program operator.

The operator of a school-age child care program is responsible for compliance with the requirements set forth in this chapter and North Dakota Century Code chapter 50-11.1. The operator:

1. Shall designate a qualified director, shall delegate appropriate duties to the director, and shall:

   a. Ensure that the director is present at the school-age child care program at least sixty percent of the time that the program is open. If the ~~operation~~operator has ~~satellite sites, the~~legal responsibility and the administrative authority over two or more school-age child care programs, a director shared between two or more school-age child care programs shall be present a combined total of sixty percent of the school-age ~~program's~~programs' hours of operation.

   b. Ensure that when the director and designated acting director are not present at the program, a person who meets the qualifications of a supervisor is on duty.

   c. Ensure that the individual designated as an acting director for longer than thirty consecutive days meets the qualifications of a school-age child care program director.

d. Ensure that if the operator of the school-age child care program is also the director, that the operator meets the qualifications of a director set forth in section 75-03-11.1-08.1;

2. Shall apply for a license for the school-age child care program;

3. Shall provide an environment that is physically and socially adequate for children;

4. Shall notify the department or its authorized agent of any major changes in the operation of, or in the ownership or governing body of the school-age child care program, including staff member changes;

5. Shall ensure that the school-age child care program carries liability insurance against bodily injury and property damage;

6. Shall formulate written policies and procedures for the operation of the school-age child care program relating to:

   a. Hiring practices and personnel policies for all staff members;

   b. Methods for obtaining references and employment histories of staff members;

   c. Methods of conducting staff member performance evaluations;

   d. Children's activities, care, and enrollment;

   e. The responsibilities and rights of staff members and parents;

   f. An explanation of how accidents and illnesses may be handled;

   g. The methods of developmentally appropriate discipline and guidance techniques that are to be used;

   h. The process for a parent or staff member to report a complaint, a suspected licensing violation, and suspected child abuse or neglect;

   i. The care and safeguarding of personal belongings brought to the child care center by a child or by another on a child's behalf;

   j. Procedure for accountability when a child fails to arrive as expected at the school-age child care program; and

   k. Transportation procedures, if the operator provides transportation;

7. Shall maintain enrollment, attendance, health, and other required records;

8. May select an emergency designee;

9. Shall maintain necessary information to verify staff member qualifications and to ensure safe care for the children in the school-age child care program;

10. Shall inform parents of enrolled children and other interested parties about the school-age child care program's goals, policies, procedures, and content of the program;

11. Shall advise parents of enrolled children of the school-age child care program's service fees, operating policies and procedures, location, and the name, address, and telephone number of the operator and the director;

12. Shall provide parents of enrolled children information regarding the effective date, duration, scope, and impact of any significant changes in the school-age child care program's services;

13. Shall ensure that the school-age child care program is sufficiently staffed at all times to meet the child to staff ratios for children in attendance and that no more children than the licensed capacity are served at any one time;

14. Shall ensure that the school-age child care program has sufficient qualified staff members available to substitute for regularly assigned staff who are sick, on leave, or who are otherwise unable to be on duty;

15. Shall ensure that there are signed written agreements with the parents of each child that specify the fees to be paid, methods of payment, and policies regarding delinquency of fees;

16. Shall provide parents with unlimited access and opportunities for parents to observe their children while in care and provide parents with regular opportunities to meet with staff members responsible for caring for or teaching children before and during enrollment to discuss their children's needs. Providing unlimited access does not prohibit a school-age child care program from locking its doors when children are in care;

17. Shall provide parents, upon request, with progress reports on their children;

18. Shall ensure that provisions are made for safe arrival and departure of all children, and a system is developed to ensure that children are released only as authorized by the parent;

19. Shall develop a system to ensure the safety of children whose parents have agreed to allow them to leave the program without supervision, which must include, at a minimum:

    a. Written permission from the parents allowing a child to leave the program without supervision; and

    b. Consistent sign-out procedures for released children;

20. Shall report immediately, as a mandated reporter, any suspected child abuse or neglect as required by North Dakota Century Code chapter 50-25.1;

21. Shall meet the qualifications of the director set forth in section 75-03-11.1-08.1 if the operator of the school-age child care program is also the director;

22. Shall ensure that staff members responsible for caring for or teaching children under the age of eighteen are directly supervised by an adult staff member; and

23. Shall report to the department or its authorized agent within twenty-four hours:

    a. The death or serious accident or illness requiring hospitalization of a child while in the care of the program or attributable to care received in the program;

    b. An injury to any child which occurs while the child is in the care of the program and which requires medical treatment;

    c. Poisonings or errors in the administration of medication;

    d. Closures or relocations of child care programs due to emergencies; and

    e. Fire that occurs or explosions that occur in or on the premises of the school-age child care program.

24. Shall ensure that each child is released only to the child's parent, legal custodian, guardian, or an individual who has been authorized by the child's parent, legal custodian, or guardian.

History: Effective June 1, 1995; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; April 1, 2016; April 1, 2018; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-11.1-09. Staffing and group size requirements.

1. The number of staff members responsible for caring for or teaching children and their responsibilities must reflect program requirements and individual differences in the needs of the children enrolled, and may permit mixed groups, if necessary. Service personnel engaged in housekeeping and food preparation may not be counted in the child to staff ratio for periods of time when they are engaged in housekeeping or food preparation. The operator shall ensure that a child with special needs requiring more than usual care and supervision has adequate care and supervision without adversely affecting care provided to the other children in the school-age child care program.

2. Staffing requirements and maximum group size.

   a. The operator of a school-age child care program shall ensure that the program is sufficiently staffed at all times to meet the child to staff ratios for children in attendance, and that no more children than the licensed capacity are served at one time. ~~The minimum ratio of staff members responsible for caring for or teaching children to children and maximum group size of children must be:~~

      ~~(1) For one to fourteen children, one staff member; and~~

      ~~(2) For fifteen children or more, two staff members, with a maximum group size of thirty children.~~

      ~~(3) The provisions in this subsection relating to maximum group size do not apply to school-age child care program operators licensed prior to January 1, 1999, if those operators are otherwise qualified to operate a school-age child care program. Any school-age child care program operator who discontinues operation of the school-age child care program under a valid license, or who fails to renew the license when it expires, will not be exempt from the requirements relating to maximum group size if the operator subsequently reapplies for a school-age child care program license. This exemption for operators licensed prior to January 1, 1999, will end on January 1, 2015, after which time all operators will be subject to the requirements of this subsection~~One staff member may care for or teach a maximum of twenty children, with a maximum group size of forty children.

   b. A staff member may be counted in the required ratio only for the time the staff member is directly responsible for a group of children.

   c. The director shall ensure that staff members responsible for caring for or teaching children and children under the age of eighteen are supervised by an adult at all times while in the school-age child care program.

~~3. Children using the licensed program for a McGruff safe house, a block house, or a certified safe house program during an emergency are not counted under this section.~~

History: Effective June 1, 1995; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-02.1, 50-11.1-04, 50-11.1-08

75-03-11.1-16. Minimum emergency evacuation and disaster plan.

1. The operator shall establish and post an emergency disaster plan for the safety of the children in care. The operator shall develop written disaster plans in cooperation with local emergency management agencies. The plan must include:

   a. Emergency procedures, including the availability of emergency food, water, and first-aid supplies;

   b. ~~What will be done if parents are unable to pick up their child as a result of an emergency; and~~Procedures for evacuation, relocation, shelter-in-place, and lockdown;

   c. ~~What will be done if the school-age child care program has to be relocated or must close as a result of the emergency.~~Communications and reunification with families;

   d. Continuity of operations; and

   e. Accommodations for infants, toddlers, children with disabilities, and children with chronic medical conditions.

2. Fire and emergency evacuation drills must be performed monthly.

History: Effective June 1, 1995; amended effective January 1, 1999; January 1, 2011; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-08

75-03-11.1-22. Records.

1. The operator shall keep a copy of this chapter on the premises of the school-age child care program ~~and all satellite sites~~ and shall make it available to staff members at all times.

2. The operator shall maintain the following records and shall keep copies at the school age program premises ~~and satellite sites~~ where the child is enrolled:

   a. The child's full name, birth date, and current home address;

   b. Legal names of the child's parents, and ~~the~~current business and personal telephone numbers where they can be reached;

   c. Names and telephone numbers of individuals who may assume responsibility for the child if the individual legally responsible for the child cannot be reached immediately in an emergency;

   d. A written statement from the parents authorizing emergency medical care;

   e. Names and telephone numbers of individuals authorized to take the child from the school-age child care program; and

   f. A current health assessment or a health assessment statement completed by the parent, obtained at the time of initial enrollment of the child which must indicate any special precautions for diet, medication, or activity. This assessment must be completed annually.

3. The operator shall record and verify the identification of the child through official documentation such as a certified birth certificate, certified school records, passport, or any other documentary evidence the operator considers appropriate proof of identity and shall comply with North Dakota Century Code section 12-60-26.

4. The operator shall ensure that all records, photographs, and information maintained with respect to children receiving child care services are kept confidential, and that access is limited to staff members, the parents, and to the following, unless protected by law:

   a. The authorized agent and department representatives;

   b. Individuals having a definite interest in the well-being of the child concerned and who, in the judgment of the department, are in a position to serve the child's interests should that be necessary; and

   c. Individuals who possess written authorization from the child's parent. The school-age child care program shall have a release of information form available and shall have the form signed prior to the release of information.

History: Effective June 1, 1995; amended effective January 1, 1999; January 1, 2011; April 1, 2016; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-11.1-27. Effect of conviction on licensure and employment.

1. An applicant, operator, director, or supervisor may not be, and a school-age child care program may not employ or allow, in any capacity that involves or permits contact between the emergency designee, substitute staff member, or staff member and any child cared for by the school-age child care program, an operator, emergency designee, substitute staff member, director, supervisor, or staff member who has been found guilty of, pled guilty to, or pled no contest to:

   a. An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-17-01, simple assault; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing a police officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 14-09-22, abuse of child; or 14-09-22.1, neglect of child;

   b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or

   c. An offense, other than an offense identified in subdivision a or b, if the department in the case of a school-age child care program applicant, operator, director, or supervisor, or the school-age child care program operator in the case of an emergency designee, substitute staff member, or staff member, determines that the individual has not been sufficiently rehabilitated. An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.

2. The department has determined that the offenses enumerated in subdivisions a and b of subsection 1 have a direct bearing on the applicant's, operator's, emergency designee's, substitute staff member's, director's, supervisor's, or staff member's ability to serve the public as an operator, emergency designee, substitute staff member, director, supervisor, or staff member.

3. In the case of a misdemeanor offense described in North Dakota Century Code sections 12.1-17-01, simple assault; 12.1-17-03, reckless endangerment; 12.1-17-06, criminal coercion; 12.1-17-07, harassment; 12.1-17-07.1, stalking; in the case of a class B misdemeanor offense described in North Dakota Century Code section 12.1-17-01.2, domestic violence; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction.

4. The operator shall establish written policies, and engage in practices that conform to those policies, to effectively implement this section before hiring any staff member.

5. An operator shall submit an application for a fingerprint-based criminal history record check at the time of application and ~~every~~within five years ~~after~~from the date of initial approval and at least once every five years thereafter. The operator shall ensure that each staff member submits an application for a fingerprint-based criminal history record check upon hire and ~~every~~within five years ~~after~~form the date of initial approval and at least once every five years thereafter. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department ~~may conduct~~shall submit a request to the bureau of criminal investigation for a nationwide name-based criminal history record ~~investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background~~ check.

