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MANAGEMENT AND BUDGET, OFFICE OF

JANUARY 2024

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4-07-20.1-08. Procedure for appeals of employer actions to human resource management services.

1. The employee shall file the properly completed prescribed appeal form with the director, human resource management services. The appeal form must be ~~delivered, mailed, or~~ transmitted by electronic means and must be received in the human resource management services office by five p.m. within fifteen working days of service of the notice of results of the agency grievance procedure or within fifteen working days from the date of the waiver. An additional fifteen working days is not available if the requested waiver is denied. The date of service of the notice shall be considered to be ~~the date the notice was mailed or~~ the date transmitted or delivered by electronic means~~, or absent proof of the date of mailing or delivery through electronic means, the date of actual delivery~~. The agency shall prepare a certificate of service or provide reliable means, to show proof of the date ~~of mailing, transmittal~~transmitted or delivered by electronic means~~, or hand delivery~~.

2. The director, human resource management services, shall within two working days submit a written request by electronic means to the director, office of administrative hearings, to conduct a hearing on behalf of the division and shall forward a copy of the appeal form to the appointing authority.

3. The administrative law judge shall initially consider whether the appeal was filed within required time limitations. If the administrative law judge determines the time limitations have not been met, the administrative law judge shall prepare an appropriate order dismissing the appeal, which shall be final, and provide a copy of it to the parties. The administrative law judge may, for good cause shown, waive the time limitations for filing an appeal. Good cause means those circumstances that reasonably and without any fault on the part of the appellant prevented the filing of an appeal in a timely fashion. In no event may an appeal be deemed timely after sixty days have elapsed from the date of the employer action.

4. The administrative law judge shall consider whether human resource management services has jurisdiction over the subject matter of the appeal and whether all rules and regulations were followed in the internal agency grievance process. If the administrative law judge is unable to establish whether human resource management services has jurisdiction over the subject matter of the appeal or whether the appropriate rules were followed, a hearing may be conducted to ascertain the facts related to those issues.

5. If the administrative law judge determines that human resource management services does not have jurisdiction in the matter of the appeal, the administrative law judge shall prepare

findings of fact and conclusions of law, if appropriate; issue a final decision dismissing the appeal; and provide a copy of them to the parties.

6. If it is determined that human resource management services has jurisdiction over the appeal, the administrative law judge shall schedule a hearing. The administrative law judge shall conduct the hearing and related proceedings, receive evidence related to the issues, prepare findings of fact and conclusions of law, and issue a final decision.

7. The administrative law judge shall notify the employee and the appointing authority of the final decision by sending each of them a copy of the findings of fact, conclusions of law, and final decision. Notification shall be accomplished in the same manner as for notification of final orders required by subsection 3 of North Dakota Century Code section 28-32-39. The parties shall implement the final decision within any time periods specified by the administrative law judge.

8. The administrative law judge shall return the completed appeal file to human resource management services by electronic means.

9. Any party to the appeal may review the recordings of the hearing by making a request to human resource management services by electronic means.

History: Effective November 1, 1996; amended effective July 1, 2004; July 1, 2008; July 1, 2010; October 1, 2023.
General Authority: NDCC 54-44.3-12(1)
Law Implemented: NDCC 54-44.3-12.2

TITLE 10

ATTORNEY GENERAL

JANUARY 2024

ARTICLE 10-07
FIRE MARSHAL

[Repealed effective January 1, 2024]

~~Chapter~~
~~10-07-01 Fire Prevention~~

TITLE 28

ENGINEERS AND LAND SURVEYORS, BOARD OF REGISTRATION FOR PROFESSIONAL

JANUARY 2024

CHAPTER 28-01-02.1

28-01-02.1-04. Officers and board staff.

1. The board shall hold an election ~~at the first meeting after July first~~in June or July of each year and elect a chairman, vice chairman, and secretary.

2. Each officer will be elected for one year and may be reelected.

3. The chairman:

   a. Shall be the executive head of the board.

   b. Shall preside at all meetings when present.

   c. Shall call meetings of the board when the chairman deems such meetings necessary.

   d. Shall sign all certificates of registration.

4. The vice chairman shall in the absence or incapacity of the chairman exercise the duties and shall possess all the powers of the chairman.

5. The secretary shall sign all official documents prepared by the board and shall sign all certificates of registration.

6. The executive director shall perform all duties as may be prescribed by the board. The associate executive director, when staffed, shall in the absence or incapacity of the executive director exercise the duties and shall possess all the powers of the executive director.

7. ~~The executive director and any other person with signatory authority on the board's accounts shall give a surety bond in an amount determined by the board.~~

~~8.~~ The office of the board may be established at a place designated by the board.

~~9.~~8. The board shall establish, appoint, and create ad hoc or standing committees to study, research, and evaluate such matters as assigned. For each committee a chairman must be designated.

~~10.~~9. Board officers and members serve without compensation except for per diem when engaged in ~~state~~board business approved by the board and for subsistence, lodging, and travel expenses at the rates established for state employees. All per diem and expenses must be

requested on the travel voucher form approved by the ~~state~~board. Receipts for reimbursement of expenses must accompany a voucher.

~~11.~~10. The board staff members must be reimbursed expenses for approved travel, lodging, and subsistence at rates established for state employees. All per diem and expenses must be requested on the travel voucher form approved by the ~~state~~board. Receipts for reimbursement of expenses must accompany a voucher.

History: Effective January 1, 1988; amended effective April 1, 1999; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-03

28-01-02.1-05. Forms - Records - Roster - Reports.

1. **Forms.** The board shall prescribe forms for applications and other documents. Copies of the forms and the instructions for completing the forms must be made available by the board office. All applications and documents must be completed in accordance with the board's instructions.

2. **Records.**

   a. The open records law requires that most records, papers, and reports of the board are public in nature and may be obtained through the executive director or designee upon request and payment of costs of reproduction, handling, and mailing.

   b. The board shall keep a record of all its proceedings, including its action on each application coming before the board.

   c. The board shall keep a record of all applications received.

   d. The board shall keep a record of all certificates issued.

   e. The board shall keep a record of all complaints received and of any actions taken on those complaints.

   f. All applications, approved or deferred, unless otherwise specified in this or other sections of this chapter, will be retained in accordance with North Dakota Century Code section ~~54-46-10~~54-46-07.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-09, 43-19.1-10, 43-19.1-11

28-01-02.1-07. Gender and definitions.

1. **Gender.** This title is to be read and interpreted in a nongender context without regard to race, creed, or sex.

2. **Definitions.** The terms used throughout this title have the same meaning as in North Dakota Century Code chapter 43-19.1, except:

   a. "Accreditation board for engineering and technology accredited curriculum" means those academic programs offered by institutions of higher learning that the accreditation board for engineering and technology (ABET) certify to have met the criteria and qualifications required to receive the designations as accredited programs in the education, training, and preparation of the graduates from such programs; engineering curriculum must have the accreditation of the engineering accreditation commission (EAC) within the

accreditation board for engineering and technology and land surveying curriculum must have either engineering accreditation commission or technology accreditation commission (TAC) or applied science accreditation commission (ASAC) of the accreditation board for engineering and technology to be acceptable to the board.

b. "Application" means the act of furnishing data, documents, and such information under oath as may be required by the board and on forms prescribed by the board.

c. "Code of ethics" means that set of rules prescribed by the board and adopted herein that govern the professional conduct of all registrants.

d. "Direct supervision" means the activities of that person who is in responsible charge of technical, engineering, or land surveying work in progress, whose professional skill and judgment are embodied in the plans, specifications, reports, plats, or other documents required to be certified pursuant to section ~~28-02.1-08-01~~28-02.1-08-03. A person in direct supervision of work directs the work of other registrants, interns, draftspersons, technicians, or clerical persons assigned to that work.

e. "Engineering intern" and "land surveyor (surveying) intern" are recognized by the board as synonymous with engineer-in-training and land surveyor-in-training provided the intern designations are conferred under the same requirements as the "in-training" designations pursuant to these rules.

f. "Examination" means that series of tests prescribed by the board that are developed to ascertain the level of proficiency in the fundamentals and in the practices of the professions regulated by the board.

g. "Form" means a printable or fillable form that captures the data required by this chapter. It includes forms replicated on electronic platforms.

h. "Gross negligence" means a substantial deviation in professional practice from the standard of professional care exercised by members of the registrant's profession, or a substantial deviation from any technical standards issued by a nationally recognized or state-recognized professional organization, or both, comprised of members of the registrant's profession, or a substantial deviation from requirements contained in state laws, board regulations, local ordinances, or regulations related to the registrant's professional practice.

i. "Inactive" means a registration that has voluntarily expired and the registrant has notified the board office of their intent to not renew.

~~h.~~j. "Incompetence" means to lack the professional qualifications, experience, education, or combination thereof to undertake a professional engagement or assignment. The following acts or omissions, among others, may be deemed to be "incompetence" and to be cause for denial, suspension, or revocation of a certificate of registration to practice engineering or land surveying and the imposition of any other lawful discipline. Incompetence includes:

(1) Recklessness or excessive errors, omissions, or failures in the registrant's record of professional practice.

(2) Mental or physical disability or addiction to alcohol or drugs that leads to the impairment of the registrant's ability to exercise due skill and care in providing professional services so as to endanger the health, safety, and welfare of the public.

k. "Lapsed" means a registration that has voluntarily expired and the registrant has not notified the board office of their intent to not renew.

~~i.~~l. "Misconduct" means:

(1) Conviction of any crime reasonably related to the practice of the registrant's profession;

(2) An adverse civil adjudication involving dishonesty, gross negligence, or incompetence;

(3) Suspension or revocation or voluntary surrender of a professional license or registration by this state or by any other jurisdiction;

(4) Any act or practice in violation of the rules of professional conduct as set forth in sections 28-03.1-01-01 through 28-03.1-01-17;

(5) Violation of any of the administrative rules set forth in this title; or

(6) Knowingly fail to comply with continuing professional competency requirements set forth in article 28-04.

~~j.~~m. "Registrant" means any individual or organization who has been approved for a certificate of registration as an engineer intern, land surveyor intern, a professional engineer, a professional land surveyor, or any combination thereof, or a temporary permit to practice engineering, or a certificate of commercial practice.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2004; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-08

CHAPTER 28-02.1-01

28-02.1-01-01. Applications - Kinds of applications.

Applications may be submitted to the board for registration as a:

1. Engineer intern.
2. Land surveyor intern.
3. Professional engineer.
   a. Examination.
   b. Endorsement.
4. Professional land surveyor.
   a. Examination.
   b. Endorsement.
5. Professional engineer temporary permitholder.
6. Business with a certificate of commercial practice to practice engineering or land surveying.
7. Reinstatement for lapsed or inactive registration ~~of a certificate holder~~.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-08

28-02.1-01-02. Completing applications.

1. All data and information requested on the board's application forms must be furnished accurately and completely.
2. When space provided on forms is inadequate, use supplementary sheets of a good grade of white paper, eight and one-half by eleven inches [215.90 by 279.40 millimeters].
3. All applications made to this board must be ~~subscribed and sworn to on the forms used by the applicant before a notary public or other persons qualified to administer oaths~~on a form prescribed and furnished by the board containing statements made under oath.
4. ~~In order to allow sufficient time for processing and for securing examinations, all applications for examinations must be filed with this board prior to January first for the spring examinations and July first for the fall examinations.~~

~~5.~~ Withholding information or providing statements that are untrue or misrepresent the facts may be cause for deferral or denial of an application.

~~6.~~5. It is the responsibility of the applicant to supply correct addresses of all references and to be sure that the completed references forms are supplied as requested.

~~7.~~6. In relating experience, the applicant must account for all employment or work experience for the period of time that has elapsed since the beginning of the employment record. If not employed, or employed in other kinds of work, this should be indicated in the experience record. Gaps in work experience that are greater than ninety days must be explained.

~~8.~~7. ~~Applications for registration properly executed and issued with verification by the national council of examiners for engineers and surveyors (NCEES) may be accepted in lieu of the same information that is required on the form prescribed by this board~~In lieu of applicants supplying the required work experience, transcripts, verification of exams, and reference letters as part of the application, a record verified by the national council of examiners for engineers and surveyors (NCEES) may be accepted, if transmitted to the board within one year of application submittal.

~~9.~~8. Provide the name and address of the corporate officers and directors or the business partners.

~~10.~~9. ~~To~~Companies must list the names and addresses of all employees who are duly registered to practice professional engineering or professional land surveying in North Dakota.

~~11. Provide the name and address of the registered agent for those business entities required to have a registered agent.~~

~~12.~~10. Submitted application records become the property of the board.

11. Companies must obtain a certificate of authority from the North Dakota secretary of state's office prior to submitting an application for a certificate of commercial practice. The certificate of authority must be active and in good standing.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-12

28-02.1-01-04. Applications from applicants with degrees from foreign schools.

1. All foreign language documentation submitted with the completed application must be accompanied with translations certified to be accurate by a competent authority.

2. All applicants shall furnish evidence of experience that can be verified.

3. All applicants seeking registration must be prepared to write examinations that are administered in the English language.

4. All foreign degrees must be evaluated by the national council of examiners for engineers and surveyors (NCEES).

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2004; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-13

28-02.1-01-05. Disposition of applications.

Applications may be approved; deferred for further information, more experience, acceptable references, or other reasons as determined by the board; or may be denied.

1. **Approved applications.** When an application is approved by the board showing that the applicant has met all the requirements for registration or certification required by the statutes of this state, the applicant must be granted registration or certification with notification by the executive director of the board.

2. **Deferred applications.** Applications deferred for any reason require proper remedy, within one year of deferment, as requested before further consideration by the board. These

applications will be closed if no corrective action is taken within one year. The applicant will be notified in writing of the application closure.

3. **Denied applications.** Applications may be denied when in the board's judgment:

   a. Reinstatement is requested after revocation and there is insufficient rehabilitation;

   b. An application has been denied for cause in other jurisdictions; or

   c. The applicant has failed to establish the applicant is of good character and reputation.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2004; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-01, 43-19.1-08
Law Implemented: NDCC 43-19.1-17, 43-19.1-25

CHAPTER 28-02.1-02

28-02.1-02-01. Processing of applications.