6. Review of fingerprint-based criminal history record check results.

   a. If an individual disputes the results of the criminal history record check required under this chapter, the individual may request a review of the results by submitting a written request for review to the department within thirty calendar days of the date of the department's memo outlining the results. The individual's request for review must include a statement of each disputed item and the reason for the dispute.

   b. The department shall assign the individual's request for review to a department review panel. An individual who has requested a review may contact the department for an informal conference regarding the review any time before the department has issued its final decision.

   c. The department shall notify the individual of the department's final decision in writing within sixty calendar days of receipt of the individual's request for review.

History: Effective June 1, 1995; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; April 1, 2014; April 1, 2016; April 1, 2018; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-06.1, 50-11.1-06.2, 50-11.1-07, 50-11.1-08, 50-11.1-09

75-03-11.1-28. Child abuse and neglect decisions.

An operator shall ensure safe care for the children receiving services in the school-age child care program.

1. If a ~~services-required~~confirmed decision made under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists, indicating that a child has been abused or neglected by an applicant, operator, director, supervisor, emergency designee, substitute staff member, or staff member, that decision has a direct bearing on the applicant's or operator's ability to serve the public in a capacity involving the provision of child care and the application or license may be denied or revoked. If a ~~services-required~~confirmed determination under North Dakota Century Code chapter 50-25.1 or a similar finding in another jurisdiction which requires proof of substantially similar elements exists indicating that a child has been abused or neglected by the applicant, operator, director, supervisor, emergency designee, substitute staff member, or staff member, the applicant or operator shall furnish information satisfactory to the department from which the department can determine the applicant's, operator's, director's, supervisor's, emergency designee's, substitute staff member's, or staff member's ability to provide care that is free of abuse and neglect. The department shall furnish the determination of current ability to the applicant or operator.

2. Each applicant, operator, director, supervisor, emergency designee, substitute staff member, and staff member shall complete, and the operator shall submit to the department or its authorized agent, a department-approved authorization for background check form no later than the first day of employment.

History: Effective June 1, 1995; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; April 1, 2014; April 1, 2016; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-04, 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-04, 50-11.1-07, 50-11.1-08

75-03-11.1-29. Correction of violations.

1. Within three business days of the receipt of a correction order, the operator shall notify the parents of each child receiving care at the school-age child care program that a correction order has been issued. In addition to providing notice to the parent of each child, the operator shall post the correction order in a conspicuous location within the school-age child care program ~~and applicable satellite location~~ until the violation has been corrected or for five days, whichever is longer.

2. Violations noted in a correction order must be corrected:

   a. For a violation of North Dakota Century Code section 50-11.1-02.2; subsection 13 of section 75-03-11.1-08; subsection 4 or 5 of section 75-03-11.1-08.4; section 75-03-11.1-09; subsection 2, 3, 10, or 20 of section 75-03-11.1-18; or section 75-03-11.1-23, within twenty-four hours.

   b. For a violation requiring the hiring of a school-age child care program director with those qualifications set forth in section 75-03-11.1-08.1 or a child care supervisor with those qualifications set forth in section 75-03-11.1-08.3, within sixty days.

   c. For a violation that requires an inspection by a state fire marshal or local fire department authority pursuant to section 75-03-11.1-17, within sixty days.

   d. For a violation that requires substantial building remodeling, construction, or change, within sixty days.

e. For all other violations, within twenty days.

3. All time periods for correction begin on the date of receipt of the correction order by the operator.

4. The department may grant an extension of additional time to correct violations, up to a period of one-half the original allowable time allotted. An extension may be granted upon application by the operator and a showing that the need for the extension is created by unforeseeable circumstances and the operator has diligently pursued the correction of the violation.

5. The operator shall furnish a written notice to the department or its authorized agent upon completion of the required corrective action. The correction order remains in effect until the department or its authorized agent confirms that the corrections have been made.

6. At the end of the period allowed for correction, the department or its authorized agent shall reinspect a school-age child care program that has been issued a correction order. If, upon reinspection, the department or its authorized agent determines that the school-age child care program has not corrected a violation identified in the correction order, the department or its authorized agent shall mail a notice of noncompliance with the correction order by certified mail to the school-age child care program. The notice must specify the violations not corrected and the penalties assessed in accordance with North Dakota Century Code section 50-11.1-07.5.

7. If a school-age child care program receives more than one correction order in a single year, the department or authorized agent may refer the school-age child care program for consulting services to assist the operator in maintaining compliance to avoid future corrective action.

8. Refutation process for a correction order:

a. An operator may refute a correction order by submitting a refutation request in writing on the form provided by the department within five calendar days of receiving the correction order.

b. The department shall respond to written refutations within five business days of receipt.

History: Effective June 1, 1995; amended effective July 1, 1996; July 1, 1996, amendments voided by the Administrative Rules Committee effective August 24, 1996; amended effective January 1, 1999; January 1, 2011; January 1, 2013; April 1, 2014; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-11.1-08
Law Implemented: NDCC 50-11.1-01, 50-11.1-07.1, 50-11.1-07.2, 50-11.1-07.3

CHAPTER 75-03-14.1
SHELTER CARE PROGRAM CERTIFICATION

75-03-14.1-01. Definitions.

1. "Agency" means the entity applying for or receiving a shelter care program certification.

2. "Attendant care" means a site for juveniles who are cited or citable by law enforcement and need constant short-term supervision on a preadjudicatory basis.

3. "Incident" means an event involving the resident and law enforcement and includes runaway status, criminal activity, behavior resulting in harm to others, harassment, violence, and discrimination.

4. "Resident" means a child age ten to eighteen years old in need of temporary safe out-of-home placement.

5. "Sentinel event" means a serious injury or trauma to a resident, attempted suicide by the resident, death of a resident, or inappropriate sexual contact involving a resident.

6. "Shelter care home" means a licensed foster home that has agreed to provide temporary shelter care to a resident in need of emergency placement and is available twenty-four hours per day.

7. "Shelter care program" means a nonsecure permanent dwelling run by an agency with certification obtained by the department, where employees offer safe shelter, food, and structured routine and is available twenty-four hours a day to a resident in need of emergency placement, not to exceed seven days, unless otherwise approved by the department.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-02. Shelter care program certification.

1. An agency may not apply for a shelter care program certification until the department has reviewed the need for additional shelter care programs. To enable the department to make a determination of need for a new shelter care program, the potential applicant shall submit an initial request for application, including the following documentation and information to the department:

a. The number, gender, and age range of the residents to be served;

b. The employee staffing, including a list of full-time and part-time positions by job titles and description;

c. A description of the proposed program;

d. A proposed budget; and

e. The geographic location of the shelter care program.

2. Upon receipt of initial request for application, the department shall:

a. Review the detailed plan for the operation proposed by the agency;

b. Ask for additional materials or information necessary for evaluation of need purposes;

c. Respond in writing within thirty days of receipt of all required information from the potential agency;

d. Send written notice of determination of need. The notice must state the specific reason for the determination. If the department determines there is need for additional shelter care program beds, the notice must be accompanied by an authorization for the agency to apply for certification to operate a shelter care program; and

e. Inform the potential agency of what is required to move forward with the application process.

3. A shelter care home may not apply for a shelter care program certification as it does not qualify as an agency.

4. If an agency receives an authorization to apply for a shelter care program certification, the agency shall submit its application in the form and manner prescribed by the department.

5. Shelter care program certification applications must include the following documentation or information:

a. A detailed plan for the operation of the shelter care program;

b. Physical location and address of the shelter care program;

c. A copy of the shelter care program floor plan with dedicated sleeping spaces;

d. A list of current employees, background check dates, annual child abuse and neglect checks, and full-time and part-time status and job titles;

e. A copy of the shelter care program's general comprehensive liability insurance;

f. A copy of the shelter care program's vehicular insurance for transportation purposes; and

g. Inspection reports.

6. Shelter care program certification is nontransferable and is valid only on the premises and for the specified number of residents indicated on the shelter care program certification.

7. An agency shall submit a new application for a shelter care program certification when there is a change in ownership.

8. Shelter care program certification is available for a maximum period of two years.

9. Shelter care program certification requires an agency to submit an annual application to the department, which will initiate an annual onsite visit each year.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-03. Shelter care program rate.

The department shall establish the fee for service for shelter care programs. The shelter care program shall enter a financial contract with the department, human service zone, tribal social service, or agency case planning for the prospective resident.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-04. Shelter care program operations.

The shelter care program shall:

1. Ensure the shelter care program is funded, staffed, and equipped in a manner required for the provision of services;

2. Provide the most recent fiscal year end financial record to the department, upon request;

3. Employ a qualified supervisor of shelter care program operations to oversee program operations, policy, and employee performance;

4. Provide twenty-four-hour supervision for all residents residing in the shelter care program;

5. Provide access to an on-call twenty-four-hour crisis line by which employees may be reached in the event of an emergency placement;

6. Establish policy and procedures specific to operations of a shelter care program, including:

    a. Policy defining residents served in the shelter care program. The shelter care program shall define the parameters of each population of residents served and allow adequate space to properly separate residents who are children in need of service or protection from children who engage in delinquent acts;

    b. Policy addressing supervision requirements of residents by employees during each shift, to include:

        (1) Awake hours; and

        (2) Overnight hours, requiring awake employees to check on residents at a minimum of every fifteen minutes, and more frequently if the acuity of the resident demands greater supervision;

    c. Nondiscrimination policy;

    d. Medication dispensing;

    e. Resident search criteria;

    f. At-risk behaviors and protocol surrounding accepting and caring for a resident who has been drinking or using drugs; and

g. Process for contacting law enforcement or emergency contacts, as needed;

7. Establish disaster planning, including protocol for when the shelter care program experiences:

a. Power outage;

b. Fire;

c. Winter blizzard conditions;

d. Flood; or

e. Tornado;

8. Establish a policy to ensure proper and efficient procedure in the event the shelter care program would cease operations, including:

a. Notification to the department at least sixty days before closure;

b. Notification to community partners at least thirty days before closure; and

c. Identification of a depository in North Dakota to maintain the retention of the shelter care program's fiscal, employee, and resident files; and

9. Notify the department, in writing, of the corrective action the shelter care program has taken, or plans to take, to comply with any resulting recommendations from the institutional child protection team. The shelter care program shall make assurances that revised practice will reduce the risk of the incident or sentinel event reoccurring. The shelter care program shall respond within thirty days of receiving written notification of the indicated determination.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-05. Employees.

1. The shelter care program clearly shall define, in writing, the roles and responsibilities of the employees assuring the health and safety of the resident and coordination of the resident's safe return to the custodian, parent, or guardian.

2. The shelter care program shall establish policy and procedures for employee roles and responsibilities, including:

a. Initial background checks;

b. Annual child abuse and neglect checks;

c. Job descriptions; and

d. Assigned shifts and protocol for shift changes.

3. The shelter care program shall make an offer of employment to an employee conditional upon the individual's consent to complete required background checks. While awaiting the results of the required background check, the shelter care program may choose to provide training and orientation to an employee. However, until the approved background check results are placed in the employee file, the employee only may have supervised interaction with residents.

4. A shelter care program shall hire a supervisor of shelter care program operations and the supervisor:

a. Must have a bachelor's degree in business or public administration, social work, behavioral science, or a human services field and have two years of related work experience in administration;

b. Shall ensure the shelter care program has written policy and procedure;

c. Shall oversee daily operations;

d. Shall administer admission and discharge criteria; and

e. Shall provide adequate supervision to all employees.

5. A shelter care program shall hire employees and the employees:

a. Must be at least twenty years of age;

b. Must have a high school diploma or equivalent;

c. Shall assure and be devoted to the health and safety of each resident in placement and coordination of the resident's safe return to the custodian, parent, or guardian;

d. Shall achieve the competencies necessary to meet the needs and engage appropriately with each resident in placement;

e. Shall prepare meals;

f. Shall organize activities and structure a daily routine for the resident in placement; and

g. Shall document a daily activity log to share with the custodian, parent, or guardian.

6. A shelter care program shall ensure there are adequate employees working to meet the minimum employee-to-resident ratios, including:

a. A rotating on-call employee who must be available twenty-four hours a day, seven days a week; and

b. Regardless of awake or overnight hours, the shelter care program must have no fewer than one employee for each six residents in placement.

7. The shelter care program shall maintain a file on each employee; including:

a. Employment application, including a record of previous employment;

b. Results of an initial fingerprint-based criminal background check and subsequent background checks as determined necessary;

c. Results of the initial child abuse or neglect record, and annually thereafter;

d. A job description specifying the employee's roles and responsibilities;

e. A statement signed by the employee acknowledging the confidentiality policy;

f. Documentation of an annual training record detailing the date, topic, and length of presentation; and

g. Evidence of the employee having read and received a copy of the law and shelter program procedures requiring the reporting of suspected child abuse and neglect, initially upon hire and annually thereafter.

8. The shelter program shall adopt a policy regarding the retention of employee files.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-06. Employee training.

Shelter care programs shall provide training to employees which includes:

1. Initial employee orientation topics of:

   a. Overall general shelter care program policy and procedures;

   b. Resident's emotional and physical needs;

   c. Resident's daily routine, activities, transportation, and meals;

   d. Expected employee conduct toward residents;

   e. Expected resident conduct while residing onsite;

   f. Shelter care program's behavior management, including de-escalation techniques;

   g. Protocol for observing and reporting resident behavior;

   h. Protocol for identifying and reporting of child abuse and neglect, including completion of child abuse and neglect mandated reporter training;

   i. Suicide prevention, including identifying signs and shelter program response;

   j. Fire safety and evacuation procedures;

   k. Disaster plan;

   l. Resident search procedures and policies;

   m. Confidentiality standards;

   n. Protocol for reporting a runaway;

   o. Protocol for emergency medical procedures;

   p. Protocol for shelter care program security and access to visitors; and

   q. Interest in becoming certified for medication distribution;

2. Required certification trainings, upon hire and updated accordingly thereafter, including:

   a. First-aid training; and

   b. Cardiopulmonary resuscitation training;

3. Institutional child abuse and neglect training, which includes how employees are to report incidents and sentinel events and what to do in the case of an institutional child abuse and neglect indicated determination; and

4. Other trainings determined necessary by the shelter care program to provide safe care to a resident.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-07. Buildings and grounds.

A shelter care program shall comply with all state, county, and local building, zoning, safety, and sanitation laws, codes, and ordinances. The shelter care program must have:

1. An inspection by the local fire department or the state fire marshal's office as determined necessary for the dwelling to ensure fire safety;
2. A proper fire extinguisher on each floor;
3. One smoke detector in each space determined necessary by the local fire department or fire marshal;
4. One carbon monoxide detector on each floor;
5. A clean, comfortable, sanitary, and safe dwelling with adequate lights, heat, and ventilation;
6. Furnishings suitable to the needs of all residents;
7. Recreational space and equipment that is safe, functional, and available for all residents;
8. One centrally located living room for the informal use of residents;
9. A dining room area large enough to accommodate the number of residents served;
10. A private space for individual interviewing and case meetings for ongoing program activities;
11. Sleeping accommodations that ensure:
    a. At least one bed for each resident;
    b. Clean linens and bedding for each resident;
    c. Appropriate privacy and separation of resident sleep space dependent on age and gender;
    d. Individual storage space to accommodate the resident's clothing and other personal belongings; and
    e. For bedrooms, at least one window that opens to the outside. A bedroom located in a basement with over half its outside walls below grade and no door opening directly to the outside may not be used for sleeping, unless the bedroom space has at least one egress window;
12. One complete bathroom to include a toilet, sink, and a tub or shower;
13. A kitchen area and food storage that meets the standards prescribed by the state department of health for food and beverage establishments. A shelter care program annually shall document compliance with these standards and provide documentation to the department;
14. Storage to lock all medications;
15. Storage to lock all toxic cleaning supplies, aerosols, chemical, agricultural, and ground maintenance chemicals, pesticides, and other poisons;

16. Storage to lock shampoos, body wash, hair products, and hand sanitizers when not distributed to resident for use. Shelter care programs shall distribute shampoos, body wash, hair products, and hand sanitizers in a limited quantity;

17. Policy and signs that address the prohibition of the use of alcohol on the premises and prohibition of the use of tobacco and vaping within the shelter care program facilities and vehicles and in the line of sight of the residents;

18. Policy and signs that prohibit firearms in program or living areas on the premises. Firearms kept at any other location on the shelter care program premises must be stored in a locked and secure area; and

19. Policy that all pet inoculations comply with local and state requirements.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-08. Admissions and discharges.

1. A shelter care program must have written resident admission and discharge policies and procedures that describe:

   a. The eligibility and criteria for admitting a resident;

   b. Procedures for completing initial screenings upon admission, including:

      (1) Mental health screening; and

      (2) Basic personal health screening, which may include documenting height, weight, and identification of any distinct markings, such as resident's birthmark, tattoos, bruises, or cuts;

   c. Procedure for discharge planning with the custodian, parent, or guardian upon date of admission; and

   d. Procedures for accepting an extension request.

2. The shelter care program shall provide documentation of a discharge report to the custodian, parent, or guardian which includes:

   a. Date of discharge;

   b. Detailed location and contact of where the resident is being discharged to; and

   c. Details of services or community referrals made by the shelter care program.

3. A shelter care program placement may not exceed seven days from date of admission unless an extension request is approved by the department. The shelter care program supervisor shall submit extension requests to the department for approval. The department may approve an extension request for up to an additional seven days upon such terms as the department may prescribe. A refusal to grant an extension request is not subject to appeal.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4, 50-11-03.2

75-03-14.1-09. Resident files.

Upon placement, a resident's file is confidential and must be protected from unauthorized examination unless permitted or required by law or regulation. The shelter care program shall adopt a policy regarding the retention of the resident file. The resident file must include:

1. Admissions application, including:

    a. Resident's full name;

    b. Date of birth;

    c. Name and contact information of the referral;

    d. Name and contact information of the resident's custodian, if applicable;

    e. Name and contact information of the resident's parent or guardian;

    f. Name and dosage of current medication; and

    g. Written consent to:

        (1) Complete initial screenings;

        (2) Provide first aid;

        (3) Transport to emergency room, if applicable; and

        (4) Distribute medications;

2. Resident photo;

3. Documentation of a daily activity log detailing the resident's time in the shelter care program; and

4. Documentation of a discharge report.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4, 50-06-15, 50-11-05

75-03-14.1-10. Correction orders.

1. The shelter care program shall comply with all sections of this chapter, in order to maintain certification from the department. The department may issue a correction order if the shelter care program violates any provision of this chapter.

2. The department may require immediate correction of a violation that threatens the life or safety of a resident and twenty days for all other violations.

3. Upon written request by the shelter care program and upon showing need for an extension created by circumstances beyond the control of the shelter care program and documentation that the shelter care program has diligently pursued correction of the violation, the department may grant extensions of time to correct violations.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-11. Incident and sentinel event reporting.

1. The shelter care program must have written policy outlining the documentation of incidents and sentinel events that occur while the resident is in placement. The policy must include:

   a. Reporting procedures of an incident as an unplanned occurrence that resulted or could have resulted in injury to people or damage to property, specifically involving the general public, residents, or employees; and

   b. Reporting procedures of a sentinel event as an unexpected occurrence involving death or serious physical or psychological injury not related to the natural course of a resident's illness or underlying condition, including any process variation for which a reoccurrence would carry a significant chance of a serious adverse outcome.

2. The shelter care program shall document the incident or sentinel event in the resident's file within twenty-four hours and notify the resident's custodian, parent, or guardian immediately or within twelve hours.

3. The shelter care program shall maintain a log of written reports of incidents and sentinel events involving residents.

4. The shelter care program shall provide employees time at the beginning of each shift to be informed of or review reports of incidents and sentinel events occurring since the employee's last shift.

5. The shelter care program shall provide employees and residents time to debrief the incident and sentinel event with supervisors.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-12. Denial, revocation, and appeal rights.

1. The department may deny or revoke a shelter care program certification if the:

   a. Application contains fraudulent information, an untrue representation, or is incomplete;

   b. Agency or shelter care program has violated any applicable provision of North Dakota Century Code chapters 50-06 and 50-11 or fails to meet the minimum requirements of this chapter; or

   c. Shelter care program fails to ensure the required shelter care program's policies under this chapter are enforced and complied with.

2. If the department decides to deny or revoke a shelter care program certification, the department shall notify the shelter care program in writing of its decision and the reasons for the denial or revocation. Upon receipt of notification of revocation, the shelter care program may not accept any additional residents and immediately shall make arrangements in cooperation with each current resident's custodian, parent, or guardian for alternative placement.

3. An agency or shelter care program may appeal a decision to deny or revoke a shelter care program certification by filing a written appeal with the department within thirty days of written notice of such a decision. Upon receipt of a timely appeal, an administrative hearing must be conducted in the manner provided in chapter 75-01-03. During an appeal, the shelter care program may not have residents.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

75-03-14.1-13. Variance.

Upon written application and good cause shown to the satisfaction of the department, the department may grant a variance regarding a specific provision of this chapter upon such terms as the department may prescribe, except no variance may permit or authorize a danger to the health or safety of any resident cared for by the shelter care program and no variance may be granted except at the discretion of the department. A shelter care program shall submit a written request to the department justifying the variance. A refusal to grant a variance is not subject to appeal.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-06-01.4

CHAPTER 75-03-23

75-03-23-01. Definitions.

The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 50-06.2. In addition, as used in this chapter:

1. "Activities of daily living" means the daily self-care personal activities that include bathing, dressing or undressing, eating or feeding, toileting, continence, transferring in and out of bed or chair or on and off the toilet, and mobility inside the home.

2. "Adaptive assessment" means an evaluation to identify adaptive devices, equipment, or modifications that enhance the independence and functional capabilities of an individual who may otherwise be unable to remain in the individual's home.

3. "Aged" means sixty-five years of age or older.

4. "Client" means an individual who meets the eligibility requirements and is receiving services reimbursed under North Dakota Century Code chapter 50-06.2 or this chapter.

5. "Congenital disability" means a disability that exists at birth or shortly thereafter, and is not attributable to a diagnosis of either mental retardation or a closely related condition of mental retardation.

6. "Department" means the North Dakota department of human services.

7. "Designee" means a person that enrolls as a qualified service provider to provide case management services for the Medicaid waiver program.

8. "Disability due to trauma" means a disability that results from an injury or assault to the body by an external force.

9. "Disability that is acquired" means a disability that results from an assault that occurs internally within the body.

10. "Disabled" means under age sixty-five with a congenital disability, a disability due to trauma, or a disability that is acquired.

11. "Functional assessment" means an instrument used to record basic demographic and medical information about an individual, including age, date of birth, spoken language, marital status, individuals residing with, emergency contacts, medical resources, health care coverage, and source and reason for referral; and to secure measurable information regarding:

    a. Physical health;

    b. Cognitive and emotional functioning;

    c. Activities of daily living;

    d. Instrumental activities of daily living;

    e. Informal supports;

    f. Need for twenty-four-hour supervision;

    g. Social participation;

    h. Physical environment;

i. Financial resources;

j. Adaptive equipment;

k. Environmental modification; and

l. Other information about the individual's condition not recorded elsewhere.

12. "Functional impairment" means the inability to perform, either by oneself or with adaptive aids or with human help, specific activities of daily living or instrumental activities of daily living.