1. All information received from references named by the applicant must be received at the board office. No member of the board or relative of the applicant may be named as a reference.

2. ~~An applicant for registration as a professional engineer or professional land surveyor may not be admitted to the examination until the applicant's application has been received, processed, and approved by the board.~~

~~3.~~ An applicant may not confer with any member of the board regarding an applicant's case while it is pending before the board. Any applicant may appear before the board at a scheduled meeting.

~~4. Applicants for registration as a professional engineer or professional land surveyor whose applications have been approved, but who fail to appear for examination four consecutive times, must be deemed to have withdrawn their applications. Further consideration must be based on reapplication.~~

3. Applications will be submitted to the board office:

   a. After successful completion of the fundamentals exam and principles and practices exam for their profession.

   b. After the applicant has obtained the required amount of work experience.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2004; October 1, 2010; October 1, 2014; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-08, 43-19.1-12

CHAPTER 28-02.1-03

28-02.1-03-01. Types of registration.

Engineers and land surveyors may become registered professional practitioners by examination, endorsement, or by temporary permit.

1. **Registration by examination.** Registration by examination is generally a two-step process for those applicants who have never been issued a registration in any other jurisdiction; who have met the general qualification requirements; who have met certain education requirements or who have the experience deemed to be satisfactory and acceptable to the board, or both; and who have successfully passed the examinations prescribed by the board.

   a. The board accepts the written examination prepared by the national council of examiners for engineers and surveyors as its standard of examinations and qualifications.

   b. The board may require one or more questions in examinations measuring familiarity with the code of ethics. Similarly, in furtherance of the board's determination of rehabilitation, an examination on the code of ethics may be required.

2. **Registration by endorsement.** Registration by endorsement is for engineers or land surveyors who hold a current registration in another jurisdiction who substantially meet, in the opinion of the board, the requirements and qualifications required by North Dakota statutes governing registration. Registration as a professional land surveyor also requires successful completion of an orientation examination pertaining to state laws and procedures.

3. **Temporary permit - Temporary registration for practicing engineering.** A temporary permit must be reviewed and approved by the board and is not a means of expedited registration. Educational and experience requirements must comply with North Dakota law. A one-time temporary permit may be issued on the basis of one project and may not exceed one year, from the date of issue. The applicant must be legally qualified to practice and hold current registration in the state or country of residence. A temporary permit must be approved prior to practicing or offering to practice engineering. Temporary permits for professional land surveyors are not authorized by North Dakota law.

History: Effective January 1, 1988; amended effective April 1, 1999; October 1, 2004; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-08, 43-19.1-12.1, 43-19.1-13, 43-19.1-14, 43-19.1-16, 43-19.1-29

CHAPTER 28-02.1-04

28-02.1-04-01. General requirements.

All applicants must:

1. Complete the applications on forms approved by the board.
2. Complete the application under oath. ~~An affidavit is required.~~
3. Furnish references as required but may not include board members or relatives of the applicant as references.

History: Effective January 1, 1988; amended effective April 1, 1999; October 1, 2004; October 1, 2010; October 1, 2014; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-12

28-02.1-04-02. Experience.

The following describes what the board considers acceptable experience. The applicant must provide proof that the experience meets these requirements.

1. The experience gained through military service must be substantially equivalent in character to civilian experience in similar fields or disciplines.
2. Experience must be of a grade and character that indicates to the board that the applicant is competent to practice and preferably be gained under the supervision of a registered professional engineer or professional land surveyor.
3. Experience must be substantially related to engineering or land surveying. Dual registration must fulfill experience requirements for each application without duplicate credits for time of gaining experience.
4. The board requires progressive experience in applying the principles and methods of engineering analysis and design for an applicant in fulfilling experience requirements if the applicant is seeking professional engineering registration.
5. The board requires progressive experience on surveying projects to indicate that it is of increasing quality and requiring greater responsibility. A substantial portion of the experience must be spent in charge of work related to property conveyance or boundary line determination, or both. The experience must demonstrate adequate experience in the technical field aspects of the profession. Applicants must demonstrate at least twelve months of cadastral/public land survey system within their documented work experience.
6. An engineering or land surveying applicant may be granted one year's experience for each postgraduate degree in the field of practice following a baccalaureate degree in the field of practice, not to exceed two years.
7. Military spouses. Military spouse applicants must satisfy the requirements located in North Dakota Century Code section 43-51-11.1.

    a. The board shall grant on a case-by-case basis exceptions to the board's licensing standards to allow a military spouse to practice the profession of engineering if upon application to the board:

        (1) The military spouse demonstrates competency in the profession through methods or standards determined by the board which must include experience in the profession

for at least two of the four years preceding the date of application under this section; and

(2) The board determines the issuance of the license will not substantially increase the risk of harm to the public.

b. The board shall issue a provisional license or temporary permit to a military spouse for which the licensure requirements under subdivision a have been substantially met. No fees may be charged a military spouse for a provisional license or temporary permit. The provisional license or temporary permit may not exceed two years and remains valid while the military spouse is making progress towards satisfying the unmet licensure requirements. A military spouse may practice under a provisional license or temporary permit until any of the following occurs:

(1) The board grants or denies the military spouse a North Dakota license under subdivision a or grants a North Dakota license under the traditional licensure method;

(2) The provisional license or temporary permit expires;

(3) The military spouse fails to comply with the terms of the provisional license or temporary permit; or

(4) The board revokes the provisional license or temporary permit based on a determination revocation is necessary to protect the health and safety of the residents of the state.

c. A military spouse issued a license under this section has the same rights and duties as a licensee issued a license under traditional licensure methods.

d. If within thirty days of receipt of a completed application under subdivision a the board does not grant or deny a license or does not issue a provisional license or temporary permit under subdivision b, the board automatically shall issue a provisional license or temporary permit. A provisional license or temporary permit issued under this subdivision remains valid until the board grants or denies the application for licensure under subdivision a or issues a provisional license or temporary permit per the requirements under subdivision b.

e. On each licensure application and renewal form the board shall inquire and maintain a record of whether an applicant or licensee is a member of the military or a military spouse. If an applicant self-identifies as and provides the board with satisfactory proof of being a military spouse, the board immediately shall commence the process to issue a license, provisional license, or temporary permit.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2010; October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-12, 43-19.1-14, 43-19.1-15, 43-19.1-16, 43-19.1-17, 43-51-11.1, 43-51-12

CHAPTER 28-02.1-05

28-02.1-05-02. Qualifications and requirements - Professional engineer by examination.

A person applying for registration as a professional engineer by examination must have an engineer intern certificate, ~~and~~the appropriate experience as required by North Dakota Century Code section 43-19.1-14, and must have passed the principles and practice of engineering examination. The experience must be subsequent to graduation~~,~~ and verifiable~~, and prior to writing the principles and practice of engineering examination~~.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2004; October 1, 2010; October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-14

CHAPTER 28-02.1-06

28-02.1-06-02. Qualifications and requirements - Professional land surveyor by examination.

A person applying for registration as a professional land surveyor by examination must have a land surveyor intern certificate ~~and~~, the appropriate experience as required by North Dakota Century Code section 43-19.1-16, and must have passed the principles and practice of surveying examination. ~~The experience must be prior to writing the principles and practice of surveying examination.~~

Upon successful completion of the principles and practice of surveying examination, professional land surveyor applicants must pass an examination pertaining to land procedures and practices in North Dakota.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2004; October 1, 2010; October 1, 2014; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-16, 43-19.1-16.1

CHAPTER 28-02.1-07

28-02.1-07-02. Issuance of certificate of commercial practice.

Certificates of commercial practice are not transferable and require the organization to:

1. Advise the board within thirty days of any disciplinary actions ~~that impair the registration and right to practice of any employee or officer of record~~administered by any jurisdiction against the certificate of commercial practice.

2. Renew and update annually the names of all employees licensed to practice engineering ~~or~~and/or land surveying in North Dakota.

3. Keep and maintain its ~~annual filing requirements~~certificate of authority with the North Dakota secretary of state's office ~~current~~active and in good standing and provide a copy to the board office.

4. A certificate of commercial practice is subject to the same disciplinary actions by the board as any individual registrant.

History: Effective January 1, 1988; amended effective April 1, 1999; October 1, 2010; October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-27

CHAPTER 28-02.1-08

28-02.1-08-01. Certificates.

1. Certificates of registration and certificates of commercial practice issued by the board should be displayed by the registrant in a prominent place in the registrant's office or principal place of business.

2. In case a certificate is lost or destroyed, a duplicate certificate will be issued upon request. The charge for a duplicate certificate shall be determined by the board.

3. Registrants may opt-in to receiving an electronic version of their certificate.

History: Effective January 1, 1988; amended effective April 1, 1999; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-20, 43-19.1-27

28-02.1-08-03. Use of seals.

1. The original copies of all drawings, plan sheets, specifications, studies, reports, plats, maps, and other engineering and surveying work product other than earthwork cross sections, each of which hereafter is referred to as a "document" in this section, must receive a seal, date, and signature.

   a. Studies, reports, and project specifications need the seal and signature only on a single introductory sheet.

   b. Every sheet or drawing in an original set of engineering plans must receive a seal and signature.

   c. If computer-generated or electronically generated seals or signatures are used on documents combined into a single file, they can be electronically applied by electronic process allowing the seal or signature to be computer-generated on all required documents by one computer action.

2. Registrants may accept assignments and assume responsibility for coordination of an entire project and sign and seal the engineering and land surveying documents for the entire project, provided that each technical segment is signed and sealed only by the qualified engineers or land surveyors who prepared the segment.

3. Registrants shall not affix their signatures or seals to any engineering or land surveying plan or document dealing with subject matter for which the registrant lacks competence by virtue of education or experience, nor to any such plan or document not prepared under the registrant's direct supervisory control.

4. A registrant shall not contract with a nonlicensed individual to provide these professional services.

5. A registrant may affix the seal and signature to drawings and documents depicting the work of two or more professionals, either from the same or different disciplines, provided it is designated by a note under the seal the specific subject matter for which each is responsible.

6. Any changes made to the final plans, specifications, drawings, reports, or other documents after final revision and sealing by the registrant are prohibited by any person other than the registrant, or another registered individual who assumes responsible charge for the directly related documents, except as provided herein. A duly registered individual making changes to final sealed documents must assume responsible charge and reseal the directly related final

documents unless the changes are construction phase revisions, including record drawings, which do not affect the functional design, and such revisions adequately reflect that changes have been made and the original plans are available for review.

7. Mere review of work prepared by another person, even if that person is the registrant's employee, does not constitute responsible charge.

8. A registrant may not affix the registrant's seal or signature to documents having titles or identities excluding the registrant's name unless:

   a. Such documents were developed by the registrant or under the registrant's responsible charge and the registrant has exercised full authority to determine their development.

   b. A registrant who is required to use the standard drawings of a sponsoring agency need not affix the registrant's seal and signature to said standard drawings.

   c. The registrant is providing the registrant's opinion as to the compliance of the document with specific identified rules or statutes and it is clearly identified that the registrant only reviewed the document and had no technical control over the contents of the document.

9. Electronic reproductions of drawings, plan sheets, specifications, studies, reports, plats, maps, and other engineering and surveying work product that are distributed to reviewing agencies, owners, clients, contractors, suppliers, and others must either contain the electronic seal and electronic signature as required by this chapter, or contain a reproduction of the seal and signature.

10. Paper or hard copy reproductions of drawings, plan sheets, specifications, studies, reports, plats, maps, and other engineering and surveying work product that are distributed to reviewing agencies, owners, clients, contractors, suppliers, and others shall contain a reproduction of the seal and signature. A new seal and original signature will not be required with such paper distribution.

11. Working drawings and unfinished documents must comply with North Dakota Century Code section 43-19.1-21.

History: Effective October 1, 2004; amended effective October 1, 2010; October 1, 2014; October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-21

CHAPTER 28-02.1-09

28-02.1-09-01. Expirations of certificates of registration.

The certificate ~~of registration issued to~~used to recognize individuals as land surveyor interns or engineer interns ~~has no~~will not be assigned a number and will not have an expiration date.

History: Effective January 1, 1988; amended effective October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-15, 43-19.1-16.1

28-02.1-09-02. Renewals.

Individual registrations and certificates of commercial practice may be renewed as follows:

1. Every ~~other~~even-numbered year, ~~beginning with 1999,~~ the board shall provide renewal notices prior to December first to the ~~last~~last-known address or electronic mail address of record for each ~~registration and certificate holder~~personal registrant. The renewal notice shall contain the amount of the renewal fee and the pending expiration date. Registrants need to opt-in to receive electronic mail notices.

2. Every year, ~~or every other year for biennial renewals,~~ the board shall mail certificate of commercial practice renewal notices prior to December first to the ~~last~~last-known address or electronic mail address of record for the ~~organization~~company. The renewal notice shall contain the amount of the renewal fee and the pending expiration date. Companies need to opt-in to receive electronic mail notices.

History: Effective January 1, 1988; amended effective November 1, 1998; April 1, 1999; October 1, 2010; October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-22

28-02.1-09-03. Reinstatements.

1. An individual registration that has ~~lapsed~~been inactive for more than one year, but less than ~~five~~four years, may become reinstated by submitting the board-approved renewal form and paying the renewal fee for the current registration period plus two years' back renewal fee provided the ~~lapsed~~inactive registrant meets all other requirements. A ~~holder of a~~ certificate of commercial practice ~~who~~that has ~~allowed the certificate to lapse~~been inactive for more than one year, but less than ~~five~~two years, may become reinstated by submitting the board-approved renewal form and paying the ~~current year renewal fee, which must be prorated for middle of biennium renewals~~renewal fee for the current registration period plus one years' back renewal fee provided the inactive holder meets all other requirements.

2. Registrations and certificates that have ~~lapsed five years~~been inactive for two or more renewal periods require reapplication updating all the required information of the applicant as if an original application. The board may require reexamination of registrants for all or a portion of the examination qualification requirements.