13. "Home and community-based services" means the array of services under the SPED program and Medicaid waiver defined in the comprehensive human service plan and the other services the department determines to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care.

14. "Institution" means a hospital, swing bed facility, nursing facility, or other provider-operated living arrangement receiving prior approval from the department.

15. "Instrumental activities of daily living" means activities requiring cognitive ability or physical ability, or both. Instrumental activities of daily living include preparing meals, shopping, managing money, housework, laundry, taking medicine, transportation, using the telephone, and mobility outside the home.

16. "Medicaid waiver program" means the federal Medicaid waiver for the aged and disabled program, as defined in subpart G of 42 CFR 441, under which the department is authorized to provide specific home and community-based services to aged and disabled persons who are at risk of being institutionalized.

17. "Natural supports" means an informal, unpaid caregiver that provides care to an applicant or client.

18. "Sanction" means an action taken by the department against a qualified service provider for noncompliance with a federal or state law, rule, or policy, or with the provisions of the Medicaid provider agreement.

~~18.~~19. "Service fee" means the amount a SPED client is required to pay toward the cost of the client's SPED services.

~~19.~~20. "Service payment" means the payment issued by the department to a qualified service provider for the provision of authorized home and community-based services to eligible aged and disabled persons.

~~20.~~21. "SPED program" means the service payments for elderly and disabled program, a state program which authorizes the department to reimburse qualified service providers for the provision of covered home and community-based services to eligible aged and disabled individuals.

~~21.~~22. "SPED program pool" means the list maintained by the department which contains the names of clients for whom SPED program funding is available when the clients' names are transferred from the SPED program pool to SPED program active status.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; January 1, 2018; January 1, 2020; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-02. Eligibility criteria.

1. An applicant must be entered in the SPED program pool before service payments may be authorized. The department shall allow entry into the SPED program pool to occur:

   a. When the department's designee submits a form in the manner prescribed by the department; or

   b. When the applicant meets the special circumstances provided in subsection 4, 5, or 6 of section 75-03-23-03.

2. An applicant's resources may not exceed fifty thousand dollars for the applicant to be eligible for services under the SPED program. For purposes of this section, resources are cash or similar assets, except recovery rebates authorized by section 2201 of the federal Coronavirus Aid, Relief, and Economic Security Act of 2020 [Pub. L. 116-136], that can be readily converted to cash and include residences owned by the applicant other than the applicant's primary residence.

3. An applicant eighteen years of age or older is eligible for the SPED program pool if:

   a. The applicant has a functional impairment as specified by the department in policies and procedures to indicate applicant eligibility;

   b. The applicant's functional impairment has lasted, or can be expected to last, three months or longer;

   c. The applicant's functional impairment is not the result of a mental illness or a condition of mental retardation, or a closely related condition;

   d. The applicant is living in North Dakota in a housing arrangement commonly considered a private residence and not in an institution;

   e. The applicant is not eligible for services under the Medicaid waiver program or the Medicaid state plan option of personal care services unless the applicant's estimated monthly benefits under this chapter, excluding the cost of case management, are between the current medically needy income level for a household of one plus the disregard established in North Dakota Century Code section 50-24.1-02.3, and the lowest level of the fee schedule for services under North Dakota Century Code chapter 50-06.2, or unless the individual is receiving a service that is not available under Medicaid or the Medicaid waiver;

   f. The applicant would receive one or more of the covered services under department policies and procedures for the specific service;

   g. The applicant agrees to the plan of care developed for the provision of home and community-based services;

   h. The applicant is not responsible for one hundred percent of the cost of the covered service provided, under the SPED program sliding fee scales based on family size and income; and

   i. The applicant has not made a disqualifying transfer of assets.

4. An applicant under eighteen years of age is eligible for the SPED program pool if the applicant is determined to need nursing facility level of care as provided for in section 75-02-02-09 and the applicant's care need is not the result of a mental illness or the condition of mental retardation, or a closely related condition.

5. An applicant under eighteen years of age:

   a. Must meet the eligibility requirements of subsections 3 and 4.

   b. Is not eligible to receive personal care services under this chapter.

   c. Is not eligible for service payments unless:

      (1) Care provided to the applicant by the applicant's parent or the applicant's spouse is provided under family home care.

      (2) The applicant is unable to regularly attend school or is severely limited in the amount of time the applicant is able to attend school.

6. An applicant must be capable of directing self-care or must have a legally responsible party to act on the applicant's behalf.

7. An applicant is not eligible for service payments if the care provided is court-ordered.

8. An applicant is eligible to receive covered services reimbursed under North Dakota Century Code chapter 50-06.2 or this chapter even if the applicant has natural supports.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018; May 19, 2020; January 1, 2022.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5), 50-06.2-04(3)

75-03-23-03. Eligibility determination - Authorization of services.

1. A person transferred to SPED program active status from the SPED program pool shall continue to meet the eligibility criteria of section 75-03-23-02 in order to remain eligible for services funded under the SPED program.

2. The department is responsible for:

   a. Verifying that the person transferred to active status continues to meet the eligibility criteria for placement into the SPED program pool;

   b. Developing a care plan;

   c. Authorizing covered services in accordance with department policies and procedures;

   d. Verifying the financial eligibility criteria in relation to income, assets, and deductions; and

   e. Assuring that other potential federal and third-party funding sources for similar services are sought first.

3. A recipient of services under the Medicaid waiver program, who becomes ineligible for the Medicaid waiver program because evaluation shows that the recipient no longer requires a nursing facility level of care, does not have to go through the SPED program pool to receive services through the SPED program provided the recipient meets all eligibility criteria in section 75-03-23-02.

4. A recipient of services under the Medicaid personal care service option, who becomes ineligible for services under the Medicaid personal care service option, does not have to go through the SPED program pool to receive services through the SPED program provided the recipient meets all eligibility criteria in section 75-03-23-02.

5. A recipient of services under the expanded service payments for elderly and disabled program, who becomes ineligible for services under the expanded service payments for elderly and disabled program, does not have to go through the SPED program pool to receive services through the SPED program provided the recipient meets all eligibility criteria in section 75-03-23-02.

6. An individual who is discharged from an inpatient hospital stay, skilled nursing facility, swing-bed facility, long-term care facility, or basic care facility or who has been off of the SPED program for fewer than ~~sixty~~ninety days, does not have to go through the SPED program pool to receive services through the SPED program provided the individual meets all eligibility criteria in section 75-03-23-02.

History: Effective June 1, 1995; amended effective January 1, 2009; July 1, 2020; January 1, 2022.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-05. Services covered under the SPED program - Programmatic criteria.

Room and board costs may not be paid in the SPED service payment. The following categories of services are covered under the SPED program and may be provided to a client:

1. The department may provide adult day care services to a client:

   a. Who requires assistance in activities of daily living or instrumental activities of daily living;

   b. Who is able to participate in group activities; and

   c. Who, if the client does not live alone, has a primary caregiver who will benefit from the temporary relief of care giving.

2. The department may provide adult foster care using a licensed adult foster care provider to a client eighteen years of age or older:

   a. Who resides in a licensed adult foster care home;

   b. Who requires care or supervision;

   c. Who would benefit from a family or shared living environment; and

   d. Whose required care does not exceed the capability of the foster care provider.

3. The department may provide chore services to a client for one-time, intermittent, or occasional activities which would enable the client to remain in the home. Activities such as heavy housework and periodic cleaning, professional extermination, snow removal, and emergency response systems may be provided. Clients receiving emergency response services must be cognitively and physically capable of activating the emergency response system. The activity must be the responsibility of the client and not the responsibility of the landlord.

4. The department may provide environmental modification to a client:

   a. Who owns or rents the home to be modified. If the home is rented the property owner shall approve the modification consistent with the property owner's obligations pursuant to section 804(f)(3)(A) of the Fair Housing Act [42 U.S.C. 3604(f)(3)(A)] before the installation of the environmental modification; and

   b. When the modification will enable the client to complete the client's own personal care or to receive care and allow the client to safely stay in the home~~;~~

~~c. When no alternative community resource is available; and~~

~~d. Limited to labor and materials for installing safety rails~~.

5. a. The department may provide extended personal care services to a client who:

(1) Requires skilled or nursing care that requires training by a nurse licensed under North Dakota Century Code chapter 43-12.1; and

(2) Has a cognitive or physical impairment that prevents the client from completing the required activity.

b. Extended personal care services do not include assistance with activities of daily living or instrumental activities of daily living.

6. The department may provide family home care services to a client who:

a. Lives in the same residence as the care provider on a twenty-four-hour basis;

b. Agrees to the provision of services by the care provider; and

c. Is the spouse of the care provider or the current or former spouse of one of the following relatives of the client: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew.

7. The department may provide home and community-based services case management services to a client who needs a functional assessment and the coordination of cost-effective delivery issues. The case management services must be provided by a social worker licensed under North Dakota Century Code section 43-41-04.

8. The department may provide home-delivered meals to a client who lives alone and is unable to prepare an adequate meal for himself or herself, or who lives with an individual who is unable or not available to prepare an adequate meal for the client.

9. The department may provide homemaker services to a client who needs assistance with environmental maintenance activities including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis~~ and who lives alone or with an adult who is unable or is not obligated to perform homemaking activities~~. The department may ~~not~~ pay a provider for laundry, shopping, ~~housekeeping,~~ meal preparation, money management, or communication, if the ~~provider lives with the client and is a relative identified within the definition of "family home care" under subsection 4 of North Dakota Century Code section 50-06.2-02, or is a former spouse of the client; except the~~activity benefits the client. The department may ~~provide essential homemaking activities such as meal preparation if the adult not receiving care who resides in the home is unavailable due to employment. The department may provide shopping assistance only if at least one other activity is performed and no other shopping assistance is available through informal networks or other community providers~~pay a provider for housekeeping activities involving the client's personal private space and if the client is living with an adult, the client's share of common living space. The homemaker services funding cap applies to a household and may not be exceeded regardless of the number of clients residing in that household.

10. Nonmedical transportation services may be provided to clients who are unable to provide their own transportation and need transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

11. The department may provide personal care services to a client who needs help or supervision with personal care activities if:

    a. The client is at least eighteen years of age; and

    b. ~~The client lives alone or is alone due to the employment of the primary caregiver or the incapacity of other adult household members; and~~

    ~~c.~~ The services are provided in the client's home or in a provider's home if the provider meets the definition of a relative as defined in subdivision c of subsection ~~5~~6 of section 75-03-23-05.

12. a. The department may provide respite care services to a client in the client's home, in the provider's home, in a nursing home, in a swing-bed facility, in a basic care facility, or in a hospital, if:

        (1) The client has a full-time primary caregiver;

        (2) The client needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

        (3) The primary caregiver's need for the relief is intermittent or occasional; and

        (4) The primary caregiver's need for relief is not due to the primary caregiver's employment or attendance at school as a part-time or full-time student.

    b. A client who is a resident of an adult foster care may choose a respite provider and is not required to use a relative of the adult foster care provider as the client's respite provider.

13. The department may provide other services as the department determines appropriate.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-06. Services covered under the Medicaid waiver program - Programmatic criteria.

Room and board costs may not be included in the Medicaid waiver service payment. The following services are covered under the Medicaid waiver program and may be provided to a client:

1. The department may provide adult day care services to a client:

    a. Who requires assistance in activities of daily living or instrumental activities of daily living;

    b. Who is able to participate in group activities; and

    c. If the client does not live alone, the client's primary caregiver will benefit from the temporary relief of care giving.

2. The department may provide adult foster care, using a licensed adult foster care provider, to a client who resides in a licensed adult foster care home who:

    a. Is eighteen years of age or older;

    b. Requires care or supervision;

    c. Would benefit from a family or shared living environment; and

d. Requires care that does not exceed the capability of the foster care provider.

3. The department may provide residential care to a client who:

   a. Has chronic moderate to severe memory loss; or

   b. Has a significant emotional, behavioral, or cognitive impairment.

4. The department may provide attendant care to a client who:

   a. Is ventilator-dependent a minimum of twenty hours per day;

   b. Is medically stable as documented at least annually by the client's primary care physician;

   c. Has identified an informal caregiver support system for contingency planning; and

   d. Is competent to participate in the development and monitoring of the care plan as documented at least annually by the client's primary care physician.

5. The department may provide chore services to a client for one-time, intermittent, or occasional activities that would enable the client to remain in the home, such as heavy housework and periodic cleaning, professional extermination, and snow removal. The activity must be the responsibility of the client and not the responsibility of the landlord.

6. The department may provide an emergency response system to a client who lives alone or with an incapacitated adult, or who lives with an individual whose routine absences from the home present a safety risk for the client, and the client is cognitively and physically capable of activating the emergency response system.

7. ~~When no alternative community resource is available, the~~The department may provide environmental modification to a client, if the client owns or rents the home to be modified and when the modification will enable the client to complete the client's own personal care or to receive care and will allow the client to safely stay in the home for a period of time that is long enough to offset the cost of the modification. If the home is rented the property owner shall approve the modification consistent with the property owner's obligations pursuant to section 804(f)(3)(A) of the Fair Housing Act [42 U.S.C. 3604(f)(3)(A)] before the installation of the environmental modification.

8. a. The department may provide family personal care to a client who:

      (1) Lives in the same residence as the care provider on a twenty-four-hour basis;

      (2) Agrees to the provision of services by the care provider; and

      (3) Is the legal spouse of the care provider or is a relative identified within the definition of "family home care" under subsection 4 of North Dakota Century Code section 50-06.2-02.

   b. Family personal care payments may not be made for assistance with the activities of communication, community integration, ~~housework,~~ laundry, meal preparation, money management, shopping, social appropriateness, or transportation unless the activity benefits the client. Family personal care payment may not be made for assistance with the activity of housework unless the activity is for the client's personal space or if the client is living with an adult, the client's share of common living space.

9. The department may provide home and community-based services case management services to a client who needs a comprehensive assessment and the coordination of

cost-effective delivery of services. Case management services provided under this subsection must be provided by a social worker licensed under North Dakota Century Code section 43-41-04.

10. The department may provide home-delivered meals to a client who lives alone and is unable to prepare an adequate meal for himself or herself or who lives with an individual who is unable or not available to prepare an adequate meal.

11. The department may provide homemaker services to a client who needs assistance with environmental maintenance activities, including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis ~~when the client lives alone or with an adult who is unable or is not obligated to complete homemaking activities~~. The department may ~~not~~ pay a provider for laundry, shopping, ~~housekeeping,~~ meal preparation, money management, or communication, if the ~~provider lives with the client and is a relative identified within the definition of "family home care" under subsection 4 of North Dakota Century Code section 50-06.2-02, or is a former spouse of the client; except the~~activity benefits the client. The department may ~~provide essential homemaking activities such as meal preparation if the responsible adult not receiving care who resides in the home is unavailable due to employment. Shopping assistance may be provided only if at least one other activity is performed and no other shopping assistance is available through informal networks or other community providers~~pay a provider for housekeeping activities involving the client's personal private space and if the client is living with an adult, the client's share of common living space. The homemaker service funding cap applies to a household and may not be exceeded regardless of the number of clients residing in that household.

12. a. The department may provide extended personal care services to a client who:

    (1) Requires skilled or nursing care that requires training by a nurse licensed under North Dakota Century Code chapter 43-12.1; and

    (2) Has a cognitive or physical impairment that prevents the client from completing the required activity.

    b. Extended personal care services do not include assistance with activities of daily living and instrumental activities of daily living.

13. The department may provide nonmedical transportation services to a client who is unable to provide his or her own transportation and who needs transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

14. The department may provide up to twenty-four hours per day of supervision to a client who has a cognitive or physical impairment that results in the client needing monitoring to assure the client's continued health and safety~~, if the client lives alone or with an individual who is not a relative identified within the definition of "family home care" under subsection 4 of North Dakota Century Code section 50-06.2-02~~.

15. a. The department may provide respite care services to a client in the client's home, in the provider's home, in a nursing home, in a swing-bed facility, in a basic care facility, or in a hospital, if:

    (1) The client has a full-time primary caregiver;

    (2) The client needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

    (3) The primary caregiver's need for the relief is intermittent or occasional; and

(4) The primary caregiver's need for relief is not due to the primary caregiver's employment or attendance at school as a part-time or full-time student.

b. A client who is a resident of an adult foster care home may choose a respite provider and is not required to use a relative of the adult foster care provider as the client's respite provider.

16. The department may provide specialized equipment and supplies to a client, if:

a. The client's need for the items is based on an adaptive assessment;

b. The items directly benefit the client's ability to perform personal care or household activities;

c. The items will reduce the intensity or frequency of human assistance required to meet the client care needs;

d. The items are necessary to prevent the client's institutionalization;

e. The items are not available under the Medicaid state plan; and

f. The client is motivated to use the item.

17. The department may provide supported employment to a client who is unlikely to obtain competitive employment at or above the minimum wage; who, because of the client's disabilities, needs intensive ongoing support to perform in a work setting; and who has successfully completed the supported employment program available through the North Dakota vocational rehabilitation program.

18. The department may provide transitional living services to a client who needs supervision, training, or assistance with self-care, communication skills, socialization, sensory and motor development, reduction or elimination of maladaptive behavior, community living, and mobility. The department may provide these services until the client's independent living skills development has been met or until an interdisciplinary team determines the service is no longer appropriate for the client.

19. The department may provide community transition services to a client who is transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the client is directly responsible for his or her own living expenses and needs nonrecurring set-up expenses. Community transition services include one-time transition costs and transition coordination.

a. Allowable expenses are those necessary to enable a client to establish a basic household that do not constitute room and board and may include:

(1) Security deposits that are required to obtain a lease on a private residence;

(2) Essential household furnishings required to occupy and use a private residence, including furniture, window coverings, food preparation items, and bed and bath linens;

(3) Setup fees or deposits for utility or service access, including telephone, electricity, heating, and water;

(4) Services necessary for the client's health and safety, such as pest eradication and one-time cleaning prior to occupancy;

(5) Moving expenses;

(6) Necessary home accessibility adaptations; and

(7) Activities to assess need and to arrange for and procure need resources.

b. Community transition services do not include monthly rental or mortgage expenses, escrow, specials, insurance, food, regular utility or service access charges, household appliances, or items that are intended for purely diversional or recreational purposes.

c. Community transition services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the client is unable to meet such expense, or when the services cannot be obtained from other sources.

20. The department may provide a nurse assessment to a client who requires an evaluation of his or her health care needs to ensure the health, welfare, and safety of the client. The service is limited to a nurse assessment, consultation, and recommendations to address the health-related need for services that are necessary to support a client in a home- or community-based setting. The service must be provided by an advanced practice registered nurse or a registered nurse who is in good standing.

21. The department may provide other services as permitted by an approved waiver.

22. Subsections 19 and 20 become effective on the effective date of approved amendments to the 1915(c) Medicaid waiver sufficient to secure federal financial participation in the cost of services provided to individuals found eligible under subsections 19 and 20, remain effective as long as federal financial participation continues to be available and state law authorizes such coverage, and is thereafter ineffective.

23. The department may provide residential habilitation up to twenty-four hours per day to a client who ~~lives alone or with an adult who is unable or is not obligated to provide care and~~ needs formalized training and supports and requires 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 habilitation may be provided in an agency foster home for adults facility or in a private residence owned or leased by a client or their family member.

24. The department may provide community support services up to twenty-four hours per day to a client ~~who lives alone or with an adult who is unable or is not obligated to provide care~~ who requires some level of ongoing daily support. This service is designed to assist with self-care tasks and socialization that improves the client's ability to independently reside and participate in an integrated community. Community support services may be provided in an agency foster home for adults facility or in a private residence owned or leased by a client or their family member.

25. The department may provide companionship services up to ten hours per month to clients who live alone and could benefit from services to help reduce social isolation.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-07. Qualified service provider standards and agreements.

1. An individual or agency seeking designation as a qualified service provider shall complete and return the applicable forms supplied by the department in the form and manner prescribed. The qualified service provider, including any employees of an agency designated as a

qualified service provider, shall meet all licensure, certification, or competency requirements applicable under state or federal law and departmental standards necessary to provide care to clients whose care is paid by public funds. An application is not complete until the individual or agency submits all required information and required provider verifications to the department.

2. A provider or an individual seeking designation as a qualified service provider:

   a. Must have the basic ability to read, write, and verbally communicate;

   b. Must not be an individual who has been found guilty of, pled guilty to, or pled no contest to:

      (1) An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or North Dakota Century Code section 12.1-17-01, simple assault, if a class C felony under subdivision a of subsection 2 of that section; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing peace officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-06.1, sexual exploitation by therapist; 12.1-20-07, sexual assault; 12.1-20-12.3, sexual extortion; 12.1-21-01, arson; 12.1-22-01, robbery; or 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 12.1-31-07, endangering a vulnerable adult; 12.1-31-07.1, exploitation of a vulnerable adult; 14-09-22, abuse of a child; 14-09-22.1, neglect of a child; subsection 1 of section 26.1-02.1-02.1, fraudulent insurance acts; or an offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the enumerated North Dakota statutes; or

      (2) An offense, other than a direct-bearing offense identified in paragraph 1 of subdivision b of subsection 2, if the department determines that the individual has not been sufficiently rehabilitated.

         (a) The department may not consider a claim that the individual has been sufficiently rehabilitated until any term of probation, parole, or other form of community corrections or imprisonment without subsequent charge or conviction has elapsed, unless sufficient evidence is provided of rehabilitation.

         (b) An individual's completion of a period of three years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation;

   c. In the case of an offense described in North Dakota Century Code section 12.1-17-01, simple assault, if a felony; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence, if a misdemeanor; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07.1, stalking; 12.1-18-03, unlawful imprisonment; 12.1-20-05, corruption or solicitation of minors, if a misdemeanor; 12.1-20-07, sexual assault, if a misdemeanor; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final

discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent convictions;

d. Shall maintain confidentiality;

e. Shall submit a request to be a qualified service provider every twenty-four months using applicable forms and shall provide documentation as required by the department;

f. Must be physically capable of performing the service for which they were hired;

g. Must be at least eighteen years of age; and

h. Must not have been the subject of a child abuse or neglect assessment for which a ~~services required~~confirmed decision was made unless the program administrator, after appropriate consultation with persons qualified to evaluate the capabilities of the provider, documenting criteria used in making the decision, and imposing any restrictions necessary, approves the request, provided the provider can demonstrate:

(1) The successful completion of an appropriate therapy; or

(2) The elimination of an underlying basis precipitating the neglect or abuse.

3. If the physical, cognitive, social, or emotional health capabilities of an applicant or provider appear to be questionable, the department may require the applicant or provide to present evidence of the applicant's or provider's ability to provide the required care based on a formal evaluation. The department is not responsible for costs of any required evaluation.

4. The offenses enumerated in paragraph 1 of subdivision b of subsection 2 have a direct bearing on an individual's ability to be enrolled as a qualified service provider.

a. An individual enrolled as a qualified service provider prior to January 1, 2009, who has been found guilty of, pled guilty to, or pled no contest to, an offense considered to have a direct bearing on the individual's ability to provide care may be considered rehabilitated and may continue to provide services if the individual has had no other offenses and provides sufficient evidence of rehabilitation to the department.

b. The department may not approve, deny, or renew an application for an individual or employee of an agency who is applying to enroll or re-enroll as a qualified service provider and who has been charged with an offense considered to have a direct bearing on the individual's ability to provide care or an offense in which the alleged victim was under the applicant's care, until final disposition of the criminal case against the individual.