3. A retired registrant, ~~upon written request to the board~~after restoring their registration to an active status by submitting the board approved renewal form and payment of the current renewal fee, may resume active engineering or land surveying practice provided the retired registrant meets all other requirements. All rights and responsibilities of a valid or active registration will be in effect, including compliance with continuing professional competency requirements.

4. A registrant whose license has been lapsed, inactive, or retired for one year or more and who meets all other requirements is required to file an interim continuing professional competency report within one year of the date of reinstatement verifying that a minimum of fifteen professional development hours have been accomplished.

5. A registrant whose license has been lapsed, inactive, or retired for less than one year and who meets all other requirements ~~must show compliance within the previous two years with the continuing professional competency requirements set forth in article 28-04~~may renew their registration to an active status. Individual registrants must show compliance within the previous two years with the continuing professional competency requirements set forth in article 28-04.

6. Registrations and certificates that have been lapsed for more than one year require reapplication updating all the required information of the applicant as if an original application.

History: Effective January 1, 1988; amended effective November 1, 1998; April 1, 1999; October 1, 2004; October 1, 2010; October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-22

CHAPTER 28-02.1-10

28-02.1-10-01. Examinations.

1. The engineering and land surveying examinations are held when offered by the national council of examiners for engineering and surveying (NCEES).

2. ~~An~~A state-specific examination for registration as a professional land surveyor pertaining to land surveying laws, procedures, and practices in North Dakota shall require a passing score determined by the board. Individuals passing the national council of examiners for engineering and surveying (NCEES) principles and practices of land surveying exam may receive access to this exam after board approval of their application. Applicants will be given one year to pass the examination.

3. The board may require one or more questions in examinations measuring familiarity with the code of ethics. Similarly, in furtherance of the board's determination of rehabilitation of a registrant whose registration has been subject to disciplinary action, an examination on the code of ethics may be required.

History: Effective January 1, 1988; amended effective August 1, 1994; April 1, 1999; October 1, 2010; October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-19

28-02.1-10-02. Fees.

The fees charged may not exceed the following:

Registration Fees

Professional engineer	~~2 year~~	$150.00
Professional land surveyor	~~2 year~~	$150.00
Certificate of commercial practice	~~1 year~~	$100.00
Temporary permit	1 year	$100.00

Biennial Renewal Fees
The fees charged may not exceed the following for biennial renewal:

	If Renewal Received Prior to December 31	If Renewal Received After December 31
Professional engineer	$150.00	$200.00
Professional land surveyor	$150.00	$200.00
Professional engineer and land surveyor	$280.00	~~$400.00~~$375.00
Retiree	$20.00	$20.00

The following annual renewal fees will be charged:

Certificate of commercial practice	$100.00	$130.00

History: Effective January 1, 1988; amended effective August 1, 1994; November 1, 1998; April 1, 1999; October 1, 2004; January 1, 2011; October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-18, 43-19.1-27

CHAPTER 28-02.1-12
RETIRED STATUS

28-02.1-12-02. ~~Affidavit~~Process for changing registration status to retired.

Those persons wishing to obtain the status of a retired registration shall complete ~~an affidavit on a form as provided by the board~~the board-approved renewal form. ~~Affidavits shall be sent to the board office. Upon receipt of said affidavit and, if deemed eligible by the board, the retired status would become effective on the date of approval by the board. It shall not be necessary that an expired certificate of registration be renewed to be eligible for this status.~~ The board will not provide a refund of renewal fees if the application for retired status is made and granted before the date of expiration of the certificate of registration. Individuals with retired registrations must complete the renewal process to regain an active registration from the board. They will retain the registration number they had prior to entering a retired status.

History: Effective October 1, 2004; amended effective January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-27

CHAPTER 28-03.1-01

28-03.1-01-01. General statement.

In order to establish and maintain a high standard of integrity, skills, and practice in the profession of engineering and land surveying, the code of ethics contained in this chapter is binding upon every person holding a certificate of registration as a professional engineer or professional land surveyor, and upon all agents, employees, officers, ~~or~~ partners, and entities holding a certificate of commercial practice.

This chapter is specifically designed to further safeguard the life, health, property, and public welfare of the citizens of North Dakota, and must be construed to be a reasonable exercise of the police power vested in the board of registration for professional engineers and land surveyors by virtue of North Dakota Century Code chapter 43-19.1, and as such the board can establish conduct, policy, and practices to be adopted.

These rules are to be read and interpreted without regard to race, creed, or sex.

The engineer or land surveyor who holds a certificate of registration from the board is charged with having knowledge of the existence of this chapter for professional conduct as an engineer or land surveyor, and also must be deemed to be familiar with the provisions and to understand them. Such knowledge shall encompass the understanding that the practice of engineering and land surveying is a privilege as opposed to a right, and the engineer or land surveyor must be forthright and candid in statements or written responses to the board or its representatives on matters pertaining to professional conduct.

History: Effective January 1, 1988; amended effective April 1, 1999; October 1, 2010; January 1, 2024.
General Authority: NDCC 43-19.1-08
Law Implemented: NDCC 43-19.1-24

28-04-01-03. General requirements.

All individual registrants must acquire thirty professional development hours every two years before renewing their license.

1. At least twenty professional development hours must be in technical subjects that directly safeguard the public's health, safety, and welfare, including technical professional management subjects such as total quality process or technical engineering or land surveying software training.

2. A maximum of ten professional development hours may be in nontechnical professional-related subjects. At least one nontechnical professional development hour must be in an ethics-oriented class.

3. ~~All registrants will be required to submit a list of continuing professional development activities that they participated in and sign a statement that they have met this requirement as part of the renewal process~~If chosen for audit, registrants will be required to submit a list of continuing professional development activities and associated certificates/documents.

4. Registrants holding both professional engineering and surveying registrations must earn a minimum of one-third, or ten professional development hours in each profession with a total of thirty professional development hours every two years. A dual registrant is not required to obtain more than thirty professional development hours per biennial renewal period because of dual registrations.

5. A maximum of fifteen qualifying professional development hours may be forwarded to the subsequent biennial renewal period.

6. Comity for continuing professional development is allowed if the registrant is currently licensed in a jurisdiction or state that requires mandatory continuing professional competency and meets the minimum requirements as established by the North Dakota state board of registration for professional engineers and land surveyors.

7. New registrants shall comply with continuing education requirements as follows: registrants who receive their license prior to the fourth quarter in an odd-numbered year shall report the full biennial requirement of thirty professional development hours at the time of next renewal; and registrants who receive their license prior to the fourth quarter in an even-numbered year shall report one-half of the biennial requirement, i.e., fifteen professional development hours, at the time of next renewal.

History: Effective October 1, 2004; amended effective October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-33
Law Implemented: NDCC 43-19.1-33

28-04-01-04. Recordkeeping.

Recordkeeping is the responsibility of the registrant. Adequate records must be maintained for a minimum of four years from the date of last biennial renewal for auditing purposes. Records may be maintained ~~by a professional registry, such as the professional development registry for engineers and surveyors. Records that are maintained by such a registry do not necessarily require approval of these courses by this board~~on an automated platform that allows the data to be exported to a commonly used and readable file type. Records required include:

1. A log showing the type of activity claimed, sponsoring organization, location, duration, date, instructor's or speaker's name, and professional development hour credits claimed. ~~This~~

~~permits the proper completion of professional development hour activities at renewal time.~~ Specific information on each activity is required. Simply stating "attending education activities at ABC Company" is not acceptable.

2. Attendance verification records in the form of certificates, attendance electronic mails, or other documents supporting evidence of attendance. The registrant must have sufficient verification for all credits claimed. Registration alone does not constitute attendance.

History: Effective October 1, 2004; amended effective January 1, 2024.
General Authority: NDCC 43-19.1-33
Law Implemented: NDCC 43-19.1-33

28-04-01-05. Qualifying activities.

The board ~~may~~does not preapprove courses, providers, or activities. ~~Until the board preapproves such courses or activities, it~~It is the responsibility of the registrant to determine whether the activity qualifies under this board's requirements. ~~The board has final approval~~During the audit process, the board will make the final determination of professional development hour credit. ~~Examples of typical qualifying and nonqualifying activities are available by contacting the office of the board or visiting the board's web site.~~ All professional development hour allowances stated in this section are biennial ~~allowances~~requirements. ~~Qualifying~~Examples of qualifying activities include:

1. **College unit, semester, or quarter hour credit for college courses.** A course must be regularly offered and participants tested with a passing grade required. One semester hour generally consists of fifteen class meetings of fifty to fifty-five minutes duration. It is assumed that twice as much study time is required as class contact time, thus equating to forty-five professional development hours. Similarly, a quarter hour qualifying course meets ten times and thus thirty professional development hours are allowed. Monitoring courses do not require a test, and therefore only the actual class contact hours are allowed. On occasion, educational institutions may offer a one-day seminar and award fractional quarter hour credit such as one-half of a quarter hour. These courses do not qualify on the quarter hour basis since they are not part of the regular curriculum of the educational institution, do not require testing, and have no provision for additional out-of-class requirements. For courses such as this, only actual contact hours will be allowed for professional development hour credit.

2. **Interactive activities.** Other qualifying courses, seminars, employer-sponsored educational activities, programs, and activities are allowed one professional development hour credit for each contact hour. A correspondence course, recorded programs, and online courses ~~(self-study)~~ must require the participant to show evidence of achievement with a final graded test or certificate of completion.

3. **Teaching credit for short courses.** Teaching credits for the instructor are twice that of the participants in qualifying courses and seminars. However, repetitive teaching of the same course will not earn additional credit.

4. **Published paper, article, or book.** A published paper, article, or book must be a serious effort to qualify. For example, a news article in a technical or professional bulletin is not considered a published paper. Although it is recognized that often many more hours are spent in being an author of a publication, ten professional development hours are allowed for publication. Only one publication may be claimed for professional development hours per renewal period. Repetitive publication of the same paper or article will not earn additional credit.

5. **Active participation in professional and technical societies and licensing boards.** Active participation in professional and technical societies is to encourage registrants to participate fully in appropriate technical and professional societies. Contact with one's peers at such meetings is considered one way to stay abreast of current topics, issues, technical

developments, ethical situations, and learning opportunities. Two professional development hours per biennium can be earned for each organization with a maximum of six professional development hours per biennium allowed. All technical and professional societies are included, but this does not include civic or trade organizations. Up to ten professional development hours per biennium may be earned by individuals who serve on any jurisdiction's licensing board for engineers and/or land surveyors.

6. **Patents.** Patents are allowed ten professional development hours after a patent is issued and the inventor submits details to the board. The invention must be related to the registrant's profession.

7. **STEM.** Active facilitation/support of STEM programs is highly encouraged. The board allows registrants to claim no more than four professional development hours per biennium for these activities. Registrants must complete and retain the board approved professional development hours certificate found on the board's website.

History: Effective October 1, 2004; amended effective October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-33
Law Implemented: NDCC 43-19.1-33

28-04-01-07. Exemptions.

A registrant may be exempt from the continuing education requirements for one of the following reasons:

1. A registrant serving on temporary active duty in the armed forces of the United States, or a registrant serving on regular active duty who is deployed for a period of time exceeding one hundred twenty consecutive days in a year, shall be exempt from obtaining the professional development hours required during that year.

2. Registrants experiencing physical disability, illness, temporary leave from professional activity, or other extenuating circumstances as reviewed and approved by the board may be exempt. Supporting documentation must be furnished to the board. In the event such a person elects to return to active practice of professional engineering or land surveying, fifteen professional development hours must be earned before returning to active practice for each year exempted not to exceed the biennial requirement of thirty professional development hours.

3. Professional engineer registrants exempt from registration by North Dakota Century Code section 43-19.1-29 but voluntarily registered are exempt from continuing professional competency requirements. A claim of exemption under this provision must be verified by the board. This exemption is based on the registrant's primary employment. If the registrant provides engineering services outside the scope of primary employment, the exemption will be voided and the registrant will be required to comply with the continuing professional competency requirements. A person who is registered because of a requirement in the person's job description or qualification for a pay grade is not voluntarily registered. Noncompliance with the provisions of this exemption shall be grounds for disciplinary action as allowed by North Dakota Century Code section 43-19.1-25.

4. Registrants who qualify for retired status on the board-approved renewal form shall be exempt from the continuing education requirements. A registrant whose license has been retired for one year or more and who meets all other requirements may reinstate a retired license~~. A registrant who has reinstated a license~~ and is required to file an interim continuing professional competency report within one year of the date of reinstatement verifying that a minimum of fifteen professional development hours have been accomplished. A registrant whose license has been retired for less than one year and who meets all other requirements may reinstate a retired license~~. A registrant who has reinstated a license~~ and must show

compliance within the previous two years with the continuing professional competency requirements set forth in this chapter at the time of reinstatement.

5. The board reserves the right to modify the requirements for continuing education based on extenuating circumstances that would prevent or restrict a registrant from obtaining the required professional development hours. This modification would not reduce the overall credits needed but allows for an extension in time to fulfill the requirements.

History: Effective October 1, 2004; amended effective October 1, 2021; January 1, 2024.
General Authority: NDCC 43-19.1-33
Law Implemented: NDCC 43-19.1-33

TITLE 33

STATE DEPARTMENT OF HEALTH

JANUARY 2024

CHAPTER 33-04-12
CORRECTION AND AMENDMENT OF VITAL RECORDS

33-04-12-01. Amendment of minor errors on birth records during the first year.

Amendment of obvious errors, transposition of letters in words of common knowledge, or omissions on birth records may be made by the state registrar within the first year after the date of birth either by the state registrar's own observation or query or upon request of ~~a person~~an individual with a direct and tangible interest in the record as defined in section 33-04-13-01. When such additions or minor amendments are made by the state registrar, a notation as to the source of the information together with the date the change was made and the initials of the authorized agent making the change shall be made on the record in such a way as not to become a part of any record issued. The record is not to be marked as "amended".

History: Amended effective January 1, 2008; January 1, 2024.
General Authority: NDCC 23-02.1-04, 28-32-02
Law Implemented: NDCC 23-02.1-25(2)

33-04-12-02. Amendments as a result of ~~gender identity change~~sex reassignment surgery.