5. Evidence of competency for adult foster care providers serving clients eligible for the developmental disability waiver must be provided in accordance with subdivision b of subsection 2 of section 75-03-21-08.

6. A provider of services for adult day care, adult foster care, attendant care, community support services, extended personal care, family personal care, nurse assessment, personal care, residential care, respite care, residential habilitation, supervision, and transitional living care shall provide evidence of competency in generally accepted procedures for:

a. Infection control and proper handwashing methods;

b. Handling and disposing of body fluids;

c. Tub, shower, and bed bathing techniques;

d. Hair care techniques, sink shampoo, and shaving;

e. Oral hygiene techniques of brushing teeth and cleaning dentures;

f. Caring for an incontinent client;

g. Feeding or assisting a client with eating;

h. Basic meal planning and preparation;

i. Assisting a client with the self-administration of medications;

j. Maintaining a kitchen, bathroom, and other rooms used by a client in a clean and safe condition, including dusting, vacuuming, floor care, garbage removal, changing linens, and other similar tasks;

k. Laundry techniques, including mending, washing, drying, folding, putting away, ironing, and related work;

l. Assisting a client with bill paying and balancing a check book;

m. Dressing and undressing a client;

n. Assisting with toileting;

o. Routine eye care;

p. Proper care of fingernails;

q. Caring for skin;

r. Turning and positioning a client in bed;

s. Transfer using a belt, standard sit, or bed to wheelchair;

t. Assisting a client with ambulation; and

u. Making wrinkle-free beds.

7. An applicant for qualified service provider status for attendant care, adult foster care, extended personal care, family personal care, nurse assessment, personal care, residential care, supervision, transitional living care, respite care, or adult day care must secure written verification that the applicant is competent to perform procedures specified in subsection 5 from a physician, chiropractor, registered nurse, licensed practical nurse, occupational therapist, physical therapist, or an individual with a professional degree in specialized areas of health care. Written verification of competency is not required if the individual holds one of the following licenses or certifications in good standing: physician, physician assistant, chiropractor, registered nurse, licensed practical nurse, registered physical therapist, registered occupational therapist, or certified nurse assistant. A certificate or another form of acknowledgment of completion of a program with a curriculum that includes the competencies in subsection 5 may be considered evidence of competence.

8. The department may approve global and client-specific endorsements to provide particular procedures for a provider based on written verification of competence to perform the procedure from a physician, chiropractor, registered nurse, occupational therapist, physical therapist, or other individual with a professional degree in a specialized area of health care or approved within the scope of the individual's health care license or certification.

9. Competence may be demonstrated in the following ways:

a. A demonstration of the procedure being performed;

b. A detailed verbal explanation of the procedure; or

c. A detailed written explanation of the procedure.

10. The department shall notify the individual or the agency of its decision on designation as a qualified service provider.

11. The department shall maintain a list of qualified service providers. Once the client's need for services has been determined, the client selects a provider from the list and the department's designee issues an authorization to provide services to the selected qualified service provider.

12. A service payment may be issued only to a qualified service provider who bills the department after the delivery of authorized services.

13. Agency providers who employ nonfamily members must have a department-approved quality improvement program that includes a process to identify, address, and mitigate harm to the clients they serve.

History: Effective June 1, 1995; amended effective March 1, 1997; January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-08. Denial of application to become a qualified service provider.

The department may deny an application to become a qualified service provider if:

1. The applicant voluntarily withdraws the application;

2. The applicant is not in compliance with applicable state laws, state regulations, or program issuances governing providers;

3. The applicant, if previously enrolled as a qualified service provider, was not in compliance with the terms set forth in the application or provider agreement;

4. The applicant, if previously enrolled as a qualified service provider, was not in compliance with the provider certification terms on the claims submitted for payment;

5. The applicant, if previously enrolled as a qualified service provider, had assigned or otherwise transferred the right to payment of a program claim, except as provided in 42 U.S.C. 1396a(a)(32);

6. The applicant, if previously enrolled as a qualified service provider, had demonstrated a pattern of submitting inaccurate billings or cost reports;

7. The applicant, if previously enrolled as a qualified service provider, had demonstrated a pattern of submitting billings for services not covered under department programs;

8. The applicant has been debarred or the applicant's license or certificate to practice in the applicant's profession or to conduct business has been suspended or terminated;

9. The applicant has delivered goods, supplies, or services that are of an inferior quality or are harmful to individuals;

10. The applicant has been convicted of an offense determined by the department to have a direct bearing upon the applicant's ability to be enrolled as a qualified service provider, or the

department determines, following conviction of any other offense, the applicant is not sufficiently rehabilitated;

11. The applicant, if previously enrolled as a qualified service provider, owes the department money for payments incorrectly made to the provider;

12. The qualified service provider is currently excluded from participation in Medicare, Medicaid, or any other federal health care program;

13. The applicant has not provided sufficient evidence to the department, after obtaining a formal evaluation under subsection 3 of section 75-03-23-07, that the applicant is physically, cognitively, socially, or emotionally capable of providing the care;

14. The applicant has been the subject of a child abuse or neglect assessment for which a ~~services required~~confirmed decision was made and the department has determined the applicant does not meet the standards to enroll;

15. The applicant previously has been terminated for inactivity and does not have a prospective public pay client;

16. The applicant previously has been terminated for inactivity and has not provided valid reason for the inactivity; or

17. For other good cause.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-08.1. Sanctions and termination of qualified service providers.

1. The department may impose sanctions against a qualified service provider for any of the reasons listed under section 75-02-05-05 or subdivisions b though g of subsection 4. Prior to imposing sanctions, the department may require provider education or a business integrity agreement.

2. The department may consider the following in determining the sanction to be imposed:

   a. Seriousness of the qualified service provider's offense.

   b. Extent of the qualified service provider's violations.

   c. Qualified service provider's history of prior violations.

   d. Prior imposition of sanctions against the qualified service provider.

   e. Prior provision of information and training to the qualified service provider.

   f. Qualified service 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. Qualified service provider's self-disclosure or self-audit discoveries.

   j. Qualified service provider's willingness to enter a business integrity agreement.

3. The department may impose any of the sanctions listed in subsections 8 or 9 of section 75-02-05-07.

4. The department may terminate a qualified service provider if:

   a. The qualified service provider voluntarily withdraws from participation as a qualified service provider.

   b. The qualified service provider is not in compliance with applicable state laws, state regulations, or program issuances governing providers.

   c. The qualified service provider is not in compliance with the terms set forth in the application or provider agreement.

   d. The qualified service provider is not in compliance with the provider certification terms on the claims submitted for payment.

   e. The qualified service provider has assigned or otherwise transferred the right to payment of a program claim, except as provided in 42 U.S.C. 1396a(a)(32).

   f. The qualified service provider has demonstrated a pattern of submitting inaccurate billings or cost reports.

   g. The qualified service provider has demonstrated a pattern of submitting billings for services not covered under department programs.

   h. The qualified service provider has been debarred or the provider's license or certificate to practice in the provider's profession or to conduct business has been suspended or terminated.

   i. The qualified service provider has delivered goods, supplies, or services that are of an inferior quality or are harmful to individuals.

   j. The qualified service provider has been convicted of an offense determined by the department to have a direct bearing upon the provider's ability to be enrolled as a qualified service provider, or the department determines, following conviction of any other offense, the provider is not sufficiently rehabilitated.

   k. The qualified service provider is currently excluded from participation in Medicare, Medicaid, or any other federal health care program.

   l. The qualified service provider has not provided sufficient evidence to the department, after obtaining a formal evaluation under subsection 3 of section 75-03-23-07 that the provider is physically, cognitively, socially, or emotionally capable of providing the care.

   m. The qualified service provider has been the subject of a child abuse or neglect assessment for which a ~~services required~~confirmed decision was made and the department has determined the provider does not meet the standards to enroll.

   n. The qualified service provider refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

   o. There has been no billing activity within the twelve months since the qualified service provider's enrollment or most recent re-enrollment date.

   p. For other good cause.

History: Effective January 1, 2020; amended effective January 1, 2022.

General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

CHAPTER 75-03-24

75-03-24-03. Eligibility determination - Authorization of services.

1. The department is responsible for:

   a. Verifying that the person transferred to active status continues to meet the eligibility criteria for placement into the ex-SPED program pool;

   b. Developing a care plan;

   c. Authorizing covered services in accordance with department policies and procedures; and

   d. Assuring that other potential federal and third-party funding sources for similar services are sought first.

2. An individual who is discharged from an inpatient hospital stay, skilled nursing facility, swing-bed facility, long-term care facility, or basic care facility or who has been off the ex-SPED program for fewer than ~~60~~ninety days, does not have to go through the ex-SPED program pool to receive services through the ex-SPED program provided the individual meets all eligibility criteria in section 75-03-24-02.

3. An applicant is eligible to receive covered services reimbursed under North Dakota Century Code chapter 50-06.2 or this chapter even if the applicant has natural supports.

History: Effective April 1, 2012; amended effective July 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.7-02
Law Implemented: NDCC 50-24.7

75-03-24-07. Services covered under the ex-SPED program - Programmatic criteria.

Room and board costs may not be paid in the ex-SPED service payment. The following categories of services are covered under the ex-SPED program and may be provided to a client:

1. The department may provide adult day care services to a client:

   a. Who requires assistance in activities of daily living or instrumental activities of daily living;

   b. Who is able to participate in group activities; and

   c. Who, if the client does not live alone, has a primary caregiver who will benefit from the temporary relief of caregiving.

2. The department may provide adult family foster care, using a licensed adult family foster care provider, to a client eighteen years of age or older:

   a. Who resides in a licensed adult family foster care home;

   b. Who requires care or supervision;

   c. Who would benefit from a family environment; and

   d. Whose required care does not exceed the capability of the foster care provider.

3. The department may provide chore services to a client for one-time, intermittent, or occasional activities which would enable the client to remain in the home. Activities such as heavy housework and periodic cleaning, professional extermination, snow removal, and emergency response systems may be provided. Clients receiving emergency response services must be

cognitively and physically capable of activating the emergency response system. The activity must be the responsibility of the client and not the responsibility of the landlord.

4. The department may provide environmental modification to a client:

   a. Who owns or rents the home to be modified. If the home is rented the property owner shall approve the modification consistent with the property owner's obligations pursuant to section 804(f)(3)(A) of the Fair Housing Act [42 U.S.C. 3604(f)(3)(A)] before the installation of the environmental modification; and

   b. When the modification will enable the client to complete the client's own personal care or to receive care and allow the client to safely stay in the home;

   ~~c. When no alternative community resource is available; and~~

   ~~d. Limited to labor and materials for installing safety rails~~.

5. The department may provide family home care services to a client:

   a. Who lives in the same residence as the care provider on a twenty-four-hour basis;

   b. Who agrees to the provision of services by the care provider; and

   c. Whose care provider is a relative identified within the definition of "family home care" under subsection 2 of North Dakota Century Code section 50-06.2-02 and is enrolled as a qualified service provider.

6. The department may provide home-delivered meals to a client who lives alone and is unable to prepare an adequate meal for himself or herself, or who lives with an individual who is unable or not available to prepare an adequate meal for the client.