1. **Evidence and documents required.** The birth record of ~~a person~~an individual born in this state who has undergone ~~a~~an acceptable sex ~~conversion operation~~reassignment surgery, where the sex of the individual was changed with anatomically correct genitalia for the identified sex as certified by a medical provider, may be amended as follows:

   a. Upon written request of the ~~person~~individual who has undergone the ~~operation~~surgery;

   b. ~~An affidavit~~A notarized form, provided by the department, signed by a ~~physician~~medical provider that ~~the physician~~ has performed ~~an operation~~the surgery on the ~~person~~individual, and that by reason of the ~~operation~~surgery, the sex ~~designation~~ of ~~such~~

~~person's birth record should be~~the individual has been changed to the anatomically correct genitalia of the identified sex; and

c. An order of a court of competent jurisdiction decreeing a legal change in name, if one is so desired.

2. **New record.** Pursuant to such amendment, a new record of birth will be created by the state registrar showing original data as transcribed from the original record excepting those items that have been amended. The new record will be clearly marked in the upper margin with the word "amended" and a description of the amended items may be added to the certified copy for clarification.

3. **Sealing of original record.** The original record shall be then placed in a special file and shall not be open to inspection except by order of a court of competent jurisdiction or by the state registrar for purpose of carrying out the provisions of North Dakota Century Code chapter 23-02.1 and properly administering the vital records registration program.

4. **Acceptable sex reassignment surgeries.** The vital records office shall maintain a list of acceptable sex reassignment surgeries that must be routinely reviewed to ensure the list is updated as any new acceptable surgeries meeting the criteria become available. The acceptable sex reassignment surgeries must change an individual's sex with the correct genitalia of the new identified sex and remove the sexual function of the previous sex.

History: Amended effective January 1, 2008; January 1, 2024.
General Authority: NDCC 23-02.1-04, 28-32-02
Law Implemented: NDCC 23-02.1-04

33-04-12-04. Who may apply.

1. To amend a birth record, application may be made by one of the parents, the guardian, or the registrant if at least eighteen years of age.

2. To amend a death or fetal death record, application may be made by the next of kin or the funeral director or ~~person~~an individual acting as such. Applications to amend the medical certification of cause of death shall be made by the attending physician or coroner.

History: Amended effective January 1, 2008; January 1, 2024.
General Authority: NDCC 23-02.1-04, 28-32-02
Law Implemented: NDCC 23-02.1-25(3)

33-04-12-07. Medical items.

All items in the medical certification or of a medical nature may be amended only upon receipt of a signed statement from those ~~persons~~individuals responsible for the completion of such items. The state registrar may require documentary evidence to substantiate the requested amendment.

History: Amended effective January 1, 2024.
General Authority: NDCC 23-02.1-04, 28-32-02
Law Implemented: NDCC 23-02.1-04

CHAPTER 33-06-01

33-06-01-01. Reportable conditions.

All reports and information concerning reportable conditions are confidential and not open to inspection. The following designated reportable conditions must be reported to the ~~state~~ department of health and human services by the persons designated in chapter 33-06-02. If any reportable condition is designated by an asterisk, an appropriate sample or isolate must be submitted to the ~~division of microbiology (~~public health laboratory~~)~~ in addition to the required report.

1. Acute flaccid myelitis.
2. Alpha-gal syndrome.
3. Anthrax*.
~~3.~~4. Arboviral infection.
~~4.~~5. Botulism*.
~~5.~~6. Brucellosis*.
~~6.~~7. Campylobacteriosis.
~~7.~~8. Cancer, all malignant and in situ carcinomas; in addition, all benign cancers of the central nervous system, pituitary gland, pineal gland, and craniopharyngeal duct. Carcinoma in situ of the cervix is not collected. Basal or squamous cell carcinoma is not collected unless diagnosed in the labia, clitoris, vulva, prepuce, penis, or scrotum.
~~8.~~9. Candida auris*.
~~9.~~10. CD4 test results (all).
~~10.~~11. Chickenpox (varicella).
~~11.~~12. Chlamydial infections.
~~12.~~13. Cholera*.
~~13.~~14. Cluster of severe or unexplained illness or deaths.
~~14.~~15. Coccidioidomycosis.
~~15.~~16. Creutzfeldt-Jakob disease.
~~16.~~17. Critical ~~congential~~congenital heart disease (CCHD).
~~17.~~18. Cryptosporidiosis.
~~18.~~19. ~~Cycloporiasis~~Cyclosporiasis.
~~19.~~20. Diphtheria*.
~~20.~~21. E. coli, shiga toxin-producing*.
~~21.~~22. Fetal alcohol syndrome (FAS).
~~22.~~23. Foodborne or waterborne outbreaks.
~~23.~~24. Giardiasis.

~~24.~~25. Glanders*.

~~25.~~26. Gonorrhea.

~~26.~~27. Haemophilus influenzae infection (invasive infection with haemophilus influenzae isolated from blood, cerebral spinal fluid, or other normal sterile site)*.

~~27.~~28. Hantavirus*.

~~28.~~29. Hemolytic uremic syndrome.

~~29.~~30. Hepatitis (A*, B, C, D, and E), including hepatitis B and C nucleic acid test result (detectable or nondetectable) and hepatitis C genotype results.

~~30.~~31. Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS). (Any positive HIV test result, including gene sequencing and drug resistance patterns.) Human immunodeficiency virus (HIV) nucleic acid test result (including nondetectable).

~~31.~~32. Influenza (electronic laboratory reporting, novel cases, and pediatric deaths)*.

~~32.~~33. Laboratory incidences involving the possible release of category A bioterrorism agents or novel influenza viruses into the laboratory environment.

~~33.~~34. Lead blood level results (all).

~~34.~~35. Legionellosis.

~~35.~~36. Leptospirosis.

~~36.~~37. Listeriosis*.

~~37.~~38. Malaria*.

~~38.~~39. Measles (rubeola)*.

~~39.~~40. Melioidosis*.

~~40.~~41. Meningococcal disease (invasive infection with ~~neisseria~~Neisseria meningitidis isolated from blood, cerebral spinal fluid, or other normal sterile site)*.

~~41.~~42. Mumps*.

~~42.~~43. Neonatal abstinence syndrome (NAS).

~~43.~~44. Nipah viral infections*.

~~44.~~45. Nosocomial outbreaks.

~~45.~~46. Novel severe acute ~~respiratory~~ illness*.

~~46.~~47. Organisms resistant to carbapenem or with emerging antimicrobial resistance*.

48. Orthopoxvirus*.

~~47.~~49. Overdose.

~~48.~~50. Pertussis.

~~49.~~51. Plague*.

~~50.~~52. Poliomyelitis*.

~~51.~~53. Pregnancy in a person infected with hepatitis B or C, HIV, or syphilis.

~~52.~~54. Q fever*.

~~53.~~55. Rabies (animal or human*), all results.

56. Respiratory panel test result (electronic laboratory reporting).

57. Respiratory syncytial virus (electronic laboratory reporting and pediatric deaths).

~~54.~~58. Rubella*.

~~55.~~59. Salmonellosis*.

~~56.~~60. Scabies outbreaks in institutions.

61. Severe acute respiratory syndrome-associated coronavirus disease (electronic laboratory reporting and pediatric deaths)*.

~~57.~~62. Shigellosis*.

~~58. Smallpox*.~~

~~59.~~63. Staphylococcus aureus, vancomycin resistant and intermediate resistant (VRSA and VISA)*.

~~60.~~64. Staphylococcus enterotoxin B intoxication*.

~~61.~~65. Streptococcus pneumoniae infections (invasive infection isolated from blood, cerebral spinal fluid, or other normal sterile site)*.

~~62.~~66. Suicide and suicide attempts.

~~63.~~67. Syphilis.

~~64.~~68. Tetanus.

~~65.~~69. Tickborne diseases*.

~~66.~~70. Trichinosis.

~~67.~~71. Tuberculosis (tuberculosis infection caused by Mycobacterium tuberculosis or Mycobacterium bovis)*. ~~Suspected or confirmed cases of tuberculosis disease must be reported within twenty-four hours.~~ Laboratories that receive specimens for tuberculosis testing shall report all results obtained by an appropriate procedure. This includes all smear results for acid-fast bacilli, results of cultures to look for M. tuberculosis complex, and results of rapid methodologies, including nucleic acid amplifications which are performed when M. tuberculosis complex is suspected (only via electronic laboratory reporting). Positive results of tests performed by purified protein derivative antigen ~~or~~and all results by any other ~~diagnostic~~ test approved for the purpose of identifying tuberculosis infection, (i.e. interferon gamma release assay) with corresponding values as available.

~~68.~~72. Tularemia*.

~~69.~~73. Tumors of the central nervous system.

~~70.~~74. Typhoid fever*.

~~71.~~75. Unexplained or emerging critical illness or death.

~~72.~~76. Vibriosis*.

~~73.~~77. Violent death.

~~74.~~78. Viral hemorrhagic fevers.

~~75.~~79. Weapons of mass destruction suspected event.

~~76.~~80. Yellow fever*.

History: Amended effective May 1, 1984; December 1, 1986; January 1, 1988; January 1, 1989; October 1, 1990; January 1, 1991; February 1, 1992; May 1, 1994; January 1, 1995; July 1, 1996; February 1, 2000; August 1, 2002; March 1, 2003; July 1, 2004; April 1, 2007; January 1, 2011; January 1, 2018; October 1, 2019; January 1, 2024.
General Authority: NDCC 23-07-01
Law Implemented: NDCC 23-07-01

CHAPTER 33-07-01.1

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

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

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

   b. Skilled nursing facilities and nursing facilities.

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

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

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

   a. ~~Any institutions that are regularly~~American society of addiction medicine level 3.7 substance use treatment programs licensed by the ~~social service board of North Dakota, such as homes for unmarried mothers~~department that are independent from a medical hospital.

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

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

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

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

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

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

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

or their families used within their hearing distance to describe the patients, regardless of their age, ability to comprehend, or disability.

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

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

d. "Bed capacity" is bed space designed for inpatient care.

(1) Areas to be included:

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

[1] Intensive care or cardiac care units.

[2] Minimal or self-care units.

(b) Isolation units.

(c) Pediatrics units, including:

[1] Pediatric bassinets.

[2] Incubators located in the pediatrics department.

(2) Areas to be excluded:

(a) Newborn nurseries in the obstetrical department.

(b) Labor and delivery rooms.

(c) Recovery rooms.

(d) Emergency units.

(e) Preparation or anesthesia induction rooms.

(f) Rooms designed for diagnostic or treatment procedures.

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

e. "Department" means the North Dakota ~~state~~ department of health and human services.

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

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

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

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

[1] Dietary services.

[2] Medical records services.

[3] Pharmaceutical services.

[4] Laboratory services.

[5] Radiology services.

[6] Emergency services.

[7] Social services.

[8] Basic rehabilitation services.

[9] Housekeeping and related services including laundry.

[10] Central services.

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

[1] Nuclear medicine services.

[2] Surgical services.

[3] Recovery services.

[4] Anesthesia services.

[5] Respiratory care services.

[6] Obstetrical services.

[7] Specialized rehabilitation services.

[8] Psychiatric services.

[9] Outpatient birth services.

(2) "Primary care hospital" means a facility that has available twenty-four-hour licensed health care practitioner and nursing services, provides inpatient care to ill or injured ~~persons~~individuals prior to their transportation to a general acute hospital, or provides inpatient care to ~~persons~~individuals needing acute-type care for a period of no longer than an average of ninety-six hours, excluding ~~persons~~individuals participating in a federal swing-bed program.

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

[1] Dietary services.

[2] Medical records services.

[3] Pharmaceutical services.

[4] Laboratory services.

[5] Radiology services.

[6] Emergency services.

[7] Social services.

[8] Basic rehabilitation services.

[9] Housekeeping and related services including laundry.

[10] Central services.

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

[1] Nuclear medicine services.

[2] Surgical services.

[3] Recovery services.

[4] Anesthesia services.

[5] Respiratory care services.

[6] Obstetrical services.

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

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

[1] Dietary services.

[2] Medical records services.

[3] Pharmaceutical services.

[4] Laboratory services.

[5] Radiology services.

[6] Emergency services.

[7] Social services.

[8] Basic rehabilitation services.

[9] Housekeeping and related services including laundry.

[10] Central services.

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

[1] Nuclear medicine services.

[2] Surgical services.

[3] Recovery services.

[4] Anesthesia services.

[5] Respiratory care services.

[6] Obstetrical services.

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

[1] "Psychiatric hospital" means a facility or unit providing psychiatric services to patients with a diagnosis of mental illness. A psychiatric hospital is a hospital licensed to provide only psychiatric services or is a distinct unit providing only psychiatric services located in a general acute hospital. Psychiatric hospitals must provide services consistent with section 33-07-01-36.

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

[3] "Outpatient birth hospital" means a facility, separate from acute obstetric and newborn care, providing outpatient obstetrical, birthing, and neonatal services to patients. Outpatient birth services are organized to provide maternity care in which births are planned to occur in a setting away from the ~~mother's~~individual's usual residence following a low-risk pregnancy with anticipation of a low-risk birth. Low-risk pregnancy and birth means a normal uncomplicated birth as defined by generally accepted criteria of maternal and fetal health. A low-risk pregnancy and birth must be full term, singleton, and multipara, with vertex presentation.

[4] "Rural emergency hospital" means a facility that operates for the purpose of providing emergency department services, observation care, and other outpatient medical and health services in which the annual per-patient average length of stay does not exceed twenty-four hours. The facility may not provide inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish posthospital extended care services.

h. "Level I nursery" means a well newborn nursery, consistent with American academy of pediatrics standards, providing a basic level of care to neonates who are low risk.

i. "Level II nursery" means a special care nursery, consistent with American academy of pediatrics standards, for stable or moderately ill newborn infants who are born at greater than or equal to thirty-two weeks gestation or who weigh greater than or equal to one

thousand five hundred grams at birth with problems that are expected to resolve rapidly and who would not be anticipated to need subspecialty-level services on an urgent basis.

j. "Level III nursery" means a neonatal intensive care unit, consistent with American academy of pediatrics standards, for infants who are born at less than thirty-two weeks gestation, weigh less than one thousand five hundred grams at birth, or have medical or surgical conditions.

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

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

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

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

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

p. "Nursing facilities" are the following:

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

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

q. "Outpatient facility" (including ambulatory surgical centers and trauma centers - excluding physicians' clinic) means a facility, located in or apart from a hospital; providing community service for the diagnosis or diagnosis and treatment of ambulatory patients (including ambulatory inpatients) in need of physical or mental care:

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

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

r. ~~"Qualified activities coordinator" means a qualified therapeutic recreation specialist who is eligible for registration as a therapeutic recreation specialist by the national therapeutic recreation society (branch of national recreation and park association) under its requirements; is a qualified occupational therapist as defined in North Dakota Century Code chapter 43-40; is certified as an occupational therapist assistant; or has two years~~

~~of experience in a social or recreational program within the last five years, one year of which was as a full-time employee in a patient activities program in a health care setting; or has completed a training course approved by the department.~~

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

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

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

History: Effective April 1, 1994; amended effective August 1, 1999; May 1, 2001; July 1, 2017; January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06, 31-08-01.2, 31-08-01.3

33-07-01.1-02. Issuance of license.

The department shall issue licenses and a separate license for building on separate premises to hospitals that meet the licensing requirements. The license must reflect the annual or provisional status of the hospital. The license applies only to the hospital designated on the license.

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

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

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

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

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-04. Access by the department.

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

1. Entry to all hospital premises.

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

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

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

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-08. Enforcement.

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

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

      (1) Present imminent danger to patients;

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

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

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

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

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

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

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

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

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

3. The department shall notify the hospital in writing when a decision is made to initiate a ban or limitation on admissions, a suspension or revocation of a license, or a denial to license. The

notice must include the basis of the department's decision and must advise the hospital of the right to:

a. Request a review by the department.

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

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

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

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

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

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

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

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

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

(3) Within ten days of receipt of the request for a hearing, the department shall request a hearing officer from the office of administrative hearings as provided in North Dakota Century Code chapter 54-57.

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

(5) The ~~health council~~department may accept, modify, or reject the recommended decision. If the ~~health council~~department rejects the recommended decision, it may remand the matter to the office of administrative hearings with directions. The ~~health council, through its directions,~~department may require the receipt of additional evidence, and submission of amended findings of fact, conclusions of law, and recommended decision which reflects consideration of additional evidence. The ~~health council, through its directions,~~department may require that the matter be

referred to the same or a different hearing officer, and the office of administrative hearings shall comply with that direction unless compliance is impossible.

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

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

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-09. Governing body.

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

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

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

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

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

      (1) The role and purpose of the hospital.

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

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

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

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

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

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

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

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

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

(2) Periodic performance appraisals.

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

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

(a) The right to considerate and respectful care.

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

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

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

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

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

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

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

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

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

(5) The orientation program for all new employees.

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

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

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

(9) An effective disaster plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The role and purpose of the hospital.

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

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

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

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

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

b. Ensure that the medical staff:

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

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

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

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

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

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

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

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

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

~~(4)~~(3) Sufficient staff must be available at all times to meet patient care needs.

~~(5)~~(4) That all medical orders must be in writing and signed and dated by a licensed health care practitioner.

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

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

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

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

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

h. Ensure that each order for drugs and biologicals is consistent with federal and state law and is in writing and signed by the licensed health care practitioner who is both responsible for the care of the patient and legally authorized to prescribe.

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

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

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

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

(1) A general acute hospital.

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

3. Specialized hospitals are subject to the governing body requirements for general acute hospitals in this section, with the exception of rural emergency hospitals, which are subject to the governing body requirements for primary care hospitals in this section.

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-12. Disaster plan.

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

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

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

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-14. Infection control.

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

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

   a. The responsibilities of the program include:

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

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

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

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

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

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

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

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

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

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-15. Medical staff.

1. The general acute hospital shall have an organized medical staff that is accountable to the governing body in accordance with written bylaws, rules, and regulations approved by the

governing body. The medical staff shall adopt and enforce bylaws, rules, and regulations to carry out its responsibilities which specifically provide, but are not limited to, the following:

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

b. The mechanism for appointment, reappointment, and renewal of medical staff membership, and the granting of clinical privileges initially and at least every ~~twenty-four~~thirty-six months as a part of an evaluation of staff membership. Medical staff membership and clinical privileges shall be granted by the governing body based on medical staff recommendations in accordance with the bylaws, rules, regulations, and policies of the medical staff and the hospital.

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

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

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

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

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

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

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

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

(2) Prior to granting or renewing privileges or association to any licensed health care practitioner, the hospital shall query the national practitioner data bank regarding physicians and request all previous hospital or clinical practice information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The reasons for the proposed action.

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

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

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

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

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

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

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

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

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

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

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

c. A licensed health care practitioner on staff must:

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

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

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

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

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

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

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

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

3. Specialized hospitals are subject to the medical staff requirements for general acute hospitals in this section, with the exception of rural emergency hospitals, which are subject to the medical staff requirements for primary care hospitals in this section.

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-16. Nursing services.

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

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

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

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

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

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

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

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

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

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

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

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

b. A registered nurse must provide or assign to other personnel the nursing care of each patient, including patients at a skilled nursing facility level of care in a swingbed. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. When a registered nurse is not on duty, the nurse executive or another registered nurse designated as the nurse executive's alternate must be on call and available within twenty minutes at all times.

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

3. Specialized hospitals are subject to the nursing services requirements for general acute hospitals in this section, with the exception of rural emergency hospitals, which are subject to the nursing services requirements for primary care hospitals in this section.

History: Effective April 1, 1994; amended effective August 1, 1999; January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-19. Dietary services.

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

a. The hospital shall designate an employee to be responsible for the total food service of the facility. If this employee is not a licensed registered dietitian, the employee must have at least completed a food service course approved by the academy of nutrition and dietetics or its predecessor or successor organization and receive at least monthly consultation from a licensed registered dietitian consultant.

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

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

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

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

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

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

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

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

(1) Appropriate lighting and ventilation must be maintained.

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

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

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

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

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

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

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

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

History: Effective April 1, 1994; amended effective April 1, 2013; January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

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

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

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

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

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

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

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

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

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

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

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

c. If a registered record administrator or accredited record technician is not in charge of medical records, a consultant registered record administrator or accredited record technician shall organize the service, coordinate the training of the personnel, and make at least quarterly visits to the hospital to evaluate the records and the operation of the service.

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) Tissue reports must include a report of microscopic findings if hospital regulations require that microscopic examination be done. If only gross examination is warranted, a statement that the tissue has been received and a gross description must be made by the laboratory and filed in the medical record.

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

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

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

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

(2) Telephone and verbal orders may be used provided they are given only to qualified licensed personnel and reduced to writing and dated, timed, and signed or initialed by a licensed health care practitioner responsible for the care of the patient within forty-eight hours unless the hospital policies and procedures for verbal orders and telephone orders include a process by which the reviewer of the order reads the order back to the ordering practitioner to verify its accuracy. For verbal orders and telephone orders using the read-back and verify process, the verbal orders and telephone orders must be authenticated within thirty days of discharge or within thirty days of the date the order was given if the length of stay is longer than thirty days.

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

examination and summary written by the medical students and unlicensed residents.

(4) Signature stamps may be utilized consistent with hospital policies as long as the signature stamp is utilized only by the licensed health care practitioner whose signature the signature stamp represents. Written assurance must be on file from the licensed health care practitioner to indicate that the practitioner is the sole user of the signature stamp.

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

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

(b) The safeguards to ensure confidentiality, including:

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

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

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

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

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

[1] A system that requires completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps, or obvious contradictory statements appearing within those designated fields. The system must require that correction or supplementation of previously authenticated entries must be made by additional entries, separately authenticated and made subsequent in time to the original entry.

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

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

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

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

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

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

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

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

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

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

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

History: Effective April 1, 1994; amended effective July 1, 2004; July 1, 2009; January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06, 31-08-01.2, 31-08-01.3

33-07-01.1-23. Radiology services.

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

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

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

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

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

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

f. Radiation workers must be checked by film dosimeter to determine the amount of radiation to which they are routinely exposed. Records must be maintained to reflect each individual's exposure level. These checks must be conducted on a monthly basis until the radiation exposure history for the radiation worker indicates levels below maximum permissible dose for a period of one year. When radiation dose levels have remained below the maximum permissible dose for a year, radiation doses may be monitored on a quarterly basis as long as the exposure remains below the maximum permissible dose.

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

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

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-25. Emergency services.

1. Each general acute hospital shall provide emergency services to its inpatients. If the hospital does not provide emergency services to the public, it shall be prepared to provide immediate lifesaving measures to ~~persons~~individuals who may appear for emergency care and arrange for their transfer to another hospital that does provide a public emergency service.

   a. Each hospital shall have a well-defined plan for emergency care service based on the capability of the hospital and its specialized supportive services.

      (1) The hospital plan for emergency care services must be developed to coordinate with representatives of community emergency medical services agencies or groups.

      (2) Hospitals without emergency service for the public shall have written policies and procedures governing the handling of emergencies.

   b. Every hospital with an emergency service shall provide treatment to every ~~person~~individual in an emergency without discrimination on account of economic status or source of payment.

   c. Every emergency service shall have a qualified licensed health care practitioner designated in charge of the emergency medical services to ensure that emergency patient care services meet the standards herein and for the coordination of professional coverage according to a plan established by the medical staff and approved by the governing body.

   d. A hospital must have one or more licensed health care practitioners qualified by training and experience in care of emergency patients on duty or call at all times and available to respond to emergencies within thirty minutes. The licensed health care practitioner shall determine the nature, level, and urgency of care required of all ~~persons~~individuals

seeking treatment and categorize them accordingly, assuring that serious cases are accorded priority treatment.

e. The staffing pattern of nursing or allied health personnel must be consistent with the scope and complexity of the emergency services provided. At least one licensed ~~person~~individual who is qualified by training and experience in emergency care must be assigned to the emergency services at all times.

f. A current roster of licensed health care practitioners, medical specialists, or consultants on emergency call, including alternates, must be kept posted at all times in the emergency service area.

g. There must be current written policies governing emergency services. The policies and procedures must pertain to at least the following:

(1) Medical staff and obligation for emergency patient care.

(2) Circumstances under which definitive care will not be provided and procedures to be followed in referrals.

(3) Procedures that may or may not be performed in the emergency service area.

(4) Handling of ~~persons~~individuals who are emotionally ill, under the influence of drugs or alcohol, dead on arrival, or other categories of special cases as determined necessary.

(5) Procedures for early transfer of severely ill or injured to special in-house treatment areas or to other facilities.

(6) Written instructions to be given for followup care and disposition of all cases.

(7) Notification of patient's personal licensed health care practitioner and transmission of relevant reports.

(8) Disclosure of patient information in accordance with federal and state law.

(9) Communication with police, health authorities, and emergency vehicle operators.

(10) Appropriate utilization of observation beds.

(11) Procurement of equipment and drugs.

(12) Location and storage of medications, supplies, and special equipment.

(13) Operation of the emergency service in times of disaster.

h. A list of poison antidotes and the telephone number of the poison control center must be posted in a prominent place in the emergency service area.

i. The emergency service shall have necessary supportive services available on a twenty-four-hour basis. These services must include onsite clinical laboratory service plasma expanders, provision for blood or blood products; pharmaceutical service; onsite radiology service including protocol to govern the interpretation by a radiologist of diagnostic images produced by x-ray, or other modalities if provided, including a procedure for the prompt communication of the radiologist's interpretation; and surgical and anesthesia service or referral process for surgical and anesthesia service.

j. At a minimum, the following special supplies and equipment must be available in a complete set of adult and pediatric sizes for the provision of emergency services:

(1) Oxygen.

(2) Pulse oximeter.

(3) Complete set of bag/valve/mask ventilation devices.

(4) Complete set of oral and nasal airways.

(5) Suction equipment.

(6) Endotracheal intubation, pericardiocentesis, thoracotomy, and cricotracheotomy trays.

(7) Electrocardiograph.

(8) Cardiac monitor and defibrillator with battery pack.

(9) Moveable equipment cart for use as a crash cart.

(10) American heart association advanced cardiac life support recommended drug inventory.

(11) Intravenous fluids including lactated ringers solution and dextrose five percent in water.

(12) Infusion pump.

(13) Pressure infuser.

(14) Gastric lavage equipment.

(15) Urinary catheter kits.

(16) Emergency obstetrical pack.

(17) Spine board.

(18) Rigid cervical collars.

(19) Fracture splints.

(20) Sterile dressings and bandages.

(21) ~~Sterile burn sheets.~~

~~(22)~~ Gurney or exam table.

k. Facilities must be provided to assure prompt diagnosis and emergency treatment.

(1) Facilities must be separate from, and independent of, the operating rooms.

(2) The location of the emergency services must be easily accessible from an exterior entrance of the hospital.

l. Adequate emergency room medical records on every patient must be kept and must include:

(1) Patient identification and history of disease or injury.

(2) Physical findings and laboratory and x-ray reports, if any.

(3) Time of arrival, time of treatment, major diagnosis, treatment provided, and disposition including discharge instructions.

2. Primary care hospitals are subject to the emergency services requirements for general acute hospitals in this section. Primary care hospitals providing emergency services to the public may provide low intensity outpatient services consistent with those services commonly provided in a physician's office and consistent with the privileges granted to the licensed health care practitioner rendering the service.

3. Specialized hospitals are subject to the emergency services requirements for general acute hospitals in this section, with the exception of rural emergency hospitals, which are subject to the emergency services requirements for primary care hospitals in this section.

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-32. Anesthesia services.