7. The department may provide homemaker services to a client who needs assistance with environmental maintenance activities including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis ~~and who lives alone or with an adult who is unable or is not obligated to perform homemaking activities~~. The department may pay a provider for laundry, shopping, meal preparation, money management, or communication, if the activity benefits the client. The department may ~~provide essential homemaking activities such as meal preparation if the adult not receiving care who resides in the home is unavailable due to employment. The department may provide shopping assistance only if at least one other activity is performed and no other shopping assistance is available through informal networks or other community providers~~pay a provider for housekeeping activities involving the client's personal private space and if the client is living with an adult, the client's share of common living space. The homemaker service cap funding applies to a household and may not be exceeded regardless of the number of clients residing in that household.

8. Nonmedical transportation services may be provided to clients who are unable to provide their own transportation and need transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

9. The department may provide respite care services to a client in the client's home, in the provider's home, in a nursing home, in a swing-bed facility, in a basic care facility, or in a hospital, if:

   a. The client has a full-time primary caregiver;

b. The client needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

c. The primary caregiver's need for the relief is intermittent or occasional; and

d. The primary caregiver's need for relief is not due to the primary caregiver's employment or attendance at school as a part-time or full-time student.

10. The department may provide other services as the department determines appropriate.

History: Effective April 1, 2012; amended effective October 1, 2014; January 1, 2022.
General Authority: NDCC 50-24.7-02
Law Implemented: NDCC 50-24.7

CHAPTER 75-03-38
AUTISM SPECTRUM DISORDER VOUCHER PROGRAM

75-03-38-01. Definitions.

1. "Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities.

2. "Assistive technology service" means any service that directly assists an individual in the selection, acquisition, or use of an assistive technology device.

3. "Department" means the department of human services.

4. "Division" means the medical services division of the department.

5. "Federal poverty level" means the poverty guidelines that are issued each year in the federal register by the United States department of health and human services as applicable to the state of North Dakota.

6. "Provider" means a teacher, physical therapist, occupational therapist, or licensed therapist working with a child to address deficits created by an autism diagnosis.

~~6.~~7. "Qualified professional" means a primary care provider or licensed medical care provider qualified to diagnose autism spectrum disorder.

~~7.~~8. "Sensory equipment" means an item that lessens or amplifies the intensity of various forms of sensory stimulation and helps to desensitize individuals to sensory stimuli.

History: Effective July 1, 2014; amended effective April 1, 2018; January 1, 2022.
General Authority: NDCC 50-06-32.1
Law Implemented: NDCC 50-06-32.1

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's support need cannot be obtained through insurance or through other service systems, including educational and behavioral health systems and the federal Medicaid 1915(i) state plan amendment;

f. The child's needs cannot be met by a generic service or support;

g. The child lives with the child's parent, custodian, or legal guardian; and

h. The child is currently a North Dakota resident ~~for at least six months~~.

2. The department shall review complete voucher applications in the order received, and shall only approve voucher applications within the limits of legislative appropriations.

History: Effective July 1, 2014; amended effective April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-06-32.1
Law Implemented: NDCC ~~23-01-41,~~ 50-06-32.1

75-03-38-03. Application.

1. A parent, custodian, or legal guardian of a child diagnosed with an autism spectrum disorder shall provide the following information on an application form provided by the division:

   a. Verification from a qualified professional of a diagnosis of the autism spectrum disorder based on the criteria identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American psychiatric association.

   b. Verification of North Dakota residency ~~for at least six months~~.

   c. Verification of household's gross income below two hundred percent of the federal poverty level.

   d. Signed releases of information, if necessary, to the child's service providers and school.

2. A completed application must be submitted yearly.

History: Effective July 1, 2014; amended effective April 1, 2018; January 1, 2022.
General Authority: NDCC 50-06-32.1
Law Implemented: NDCC 50-06-32.1

75-03-38-04. Voucher administration.

1. Voucher support approved for a child with an autism spectrum diagnosis under this chapter may not exceed ~~twelve~~seven thousand five hundred dollars per state fiscal year.

2. Upon approval of the application, the division shall issue ~~a~~an autism voucher ~~request~~purchase form that includes a list to select from, to be completed by the parent, custodian, or legal guardian ~~of the eligible child~~ indicating the specific item or service being requested. ~~A~~For an item or service not included on the preapproved list, a description of each item or service requested~~, from a provider working with the eligible child,~~ must accompany the autism voucher ~~request~~purchase form~~, stating how the item or service will compensate for a deficit created by an autism spectrum disorder~~. This description must be from a provider who is working with the eligible child and must state how the item or service will compensate for a deficit created by an autism spectrum disorder.

3. The division may approve ~~a~~an autism voucher ~~request~~purchase for a one-time ~~purchase~~ or ~~for~~ a recurring ~~purchase~~item or service 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 autism voucher ~~requests~~purchases.

4. If a voucher is approved for recurring purchases, the division will monitor the voucher for activity.

5. If the voucher is not used for ~~sixty~~thirty 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. Unspent funds from a terminated voucher must be returned to the voucher program and the division may distribute the funds to another applicant.

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.

7. ~~The voucher~~Voucher funds ~~may not~~must be used ~~for~~on items or services that are age-appropriate, safe, cost-effective, and connected to the child. These items or services are not funded by the voucher:

   a. Items or services that are parental responsibilities, including ~~daily clothing,~~ upkeep of residence, fences, internet, housing or house maintenance, 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.~~d. Items or services that put the health and safety of the child at risk;

   ~~h.~~e. Replacement items, except for disposable products, such as sensory or tactile stimulation items;

   ~~i.~~f. Items that are restricted within property rental agreements or are the responsibility of landlords, tenants, or the homeowner;

   ~~j.~~g. Items that would cause a parent, custodian, or legal guardian to have additional or recurring costs;~~ and~~

   ~~k.~~h. Service animals or emotional support animals and related items;

   i. General entertainment;

   j. Consumer electronics for everyday use;

   k. Household items, excluding assistive technology;

   l. Food;

   m. Telephone or telecommunications, excluding assistive technology;

   n. Vehicles;

   o. Clothing, personal goods, or personal treatments, such as toiletries or aesthetic or cosmetic services, excluding compression clothing; and

   p. Recreation that benefits the entire family and vacations.

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 autism voucher purchase ~~request~~ form.

History: Effective July 1, 2014; amended effective April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-06-32.1
Law Implemented: NDCC 50-06-32.1

75-03-38-06. Variance.

Upon written application and good cause shown to the satisfaction of the department, the department may grant a variance to approve additional funding requests for respite care or tutoring to exceed seven thousand five hundred dollars per state fiscal year upon such terms as the department may prescribe, except no variance may be granted beyond the limits of legislative appropriations, and no variance may be granted except at the discretion of the department. A parent, custodian, or legal guardian with a voucher support approved for a child diagnosed with an autism spectrum disorder under this chapter shall submit a written request to the department justifying the variance. A refusal to grant a variance is not subject to appeal.

History: Effective January 1, 2022.
General Authority: NDCC 50-06-32.1
Law Implemented: NDCC 50-06-32.1

CHAPTER 75-03-39
AUTISM SERVICES WAIVER

Section
75-03-39-01 Definitions
75-03-39-02 Eligibility for Services Under the Medicaid Autism Spectrum Disorder Birth Through ~~Thirteen~~Fifteen Waiver

75-03-39-02. Eligibility for services under the Medicaid autism spectrum disorder birth through ~~thirteen~~fifteen waiver.

1. A child is eligible for autism services under the department's Medicaid autism spectrum disorder birth through ~~thirteen~~fifteen waiver if the following conditions are met:

   a. The age of the child is birth through ~~thirteen~~fifteen years of age;

   b. The child has an autism spectrum disorder diagnosis from a qualified professional able to determine diagnosis; ~~and~~

   c. An autism spectrum disorder waiver slot is available; and

   d. The child meets the institutional level of care required by the centers for Medicare and Medicaid services.

2. Annual redetermination for continued waiver services is required to determine if the child meets the institutional level of care required by the centers for Medicare and Medicaid services.

History: Effective July 1, 2014; amended effective April 1, 2018; January 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-26
Law Implemented: NDCC 50-24.1-26

75-04-01-22. Applicant's buildings.

Applicants occupying buildings, whether owned or leased, shall provide the department with a license or registration certificate properly issued pursuant to North Dakota Century Code chapter 15.1-34 or 50-11 or with:

1. The written report of an authorized fire inspector, following an initial or subsequent annual inspection of a building pursuant to section 75-04-01-23, which states:

   a. Rated occupancy and approval of the building for occupancy; or

   b. Existing hazards and recommendations for correction which, if followed, would result in approval of the building for occupancy;

2. ~~A statement prepared by a sanitarian or authorized public health officer, following an initial or subsequent annual inspection that the building's plumbing, water supply, sewer disposal, and food storage and handling meet acceptable standards to assure a healthy environment;~~

~~3.~~ A written statement prepared by the appropriate county or municipal official having jurisdiction that the premises are in compliance with local zoning laws and ordinances; and

~~4.~~3. For existing buildings, floor plans drawn to scale showing the use of each room or area and a site plan showing the source of utilities and waste disposal; or

~~5.~~4. Plans and specifications of buildings and site plans for facilities, proposed for use, but not yet constructed, showing the proposed use of each room or area and the source of utilities and waste disposal.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; April 1, 2018; January 1, 2022.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-06

TITLE 92

WORKFORCE SAFETY AND INSURANCE

JANUARY 2022

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

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

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

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

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

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

As used in subparagraph 6 of subdivision a of subsection ~~10~~11 of North Dakota Century Code section 65-01-02:

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

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

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

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 ~~seventy~~eighty-five dollars per hour for all actual and reasonable time other than travel time. The organization shall pay attorney travel time at ~~eighty-five~~ninety-three dollars per hour.

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

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

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

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

   ~~d.~~c. ~~Six~~Seven thousand ~~nine~~five hundred ~~fifty~~five dollars, plus reasonable costs incurred, if the employee's district court appeal is settled prior to submission of briefs. ~~Nine~~Ten thousand ~~three hundred~~forty-five dollars, plus reasonable costs incurred, if the employee prevails after hearing by the district court.

   ~~e.~~d. ~~Eleven~~Tweleve thousand ~~one hundred fifty~~forty dollars, plus reasonable costs incurred, if the employee's North Dakota supreme court appeal is settled prior to hearing. ~~Twelve~~Thirteen thousand two hundred ~~fifty~~thirty dollars, plus reasonable costs incurred, if the employee prevails after hearing by the supreme court.

   ~~f.~~e. ~~One~~Two thousand ~~eight hundred fifty~~ dollars, plus reasonable costs incurred, if the employee requests binding dispute resolution and prevails.

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

4. The maximum fees specified in subdivisions a, b, c, and d~~, 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; January 1, 2022.

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 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 a payroll report on which the employer shall submit payroll expenditures ~~from~~for the preceding payroll ~~year~~reporting period. 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. The employer shall submit an electronic report of payroll information in a format approved by the organization. The report must be received by the organization by the last day of the month following the expiration date of the employer's payroll reporting 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 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 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 if the organization and the employer have agreed in writing to a payment schedule on a delinquent account. If the employer defaults on the agreed payment schedule, 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 employer's failure to submit the payroll report. The notification must indicate that the organization may assess a penalty of up to ~~two~~five 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,~~by the due date provided by letter from the organization to the employer, the organization shall assess a penalty of fifty dollars. A second fifty-dollar penalty is assessed against the employer if the payroll report remains unsubmitted after an additional fifteen days. 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~~period, 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 unless the organization determines the information submitted by the employer is unreliable or inaccurate.

9. The organization may ~~also~~ cancel ~~the~~an employer's account which has failed to pay premium owing or failed to submit a payroll report.

~~9.~~10. If the organization receives an employer payroll report more than sixty days after the expiration of the employer's payroll period, the employer's billing statement may show a past-due premium billing due date. Any employer account billed without benefit of the employer payroll report may show a past-due billing due date.