1. General acute hospitals providing surgical services shall provide anesthesia services to meet the needs of the patients served and shall ensure the following:

a. The anesthesia service must be under the direction of a qualified physician who is a member of the medical staff.

b. The anesthesia service must be organized under current written policies and procedures regarding staff qualifications, the administration of anesthetics, the maintenance of safety controls, and required electronic monitoring of patient vital signs and oxygen levels during the anesthetic procedures consistent with current standards of practice. The anesthesia service is responsible for all anesthetics administered in the hospital.

c. The patient must receive a preoperative visit from the anesthesiologist or the certified registered nurse anesthetist involved in the case.

d. The anesthesia service shall establish policies, procedures, rules, and regulations for the control, storage, and safe use of combustible anesthetics, oxygen, and other medicinal gases in accordance with national fire protection association standards; types of anesthesia to be administered and procedures for each; personnel permitted to administer anesthesia; infection control; safety regulations to be followed; and responsibility for regular inspection, maintenance, and repair of anesthesia equipment and supplies.

e. Anesthesia services may be initiated only when ordered by a member of the medical staff and must be administered only by ~~persons~~individuals qualified and licensed in the management of such materials.

f. An intraoperative anesthetic record must be made a part of the patient's medical record. Drugs used, vital signs, and other relevant information must be recorded at regular intervals during anesthesia.

(1) There must be a preanesthesia evaluation by an individual qualified and licensed to administer anesthesia, performed within forty-eight hours prior to the surgery, with findings recorded in the patient's medical record.

(2) Except in emergency, anesthetic may not be administered until the patient has had a history and physical examination, and a record made of the findings.

g. Postanesthetic followup visits must be made within forty-eight hours after the procedure by the anesthesiologist, certified registered nurse anesthetist, or responsible physician who shall note and record any postoperative abnormalities or complications from anesthesia.

2. If the primary care hospital provides anesthesia services, the hospital shall comply with anesthesia services requirements for general acute hospitals in this section.

3. Specialized hospitals providing surgical services shall comply with the anesthesia services requirements for general acute hospitals in this section.

History: Effective April 1, 1994; amended effective August 1, 1999; January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-33. Respiratory care services.

1. If the general acute hospital provides respiratory care services, the services must be under the supervision of a licensed health care practitioner, organized and integrated with other services of the hospital.

a. Respiratory care policies and procedures must be developed, implemented, and updated as needed for at least the following:

(1) Responsibility of the service to the medical staff.

(2) Clear protocol as to who can perform specific procedures.

(3) Written procedures for each type of therapeutic or diagnostic procedure.

(4) Written procedures for the cleaning, disinfection, or sterilization of all equipment that is not disposable.

(5) Written procedures for infection control.

(6) Written procedures for the control of all water used for respiratory therapy, if applicable.

(7) Protocol that establishes calibration and operation of equipment consistent with manufacturer's specifications and ensures that all equipment is maintained according to an established schedule.

b. All treatments involving respiratory care must be recorded in the patient's medical record by the ~~person~~individual rendering the service, and must include type of therapy, date and time of treatments, any adverse reactions to treatments, and records of periodic evaluations by the licensed health care practitioner.

c. All treatments must be administered by respiratory therapists or other qualified staff in compliance with state law.

2. If the primary care hospital provides respiratory care services, the hospital shall comply with the respiratory care services requirements for general acute hospitals in this section.

3. If the specialized hospital provides respiratory care services, the hospital shall comply with the respiratory care services requirements for general acute hospitals in this section.

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-34. Obstetrical services.

1. All general acute hospitals providing obstetrical services shall provide for the admission, medical care, transfer, or discharge of obstetric and neonatal patients. Obstetrical services must include the following:

   a. The obstetrical services must have an organized obstetric staff with a chief of obstetrical services who is either certified or qualified in obstetrics or a physician who regularly practices obstetrics as head of the obstetrical service. The level of qualification and expertise of the chief of the obstetrical services must be appropriate to the level of care rendered in the hospital. Responsibilities of the chief of the obstetrical service include:

      (1) The general supervision of the care of obstetrical patients.

      (2) The arrangement of conferences held at regular intervals to review surgical procedures and operations, complications, and mortality.

      (3) The provision for exchange of information between medical, administrative, and nursing staffs.

   b. Only members of the medical staff with appropriate privileges may admit and care for patients in the obstetrical services areas. A roster of licensed health care practitioners, specifying the obstetrical privileges of each, must be maintained and available to staff in the obstetrical services area and in the files of the hospital administration.

   c. Obstetrical patients under the effect of an analgesic or an anesthetic, in active labor or delivery, must be monitored and attended in accordance with the current standards of practice for obstetric-gynecologic services as identified by the association of women's health, obstetric and neonatal nursing and defined by hospital policies and procedures.

   d. Fetal maturity must be established and documented prior to elective inductions and Caesarean sections.

   e. There must be a written policy and procedure established in accordance with the current standards of practice as identified by the association of women's health, obstetric, and neonatal nursing concerning the administration and documentation of oxytocic drugs and their effects. Oxytocin may be used for medical induction or stimulation of labor only when qualified personnel, determined by the medical staff, can attend the patient closely. If electronic fetal monitoring is not available, the patient must be monitored on a one-to-one basis during the administration of the oxytocic drugs. The following areas must be included in the written policy and procedure for administration and documentation of oxytocic medications:

      (1) The licensed health care practitioner shall evaluate the patient for induction or stimulation, especially with regard to indications for use of oxytocic medications.

      (2) The licensed health care practitioner or other individuals starting the oxytocin shall be familiar with its effects and complications and be qualified to identify both maternal and fetal complications.

      (3) A qualified licensed health care practitioner shall be immediately available as necessary to manage complications effectively.

f. Birthing and delivery rooms must be equipped and staffed to provide emergency resuscitation for infants in accordance with the current association of women's health, obstetric, and neonatal nursing standards of practice. Only personnel qualified and trained to do so may use infant emergency resuscitation equipment.

g. Equipment and personnel trained to use the equipment to maintain a neutral thermal environment for the neonate must be available and utilized as needed.

h. Nursing staff for obstetrical services must include:

(1) Nursing supervision by a registered nurse must be provided for the entire twenty-four-hour period the obstetrical services is occupied.

(2) At least one nurse trained in obstetrical and nursery care must be assigned to the care of ~~mothers~~patients and infants at all times. Infants must be visually or electronically monitored at all times.

(3) A registered nurse must be in attendance at all deliveries, and must be available to monitor the ~~mother's~~patient's general condition and that of the fetus during labor.

i. A clean nursery must be provided near the ~~mothers'~~patients' rooms with adequate lighting and ventilation and must include the following:

(1) Bassinets equipped to provide for the medical examination of the newborn and for the storage of necessary supplies and equipment.

(2) A glass observation window through which infants may be viewed.

(3) Each nursery must have immediately on hand equipment necessary to stabilize the sick infant in accordance with current standards of practice established by the association of women's health, obstetric, and neonatal nursing and defined in hospital policies.

j. The hospital shall identify specific rooms and beds to be used exclusively for obstetrical patients, obstetrical and gynecological patients, and nursery patients as provided in a plan specifically approved by the department.

(1) Obstetrical services must be located and arranged to provide maximum protection for obstetrical and neonatal patients from infection and cross-infection from patients in other services of the hospital.

(2) Obstetrical services must be located in the hospital so as to prevent through traffic to any other part of the hospital.

2. If the primary care hospital provides obstetrical services, the hospital shall comply with obstetrical services requirements for general acute hospitals in this section.

3. If a specialized hospital provides obstetrical services, the specialized hospital is subject to the obstetrical services requirements for general acute hospitals.

History: Effective April 1, 1994; amended effective May 1, 1998; August 1, 1999; January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-34.1. Outpatient birth services in hospitals.

1. General acute hospitals providing outpatient birth services in hospitals are subject to the outpatient birth services requirements for specialized hospitals in this section.

2. Primary care hospitals may not provide outpatient birth services.

3. Any facility that provides outpatient birth services shall comply with this section. A facility may not hold itself out to the public as providing outpatient birth services unless such outpatient birth service has been licensed by the department and meets the requirements for outpatient birth services in this section.

   a. The facility provides peripartum care of low-risk ~~women~~patients for whom prenatal and intrapartum history, physical examination, and laboratory screening procedures have demonstrated normal, uncomplicated singleton term (thirty-seven to forty-one and six-sevenths weeks), multipara pregnancies with a spontaneous labor, and vertex presentation that are expected to have an uncomplicated birth. The policy and procedures must specify medical and social criterion to determine risk status at admission and during labor.

   b. Patients who are not considered low risk, patients who experience no cervical dilation in over three hours who are considered in active labor according to the American college of obstetricians and gynecologists standards, and patients who develop a high-risk condition based on standards of practice shall be transferred as described in subsection 6.

   c. Patients shall be fully informed on and provide written consent to the benefits and risks of the services available and alternatives if more advanced services are required.

   d. Surgical procedures must be limited to those procedures normally encountered during uncomplicated childbirth, such as episiotomy and repair, and must not include operative obstetrics or cesarean section. Circumcisions of newborns are allowed.

   e. Labor may not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor nor may labor be induced by artificial rupture of membranes.

   f. Vacuum extractors, forceps, and recorded electronic fetal monitors are not appropriate for use after admittance in active labor in outpatient birth services. Patients requiring these interventions shall be transferred as described in subsection 6.

   g. General and conduction anesthesia may not be administered. Local anesthesia and pudendal block may be administered if procedures are established and approved by medical staff.

   h. Emergency medications, equipment, and supplies must be available, including tocolytics and uterotonic medications. Nothing in the foregoing should be construed to prohibit exercise of medical skills or the use of emergency medications to benefit the ~~mother~~patient or the baby in case of emergency. Patients requiring these interventions shall be transferred as described in subsection 6.

   i. ~~Mothers~~Patients and infants must be discharged within twenty-six hours after birth in accordance with standards set by the medical staff and specified in the policies and procedures. A program for prompt followup care and postpartum evaluation after discharge must be ensured and outlined in the policies and procedures. This program must include assessment of infant health, including physical examination, laboratory and screening tests required by state law at the appropriate times, maternal postpartum status, instruction in child care including immunization, referral to sources of pediatric care, provision of family planning services, and assessment of ~~mother-child~~bonding relationship, including breastfeeding.

4. The outpatient birth services shall ensure care is provided by licensed health care practitioners and nursing staff with access to and availability of consulting clinical specialists as follows:

   a. Every birth must be attended by at least two health care professionals, licensed or certified consistent with state laws, with relevant experience, training, and demonstrated competence and who have maintained competence in basic life support, including fluid resuscitation and a neonatal resuscitation program to respond to patient needs.

   b. The primary maternity care licensed health care practitioner who attends each birth shall be educated, licensed, and have approved clinical privileges to provide birthing services.

   c. A licensed health care practitioner with relevant experience, training, and demonstrated competence shall be on call and readily available within a reasonable time of birth for resuscitation if needed.

   d. A licensed health care practitioner with relevant experience, training, and demonstrated competence shall assess the neonate within twenty-four hours of delivery.

   e. There must be adequate numbers of nursing staff who have completed orientation and demonstrated competence in the care of uncomplicated pregnancies with the ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems which occur during the antepartum, intrapartum, or postpartum period until the patient can be discharged or transferred to a facility at which specialty maternal care is available.

5. An appropriately staffed level I nursery must be available on the premises.

6. There must be criteria and a written agreement for transfer of patients to an acute care hospital capable of providing inpatient obstetrical and neonatal services with a level II or level III nursery. The outpatient birth services must be located within thirty minutes of this hospital.

7. There must be provisions in place either directly or by agreement for transport services, obstetric consultation services, pediatric consultation services, and childbirth and parent education support services.

8. The outpatient birth service shall develop and implement policies and procedures to ensure physical security of ~~mothers~~patients and newborns.

History: Effective July 1, 2017; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

33-07-01.1-36. Psychiatric services in hospitals.

1. General acute hospitals providing psychiatric services are subject to the psychiatric services in hospitals requirements for specialized hospitals in this section. If, in the course of the inspection of a general acute hospital, the department finds from a review of the psychiatric treatment rendered and the adequacy of the consultation and referral resources that the hospital practice and staffing warrants the establishment of a psychiatric service, the department shall notify the hospital of the need to establish the service in a manner that complies with this section.

2. Primary care hospitals may not provide psychiatric services.

3. Any facility that provides or purports to provide psychiatric inpatient or inpatient and outpatient diagnosis or treatment on other than an emergency basis shall comply with this section. A hospital may not hold itself out to the public as providing psychiatric services unless such psychiatric service has been licensed by the department and meets the requirements for a psychiatric hospital in this section.

   a. Hospitals accredited by a national accrediting entity in the category of psychiatric services shall submit, upon receipt, all accreditation survey results, recommendations, and plans of correction to the department.

   b. In hospitals without an approved psychiatric service, psychiatric care to patients with a primary diagnosis of a psychiatric disorder may be rendered on an emergency basis by appropriate members of the medical staff as determined by the hospital. Psychiatric consultation must be available and utilized appropriately as determined by the hospital.

   c. The organization and responsibilities of the medical staff for psychiatric services must be in accordance with licensure requirements, except as amended and modified:

      (1) The physician in charge of the psychiatric services must be a psychiatrist who is licensed to practice medicine in North Dakota.

      (2) The psychiatrists on the staff of the psychiatric hospital or psychiatric services of a general acute hospital must have as minimum qualifications at least three years' approved residency training in psychiatry or equivalent training and experience. If physicians other than psychiatrists are authorized to treat patients in a psychiatric hospital or in a psychiatric service there must be timely evidence of psychiatric consultation after the patient is admitted, and ongoing consultation with a psychiatrist who is a member of the psychiatric staff, as needed.

      (3) There must be other medical staff in appropriate specialties, available at all times to the psychiatric staff.

   d. The organization and staffing of the nursing service must be in accordance with the licensure requirements, except as amended and modified:

      (1) The registered nurse supervising the nursing services of the psychiatric services must have experience and demonstrated competency in psychiatric nursing.

      (2) The nursing personnel of the psychiatric services in a general acute hospital must be a separate staff who are assigned to the psychiatric services.

      (3) There must be at least one registered nurse with experience in psychiatric nursing on duty at all times on each psychiatric nursing unit. The number of registered nurses and other nursing personnel must be adequate to provide the individual patient care required to carry out the patient care plan for each patient.

   e. The following services or consultative resources are required: clinical psychological services, social work services, and occupation and recreational therapy services. These services must be under the direction of a psychiatrist in charge of the psychiatric services in a general acute hospital or the psychiatric diagnosis or treatment units in a psychiatric hospital. The staff used to support these services must be adequate in number and be qualified by professional education, experience, and demonstrated ability. If registration or licensing of personnel is required by statute or regulation, the registration number must be on file and available upon request.

   f. Personnel development and training for psychiatric services staff must include the following:

(1) There must be written evidence of orientation training for all staff and ongoing, planned, and scheduled inservice training for all staff.

(2) Ongoing interdisciplinary staff conferences must be held to ensure communication, coordination, and participation of all professional staff and personnel involved in the care of patients.

g. Specialized procedures for psychiatric services must be provided for and implemented as follows:

(1) A patient may not be subject to the withholding of privileges or to any system of rewards, except as part of a treatment plan.

(2) Electroconvulsive therapy, experimental treatments involving any risk to the patient, or aversion therapy may not be prescribed, unless:

(a) The patient's treatment team has documented in the patient's record that all reasonable and less intensive treatment modalities have been considered, the treatment represents the most effective therapy for the patient at that time, the patient has been given a full explanation of the nature and duration of the proposed treatment and why the treatment team is recommending the treatment, and the patient has been informed of the right to accept or refuse the proposed treatment and, if the patient consents, has the right to revoke the consent for any reason at any time prior to or between treatments.

(b) The treatment was recommended by qualified staff members trained and experienced in the treatment procedure and has been approved by the psychiatrist.

(c) The patient has given written informed consent to the specific proposed treatment. In the alternative, oral informed consent is sufficient if that consent is witnessed by two ~~persons~~individuals not part of the patient's treatment team. In either case, such consent must be limited to a specified number of maximum treatments over a period of time and must be revocable at any time before or between treatments. Such withdrawal of consent is immediately effective.

(d) If a patient's treatment team determines that the patient could benefit from one of those specified treatments but also believes that the patient does not have the capacity to give informed consent to the treatment, appropriate consent consistent with applicable state laws must be obtained before such treatment may be administered to the patient.

(3) A patient may not be subject to chemical, physical, or psychological restraints, including seclusion, other than in accordance with the policy and procedures for seclusion and restraint approved by the medical staff and governing body. A copy of the applicable regulations must be made available to patients upon request.

(4) A patient may not be the subject of any research, unless conducted in strict compliance with federal regulations on the protection of human subjects. Patients considered for research approved by the hospital must receive and understand a full explanation of the nature of the research, the expected benefit, and the potential risk involved. Copies of the federal regulations must be made available to patients or their advocates involved in, or considering becoming involved in, research.

h. If the treatment team determines that continued voluntary inpatient treatment is not indicated, the treatment team shall discharge the patient with an appropriate

postdischarge plan. The postdischarge plan must address followup needs, future consultative needs, or in the event of patient regression or deterioration, treatment or admission needs.

i. Care of patients for psychiatric services must include the following:

(1) Each psychiatric unit shall have available recreational and occupational therapy and other appropriate facilities adequate in size in relation to patient population, number of beds, and program.

(2) Restraints and seclusion facilities must be available, and written policies must be established for their use. Mechanical restraints or seclusion may be used only on the written order of a physician. This written order must be valid for specific periods of time. In an emergency, the licensed professional in charge may order restraints. Confirmation of the order by a physician must be secured. Policies and procedures regarding use of restraints and seclusion must be reviewed annually. The patient medical record must indicate justification for the restraint, time applied and released, and other pertinent information.

(3) A current policy and procedure manual must be maintained for the psychiatric service. The manual must include procedures for the care and treatment of patients including the care of suicidal and assaultive patients, and the elopement of patients. The manual must identify the relationship with state agencies and community organizations providing psychiatric services. It must also describe plans for the evaluation and disposition of psychiatric emergencies.

(4) The design of facilities and the selection of equipment and furnishings must be conducive to the psychiatric program and must minimize hazards to psychiatric patients.

j. The psychiatric services shall develop an interdisciplinary team composed of mental health professionals, health professionals, and other ~~persons~~individuals who may be relevant to the patient's treatment. At least one member of the team must be a psychiatrist. The team and patient or advocate shall formulate and evaluate an appropriate treatment plan for the patient.

(1) The director of the interdisciplinary team shall assure that staff trained and experienced in the use of modalities proposed in the treatment plan participate in its development, implementation, and review.

(2) The director of the interdisciplinary team is responsible for:

(a) Ensuring that the ~~person~~patient in treatment is encouraged to become increasingly involved in the treatment planning process.

(b) Implementing and reviewing the individualized treatment plan and participating in the coordination of service delivery with other service providers.

(c) Ensuring that the unique skills and knowledge of each team member are utilized and that specialty consultants are utilized when needed.

(3) Although an interdisciplinary team must be under the direction of a psychiatrist, specific treatment modalities may be under the direction of other mental health professionals when they are specifically trained to administer or direct such modalities.

k. A comprehensive individualized treatment plan must:

(1) Be formulated to the extent feasible with the consultation of the patient. When appropriate to the patient's age, or with the patient's consent, the patient's family, personal guardian, or appropriate other ~~persons~~individuals should be consulted about the plan.

(2) Be based upon diagnostic evaluation that includes examination of medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental aspects of the patient's situation.

(3) Set forth treatment objectives and prescribe an integrated program of therapies, activities, experiences, and appropriate education designed to meet these objectives.

(4) Result from the collaborative recommendation of the patient's interdisciplinary team.

(5) Be maintained and updated with progress notes, and be retained in the patient's medical record.

(6) State the basis for the restraints if the plan provides for restraints. The patient medical record must indicate what less restrictive alternatives were considered and why they were not utilized.

(7) Be written in terms easily explainable to the lay person. A copy of the current treatment plan must be available for review by the ~~person~~patient in treatment.

(8) Note when the most appropriate form of treatment for the individual is not available or is too expensive to be feasible.

l. At least once every seven days every ~~person~~patient in treatment must be plan reviewed. A report of the review and findings must be summarized in the patient's medical record and the treatment plan must be updated as necessary.

m. Subject to certain limitations authorized by a parent, legal guardian, legal custodian, or a court of law concerning a minor or guardian of an individual who is incapacitated ~~person~~ or restrictions by the treating physician or psychiatrist, which in their professional judgment is in the best interest of the patient, each patient has the right to:

(1) Receive or refuse treatment for mental and physical ailments and for the prevention of illness or disability.

(2) The least restrictive conditions necessary to achieve the purposes of the treatment plan.

(3) Be treated with dignity and respect.

(4) Be free from unnecessary restraint and isolation.

(5) Visitation and telephone communications.

(6) Send and receive mail.

(7) Keep personal clothing and possessions.

(8) Regular opportunities for outdoor physical exercise.

(9) Participate in religious worship of choice.

(10) Be free from unnecessary medication.

(11) Exercise all civil rights, including the right to habeas corpus.

(12) Not be subjected to experimental research without the express written consent of the patient or of the patient's guardian.

(13) Not be subjected to psychosurgery, electroconvulsive treatment, or aversive reinforcement conditioning, without the express and informed written consent of the patient or the patient's guardian.

n. Each hospital must have a clearly defined appeal system through which any patient who wishes to voice objections concerning the patient's treatment must be heard and have objections determined.

(1) Each hospital shall monitor the appeal system to see that it works properly and records must be maintained for review by the department in order to investigate any complaint.

(2) All patients must be advised of such system and be encouraged to use it when they believe their treatment plan is not necessary or appropriate to their needs.

o. Medical record requirements for psychiatric hospitals and psychiatric services of general acute hospitals must include the following:

(1) Medical records must stress the psychiatric components of the patient's condition and care including history of findings and treatment rendered for the psychiatric condition for which the patient is hospitalized.

(2) A provisional or admitting diagnosis must be made on every patient at the time of admission and include the diagnoses of current diseases as well as the psychiatric diagnoses.

(3) Data from all pertinent sources must be included, in addition to data obtained from the patient.

(4) A psychiatric evaluation must be performed within forty-eight hours of admission, include a medical history, contain a record of mental status, and note the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functions, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretive, fashion.

(5) A complete neurological examination must be recorded at the time of the admission physical examination, when indicated.

(6) Social service records, including reports of interviews with patients, family members, and others must provide an assessment of home plans, family attitudes, and community resource contacts, with appropriate recommendations for family or community resource involvement, as well as a social history.

(7) Reports of consultations, reports of electroencephalograms, and other pertinent reports of special studies.

(8) The patient's comprehensive treatment plan must be recorded, must be based on an inventory of the patient's strengths as well as disabilities, and must include a substantiated diagnosis in the terminology of the most current edition of the American psychiatric association's diagnostic and statistical manual, short-term and long-range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it

provides adequate justification and documentation for the diagnoses and for the treatment and rehabilitation activities carried out.

(9) The treatment received by the patient must be documented to assure that all active therapeutic efforts such as individual and group psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, industrial or work therapy, nursing care, and other therapeutic interventions are included.

(10) The discharge summary must include a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning followup or aftercare as well as a brief summary of the patient's condition on discharge.

(11) Confidentiality of the psychiatric record must be recognized and safeguarded in medical records services of the hospital.

History: Effective April 1, 1994; amended effective January 1, 2024.
General Authority: NDCC 23-01-03(3), 28-32-02
Law Implemented: NDCC 23-16-06

CHAPTER 33-07-03.2

33-07-03.2-01. Definitions.

The following terms are defined for this chapter, chapter 33-07-04.2, and North Dakota Century Code chapter 23-16:

1. "Abuse" for the purposes of this chapter is defined in section 33-07-06-01.
2. "Adult day care" means the provision of facility services to meet the needs of individuals who do not remain in the facility overnight.
3. "Authentication" means identification of the individual who made the resident record entry by that individual in writing, and verification that the contents are what the individual intended.
4. "Bed capacity" means bed space designed for resident care.
5. "Department" means the ~~state~~ department of health and human services.
6. "Discharge" means movement from a facility to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident.
7. "Emanating services" means services which are provided from a facility to nonresidents.
8. "Facility" means a nursing facility.
9. "Governing body" means the individual or group in whom legal responsibility is vested for conducting the affairs of a private or governmental facility. Governing body includes, where appropriate, a proprietor, the partners of any partnership including limited partnerships, the board of directors and the shareholders or members of any corporation including limited liability companies and nonprofit corporations, a city council or commission, a county commission or ~~social~~human service zone board, a governmental commission or administrative entity, and any other person or persons vested with management of the affairs of the facility irrespective of the name or names by which the person or group is designated.
10. "Licensed health care practitioner" means an individual who is licensed or certified to provide medical, medically related, or advanced registered nursing care to individuals in North Dakota.
11. "Licensee" means the legal entity responsible for the operation of a facility.
12. "Medical staff" means a formal organization of licensed health care practitioners with the delegated authority and responsibility to maintain proper standards of medical care.
13. "Misappropriation of resident property" means the willful misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Willful for the purpose of this definition means to do so intentionally, knowingly, or recklessly.
    a. "Intentionally" means to do deliberately or purposely.
    b. "Knowingly" means to be aware or cognizant of what one is doing, whether or not it is one's purpose to do so.
    c. "Recklessly" means to consciously engage in an act without regard or thought to the consequences.
14. "Neglect" for the purposes of this chapter is defined in section 33-07-06-01.

15. "Nursing facility" means an institution or a distinct part of an institution established to provide health care under the supervision of a licensed health care practitioner and continuous nursing care for twenty-four or more consecutive hours to two or more residents who are not related to the licensee by marriage, blood, or adoption; and who do not require care in a hospital setting.

16. "Paid feeding assistant" means an individual who has successfully completed a department-approved paid feeding assistant training course and is paid to feed or provide assistance with feeding residents of a nursing facility.

17. ~~"Rural area" means an area defined by the United States bureau of the census as a rural area.~~

~~18.~~ "Secured unit" means a specific area of the facility that has a restricting device separating the residents in the unit from the residents in the remainder of the facility.

~~19.~~18. "Signature" means the name of the individual written by the individual or an otherwise approved identification mechanism used by the individual that may include the approved use of a rubber stamp or an electronic signature.

~~20.~~19. "Transfer" means movement from a facility to another institutional setting when the legal responsibility for the care of the resident changes from the transferring facility to the receiving institutional setting.

~~21.~~20. "Writing" means the use of any tangible medium for entries into the medical record, including ink or electronic or computer coding, unless otherwise specifically required.

History: Effective July 1, 1996; amended effective May 1, 2001; July 1, 2004; January 1, 2024.
General Authority: NDCC ~~23-01-03, 28-32-02~~50-06-16
Law Implemented: NDCC 23-16-01~~, 28-32-02~~

33-07-03.2-17. Resident record services.

The governing body of the facility shall establish and implement policies and procedures to ensure the facility has a resident record service with administrative responsibility for resident records.

1. A resident record must be maintained and kept confidential for each resident admitted to the facility. The resident record shall be complete, accurately and legibly documented, and readily accessible.

   a. The resident or the resident's legal representative have the right to view and authorize release of their medical information.

   b. The facility shall develop policies which address access to resident records.

   c. Resident records may be removed from the facility only upon subpoena, court order, or pursuant to facility policies when a copy of the original record is maintained at the facility.

2. All records of discharged residents must be preserved for a period of ten years from date of discharge. Records of deceased residents must be preserved to seven years.

   a. In the case of minors, records must be retained for the period of minority and ten years from the date of live discharge. Records of deceased residents who are minors must be preserved for the period of minority and seven years.

   b. It is the governing body's responsibility to determine which records have research, legal, or medical value and to preserve such records beyond the above-identified time frames

until such time the governing body determines the records no longer have a research, legal, or medical value.