~~10.~~11. 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.~~12. 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~~five 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; January 1, 2022.
General Authority: NDCC 65-02-08, 65-04-06, 65-04-19, 65-04-33
Law Implemented: NDCC 65-04-33

92-01-02-24. Rehabilitation services.

1. When an employment opportunity suited to an employee's education, experience, and marketable skills is identified within thirty-five miles [56.33 kilometers] from the employee's home, the appropriate priority option must be identified as return to related occupation in the local job pool under subdivision e of subsection 4 of North Dakota Century Code section 65-05.1-01, and relocation expense under subsection 3 of North Dakota Century Code section 65-05.1-06.1 may not be paid.

2. The organization may award services to move an employee's household where the employee has actually located work under subdivision f of subsection 2 of North Dakota Century Code section 65-05.1-06.1 or under subsection 3 of North Dakota Century Code section 65-05.1-06.1 only when the employee identifies the job the employee will perform, the employee's employer, and the employee's destination. A relocation award must be the actual cost of moving the household to the location where work has been obtained. A minimum of two bids detailing the costs of relocation must be submitted to the organization for approval prior to incurring the cost. The organization shall pay per diem expenses, as set forth under subsection 2 of North Dakota Century Code section 65-05-28, for the employee only. Reimbursement for mileage expenses may not be paid for more than one motor vehicle.

3. When the rehabilitation award is for retraining, the organization shall pay the actual cost of books, tuition, and school supplies required by the school. The school must provide documentation of the costs necessary for completion of the program in which the employee is

enrolled. Reimbursable school costs may not exceed those charged to other students participating in the same program. The award for school supplies may not exceed twenty-five dollars per quarter or thirty dollars per semester unless the employee obtains prior approval of the organization by showing that the expenses are reasonable and necessary. A rehabilitation award for retraining may include tutoring assistance to employees who require tutoring to maintain a passing grade. Payment of tutoring services will be authorized when these services are not available as part of the training program. The award for tutoring services may not exceed the usual and customary rate established by the school. Expenses such as association dues or subscriptions may be reimbursed only if that expense is a course requirement.

4. An award for retraining which includes an additional rehabilitation allowance as provided in subdivision b of subsection 2 of North Dakota Century Code section 65-05.1-06.1 may continue only while the employee is actually enrolled or participating in the training program.

5. An award of a specified number of weeks of training means training must be completed during the specified period of weeks, and rehabilitation benefits may be paid only for the specified number of weeks of training.

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

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

8. The organization may provide certain selected services to assist an injured employee and the injured employee's family with coping and financial strategies while in the recovery process. The recovery process includes the medical recovery, the ability to return to gainful employment, and the need for financial stability. The services may include up to six sessions with a contracted behavioral health professional, and up to four sessions with a contracted financial services professional. Injured employee participation in these sessions is voluntary. The granting or denial of contemplated services is not appealable, and costs of the program will be made against the general fund.

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; February 1, 1998; May 1, 2002; July 1, 2006; July 1, 2010; April 1, 2012; April 1, 2016; July 1, 2017; January 1, 2022.

General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1, 65-05.1-01(2), 65-05.1-06.3

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

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

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

2. "Case management" means the ongoing coordination of medical services provided to a claimant, 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.

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

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

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

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

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

8. "Fee schedule" means the publication entitled "Workforce Safety and Insurance Medical and Hospital Fees".

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.

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

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.

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.

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

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.

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

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

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.

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

~~21.~~20. "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.~~21. "Primary health care provider" means a health care provider who is primarily responsible for the treatment of an injured employee's compensable injury.

~~23.~~22. "Remittance advice" means the form used by the organization to inform payees of the reasons for payment, reduction, or denial of medical services.

~~24.~~23. "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.

~~25.~~24. "Special report" means an allied health care professional's written response to a specific request from the organization for information, including information on causation, aggravation, preexisting conditions, and clarification of complex medical conditions, requiring the creation of a new document or the previously unperformed analysis of existing data. The explanatory reports required for procedures designated as "by report" under section 92-01-02-27 are not special reports.

~~26.~~25. "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.

~~27.~~26. "Utilization review department" means the organization's utilization review department.

~~28.~~27. "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; January 1, 2022.
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 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 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.

o. Opioid therapy exceeding ninety milligrams morphine equivalents daily unless the following criteria are met when a prescription exceeding ninety milligrams morphine equivalents daily is exceeded and as the organization deems necessary:

(1) Documented treatment plan consistent with the organization's utilization review process;

(2) Participation in a psychosocial consult with a health care provider, preferably a licensed psychologist or psychiatrist outside the health care provider's network, to address the risk and harms of opioid use under the centers for disease control and prevention "Guideline for Prescribing Opioids for Chronic Pain". The psychosocial

consult should include standardized screening using validated tools for mental health and substance abuse conditions, as well as a risk stratification plan; and

(3) Recent documentation of attempts to taper opioid use and employ non-opioid therapies for pain control.

p. Benzodiazepine therapies extending beyond a cumulative duration of four weeks, unless prescribed for treatment of a compensable anxiety disorder. In addition, the following criteria must be met when the cumulative duration of four weeks is exceeded and as the organization deems necessary:

(1) A documented treatment plan consistent with the organization's utilization review process;

(2) Participation in a psychosocial consult with a health care provider, preferably a licensed psychologist or psychiatrist outside the health care provider's network, to address the risk and harms of benzodiazepine use. The psychosocial consult should include standardized screening using validated tools for mental health and substance abuse conditions, as well as a risk stratification plan; and

(3) Recent documentation of attempts to taper benzodiazepine use and employ non-benzodiazepine therapies.

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; January 1, 2022.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07, 65-05-40

92-01-02-38. Changes of health care providers.

1. All changes from one health care provider to another must be approved by the organization. Normally, changes will be allowed only after the injured employee has been under the care of the primary health care provider for sufficient time for the 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 health care provider. For purposes of this rule, the following are not considered changes of health care provider by the injured employee:

   a. Emergency services by a health care provider;

   b. Examinations at the request of the organization;

   c. Consultations or referrals initiated by the health care provider;

   d. Referrals to radiologists and pathologists for diagnostic studies;

   e. When injured employees are required to change health care providers to receive compensable medical services~~, palliative care~~ or time loss authorization because their health care provider is no longer qualified as a primary health care provider; or

   f. Changes of primary health care provider required due to conditions beyond the injured employee's control. This would include when the health care provider terminates practice or leaves the area.

3. The injured employee must be advised when and why a change is denied. The organization reserves the right to require an injured employee to select another health care provider or specialist for treatment:

   a. When more conveniently located health care providers, qualified to provide the necessary treatment, are available;

   b. When the attending 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 an injured employee requires specialized treatment, which the primary health care provider is not qualified to render, or which is outside the scope of the primary health care provider's license to practice; or

   e. When the 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 health care provider to be appropriate and has requested the injured employee to change under this rule, the organization may select a new primary health care provider if the injured employee unreasonably refuses or delays in selecting another primary 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 injured employee to a productive role in society.

History: Effective January 1, 1994; amended effective April 1, 1997; January 1, 2000; April 1, 2020; January 1, 2022.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-40. Palliative care.

Repealed effective January 1, 2022.

~~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 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 injured employee has reached medically stationary status and the injured employee's health care provider believes that palliative care is necessary, the 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. 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 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 injured employee to continue employment or to perform the activities of daily living, and what the adverse effect would be to the 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 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 allied health care professional, employer, or injured employee may request binding dispute resolution under section 92-01-02-46.

8. 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 injured employee is medically stationary, the 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

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

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

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

3. All bills must be fully itemized, including ICD codes, and services must be identified by code numbers found in the fee schedules or as provided in these rules. The definitions of

commonality in the guidelines found in the current procedural terminology must be used as guides governing the descriptions of services, except as provided in the fee schedules or in these rules. All bills must be submitted to the organization within one year of the date of service or within one year of the date the organization accepts liability for the work injury or condition.

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

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

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

   c. Date and nature of injury;

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

   e. Date of service;

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

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

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

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

   j. Place of service;

   k. Appropriate procedure code or hospital revenue code;

   l. Charge for each service;

   m. Units of service;

   n. If dental, tooth numbers;

   o. Total bill charge.

5. All records submitted by medical service providers, including notes, except those provided by an emergency room health care provider and those on forms provided by the organization, must be typed to ensure that they are legible and reproducible. Copies of office or progress notes are required for all 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.

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

   a. Laboratory and pathology reports;

   b. X-ray findings;

   c. Operative reports;

   d. Office notes, 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.

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

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

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

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

   c. ~~The injured employee sought palliative care from that allied health care professional not compensable under section 92-01-02-40 after the injured employee was provided notice that the palliative care service is not compensable.~~

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

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

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

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

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

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

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

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

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

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

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

    b. A description of the treatment being rendered.

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

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

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

17. The organization may not pay for the cost of duplicating records when covering the treatment received by the injured employee. If the organization requests records in addition to those listed in subsection 5 or records prior to the date of injury, the organization shall pay a charge

of no more than twenty dollars for the first twenty-five pages and seventy-five cents per page after twenty-five pages. In an electronic, digital, or other computerized format, the organization shall pay a charge of thirty dollars for the first twenty-five pages and twenty-five cents per page after twenty-five pages. This charge includes any administration fee, retrieval fee, and postage expense.

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

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

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

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

History: Effective January 1, 1994; amended effective April 1, 1996; October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2008; July 1, 2010; April 1. 2012; April 1, 2014; April 1, 2016; July 1, 2017; April 1, 2020; January 1, 2022.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07, 65-05-28.2

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

1. This rule provides the procedures followed for managed care disputes. Retrospective review is the procedure provided for disputing the denial of payment for a medical service charge based on failure to request prior authorization or preservice review. Binding dispute resolution is the procedure provided for disputing managed care recommendations, including ~~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 adjuster assigned to handle the injured employee's claim. Requests for retrospective review should not be sent to the managed care vendor. The request must contain:

   a. The injured employee's name.

   b. The claim number.

   c. The date of service.

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

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

If the medical service provider knew or should have known that the patient may have a compensable work injury when the medical services for that injury were provided, the request for retrospective review must be denied. If the medical service provider did not know and should not have known that the patient may have a compensable work injury when the medical services for that injury were provided, a retrospective preservice review or preauthorization 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 injured employee's name.

   b. The claim number.

   c. All relevant medical information and documentation.

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

   e. The specific relief sought.

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

   a. The injured employee's name.

   b. The claim number.

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

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

   e. The specific relief sought.

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

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

organization may request an independent medical examination to assist with its review of a request.

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

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998; January 1, 2000; May 1, 2002; July 1, 2004; April 1, 2020; January 1, 2022.
General Authority: NDCC 65-02-08, 65-02-20
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 injured employee or someone acting on the injured employee's behalf. The employer's report may be deemed admitted pursuant to North Dakota Century Code 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 an application or 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; January 1, 2022.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-05-02

CHAPTER 92-01-03

92-01-03-03. Request for assistance - Timely request for consideration or rehearing.

A claimant shall request assistance with the resolution of a dispute that arises from an order in writing within ~~thirty~~forty-five days from the date of service of the order. An oral request is sufficient to toll the statutory time limit for requesting rehearing if that request is followed by a written request for assistance which is received by the office within ten days after the oral request was made.

History: Effective April 1, 1996; amended effective May 1, 1998; May 1, 2000; July 1, 2010; January 1, 2022.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-16, 65-02-27

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

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

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

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

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

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

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

History: Effective April 1, 1996; amended effective May 1, 1998; May 1, 2000; July 1, 2004; July 1, 2006; July 1, 2010; April 1, 2012; January 1, 2018; January 1, 2022.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-16, 65-02-27