3. ~~If the facility does not employ an accredited record technician or registered record administrator, an~~An employee of the facility must be assigned the responsibility for ensuring ~~that~~ records are maintained, completed, and preserved. ~~The designated employee shall receive consultation at least annually from an accredited record technician or registered record administrator.~~

4. Each resident record must include:

   a. The name of the resident, personal licensed health care practitioner, dentist, and designated representative or other responsible person, admitting diagnosis, final diagnosis, condition on discharge, and disposition.

   b. Initial medical evaluation including medical history, physical examination, and diagnosis.

   c. A report from the licensed health care practitioner who attended the resident in the hospital or other health care setting, and a transfer form used under a transfer agreement.

   d. Licensed health care practitioner's orders, including all medication, treatments, diet, restorative plan, activities, and special medical procedures.

   e. Licensed health care practitioner's progress notes describing significant changes in the resident's condition, written at the time of each visit.

   f. Current comprehensive resident assessment and plan of care.

   g. Quarterly reviews of resident assessments and nurse's notes containing observations made by nursing personnel for the past year.

   h. Medication and treatment records including all medications, treatments, and special procedures performed.

   i. Laboratory and x-ray reports.

   j. Consultation reports.

   k. Dental reports.

   l. Social service notes.

   m. Activity service notes.

   n. Resident care referral reports.

5. All entries into the resident record must be authenticated by the individual who made the written entry, as defined by facility policy and applicable state laws and regulations, and must at a minimum include the following:

   a. All entries the licensed health care practitioner personally makes in writing must be signed and dated by the licensed health care practitioner.

   b. Telephone and verbal orders may be used provided they are given only to qualified licensed personnel and reduced to writing and signed or initialed by a licensed health care practitioner responsible for the care of the patient.

c. Signature stamps may be used consistent with facility policies as long as the signature stamp is used only by the licensed health care practitioner whose signature the signature stamp represents. Written assurance must be on file from the licensed health care practitioner to indicate the practitioner is the sole user of the signature stamp.

d. Electronic signatures may be used if the facility's medical staff and governing body adopt a policy permitting authentication by electronic signature. The policy must include:

(1) The staff within the facility authorized to authenticate entries in resident records using an electronic signature.

(2) The safeguards to ensure confidentiality, including:

(a) Each user must be assigned a unique identifier generated through a confidential access code.

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

(c) The user must certify in writing the user is the only individual with user access to the identifier and the only individual authorized to use the signature code.

(d) The facility shall monitor the use of the identifiers periodically and take corrective action as needed. The process by which the facility will conduct the monitoring must be described in policy.

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

(a) A system that requires completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps, or obvious contradictory statements appearing within those designated fields. The system must require that correction or supplementation of previously authenticated entries must be made by additional entries, separately authenticated and made subsequent in time to the original entry.

(b) An opportunity for the user to verify the accuracy of the document and to ensure the signature has been properly recorded.

(c) As part of the quality improvement activities, the facility shall periodically sample records generated by the system to verify accuracy and integrity of the system.

(4) A user may terminate authorization for use of an electronic signature upon written notice to the staff member in charge of resident records.

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

(6) A list of confidential access codes must be maintained under adequate safeguards by facility administration.

History: Effective July 1, 1996; amended effective January 1, 2024.
General Authority: NDCC ~~23-01-03, 28-32-02~~50-06-16
Law Implemented: NDCC 23-01-12, 23-16-01~~, 28-32-02~~

ARTICLE 33-11
LICENSING OF EMERGENCY MEDICAL SERVICES

CHAPTER 33-11-01.1

33-11-01.1-01. Definitions.

Words defined in North Dakota Century Code chapter 23-27 shall have the same meaning in this chapter. For purposes of this chapter:

1. ~~"Cardiopulmonary resuscitation" means the American heart association health care provider standards or its equivalent which includes the skills adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.~~

~~2.~~ "Department" means the ~~state~~ department of health ~~as defined in chapter 23-01 of the North Dakota Century Code~~and human services.

~~3.~~2. "Driver" means an individual who operates a quick response unit vehicle.

~~4.~~3. "Driver's license" means the license as required under sections 39-06-01 and 39-06-02 of the North Dakota Century Code.

~~5.~~4. "Emergency medical responder" means ~~a person~~an individual who is certified as an emergency medical responder by the department.

~~6.~~5. "Emergency medical technician" means ~~a person~~an individual who is licensed as an emergency medical technician by the department.

~~7.~~6. "Equivalent" means training of equal or greater value which accomplishes the same results as determined by the department.

~~8.~~7. "Patient care provider" means a qualified individual on the quick response unit crew responsible for the care of the patient.

~~9.~~8. "Personnel" means qualified patient care providers, or drivers, or both, within a quick response unit service.

~~10.~~9. "Quick response unit run" means the response of a quick response unit vehicle and personnel to an emergency or nonemergency for the purpose of rendering medical care to someone sick or incapacitated, including canceled calls, no transports, and standby events where medical care may be rendered.

~~11. "State health council" means the council as defined in title 23 of the North Dakota Century Code.~~

~~12.~~10. "State radio" means the North Dakota department of emergency services division of state radio located at Fraine barracks in Bismarck, North Dakota.

History: Effective January 1, 2008; amended effective July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-01.2
NORTH DAKOTA GROUND AMBULANCE SERVICES

33-11-01.2-01. Definitions.

Words defined in chapter 23-27 of the North Dakota Century Code shall have the same meaning in this chapter. For purposes of this chapter:

1. ~~"Advanced first-aid ambulance attendant" means a person who meets the requirements of the advanced first-aid ambulance attendant program and is certified by the department.~~

~~2.~~ "Advanced life support ambulance service" means an emergency medical services operation licensed under and meeting all requirements of chapter 33-11-03.

~~3. "Ambulance driver" means an individual who operates an ambulance vehicle.~~

~~4.~~2. "Ambulance run" means the response of an ambulance vehicle and personnel to an emergency or nonemergency for the purpose of rendering medical care or transportation, or both, to someone ~~sick~~ill or ~~incapacitated~~injured, including canceled calls, no transports, and standby events where medical care may be rendered.

~~5. "Cardiopulmonary resuscitation" means the American heart association health care provider standards or its equivalent which includes the skills adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.~~

~~6. "Commission on accreditation of ambulance services" means the commission on accreditation of ambulance services located in Glenview, Illinois.~~

~~7.~~3. "Department" means the ~~state~~ department of health ~~as defined in chapter 23-01 of the North Dakota Century Code~~and human services.

~~8.~~4. "Designated trauma center" means a licensed hospital with a trauma designation as defined in section 33-38-01-06.

~~9.~~5. "Dispatch center" means ~~an ambulance's own~~a dispatching service that operates on a continual basis with dedicated personnel and receives ambulance run requests from a public safety answering point and radio dispatches ambulances.

~~10.~~6. "Driver's license" means the license as required under sections 39-06-01 and 39-06-02 of the North Dakota Century Code.

7. "Emergency medical service vehicle operator" means an individual who operates an ambulance or other emergency medical service vehicle and has had emergency vehicle operation training.

~~11.~~8. "Emergency medical technician" means ~~a person who is licensed as an emergency medical technician~~an individual certified by the national registry of emergency medical technicians as an emergency medical technician. An emergency medical technician is eligible for licensure as an emergency medical technician upon completion of a license application and approval by the department.

~~12.~~9. "Equivalent" means ~~training of equal or greater value which accomplishes the same results as determined by the department~~qualifications reasonably comparable to those specifically listed as required for training, certification, licensure, credentialing, or recognition.

~~13.~~10. "Headquarters ambulance service" means the base of operations for an ambulance service that operates subordinate substation ambulances.

~~14.~~11. "Industrial site ambulance service" means an ambulance service that ~~primarily~~ serves ~~an~~a private organization and ~~may or may~~ not ~~offer service to~~ the general public.

~~15.~~12. "Licensed health care facilities" means facilities licensed under chapter 23-16 of the North Dakota Century Code.

~~16. "Major trauma patient" means any patient that fits the trauma triage algorithm as defined in chapter 33-38-01.~~

~~17.~~13. "Nonemergency health transportation" means health care transportation not provided by a licensed ambulance service that takes place on a scheduled basis by licensed health care facilities to their own patients or residents whose impaired health condition requires special transportation considerations, supervision, or handling but does not indicate a need for medical treatment during transit or emergency medical treatment upon arrival at the final destination.

~~18.~~14. "Paramedic" means ~~a person who is~~an individual certified ~~as an emergency medical technician-paramedic~~ by the national registry of emergency medical technicians ~~and licensed by the~~as a paramedic. A paramedic is eligible for licensure as a paramedic upon completion of a license application and approval by the department.

~~19.~~15. "Paramedic with additional training" means evidence of successful completion of additional training and appropriate periodic skills verification in such topics as management of patients on ventilators, twelve-lead electrocardiograms or other critical care monitoring devices, drug

infusion pumps, and cardiac or other critical care medications, or any other specialized procedures or devices determined at the discretion of the paramedic's medical director.

~~20.~~16. "Personnel" means ~~qualified primary care providers, or drivers, or both, within an ambulance service~~an individual maintained on an emergency medical service agency roster.

~~21. "Primary care provider" means a qualified individual on the ambulance crew responsible for the care of the patient and supervision of all ambulance personnel while on the ambulance run.~~

~~22.~~17. "Public safety answering point" means a government-operated call center that receives 911 calls from the public and dispatches public safety resources.

~~23. "Scheduled basic life support transfer" means transfers provided on a scheduled basis by an advanced life support service to patients who need no advanced life support procedures en route.~~

18. "Revocation" means the official cancellation of a license.

19. "Sanction" means to impose a penalty for disobeying a law or rule.

20. "Service area" means the geographic area that a basic or advanced life support ground ambulance service is obligated to provide emergency medical transportation services. This includes emergency and nonemergency responses and medically appropriate patient transfers between hospitals or other medical facilities.

~~24.~~21. "Specialty care transport" means interfacility transportation, including transfers from a hospital to an aeromedical intercept site, of a critically injured or ill patient by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the ~~emergency medical technician-paramedic~~paramedic.

~~25. "State health council" means the council as defined in title 23 of the North Dakota Century Code.~~

~~26.~~22. "State radio" means the North Dakota department of emergency services division of state radio ~~located at Fraine barracks in Bismarck, North Dakota~~.

~~27.~~23. "Substation ambulance service" means a subordinate operation of a headquarters ambulance service ~~located in a separate municipality~~.

~~28. "System status management" means strategically positioning ambulances in geographic locations during various times of the day based on historical data that can aid in predicting operational demands.~~

24. "Suspension" means the temporary withdrawal of a license during the period of the suspension.

25. "Trauma patient" means any patient meeting the red or yellow criteria of the American college of surgeons national guideline for the field triage of injured patients.

History: Effective January 1, 2008; amended effective July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-02. License required - Fees.

1. ~~No ground ambulance services, as defined in chapter 23-27 of the North Dakota Century Code, shall be advertised or offered to the public or any person unless the operator of such~~

~~service is licensed by the department~~A person, as an owner, agent or otherwise, may not operate, conduct, maintain, advertise, or otherwise engage in or profess to be engaged in operating a basic life support ambulance service or advanced life support ambulance service in this state unless that person holds a license as a basic life support ambulance service or advanced life support ambulance service or is exempt from these requirements.

2. The license shall expire midnight on October thirty-first of the even year following issuance. ~~License renewal shall be on a biennial basis~~The department shall relicense for a two-year period, expiring on October thirty-first, a basic life support or advanced life support ambulance service successfully meeting the requirements of the North Dakota ambulance service licensure program.

3. A license is valid only for the ~~service~~entity for which it is issued. A license may not be sold, assigned, or transferred.

4. The license decal shall be displayed in a conspicuous place inside the patient compartment of the ambulance vehicle. ~~An operator operating more than one ambulance unit out of a town, city, or municipality will be issued duplicate licenses for each unit at no additional charge.~~

5. The nonrefundable biennial license fee~~, including special licenses,~~ shall be fifty dollars for each ~~headquarters~~ground ambulance service ~~location and fifty dollars for each substation location~~, including headquarters, substations, and industrial ambulance services.

6. Entities solely providing nonemergency health transportation services are not required to obtain a license under chapter 23-27 of the North Dakota Century Code as long as they do not advertise or offer emergency medical services to the general public or render acute medical care.

History: Effective January 1, 2008; amended effective January 1, 2024.
General Authority: NDCC 23-27-01
Law Implemented: NDCC 23-27-01

33-11-01.2-03. Application for license.

~~1. Application for the license shall be made in the manner prescribed by the department.~~

~~2. The application must be for a headquarters ambulance service or substation ambulance service at either the basic life support level as defined in chapter 33-11-02.2, or for the advanced life support level as defined in chapter 33-11-02.3.~~

~~3. New operators applying for an ambulance service license for an operation that will be based in a city already served by a licensed advanced life support ambulance service must apply for advanced life support ambulance licensure. In addition, new operators must also provide service to the same geographic response area and be able to meet the response time performance standards commensurate with the existing licenseholder.~~

An application for a basic life support ambulance service or advanced life support ambulance service license shall be submitted on a form or through an electronic process, as prescribed by the department. The application must contain the following information as well as additional information and documents that may be solicited by the application form:

1. The name and mailing address of the applicant and a primary contact individual and telephone number and electronic mail address at which that individual can be reached.

2. The name under which the applicant shall hold itself out to the public in conducting its emergency medical service operations and the address of its primary location in this state out of which it shall conduct its emergency medical service operations. If the applicant seeks to

conduct emergency medical service agency operations out of more than one location, the address of its primary operational headquarters and each other location out of which it intends to operate must be provided. If the applicant holds itself out to the public under different fictitious names for the emergency medical service operations it conducts at different locations, the fictitious name under which it intends to operate at each location must be provided.

3. The manner in which the applicant is organized.

4. The tax status of the applicant.

5. The geographic area for which the applicant intends to provide service. If the service is a type of service that is dispatched by a public safety answering point, the applicant shall detail the geographic area, if any, in which it plans to routinely respond to emergency dispatches.

6. A personnel roster.

7. The number and types of emergency medical service vehicles to be operated by the applicant and identifying information for each emergency medical service vehicle.

8. The communication access and capabilities of the applicant.

9. A full description of the emergency medical service agency services that the applicant intends to provide out of each location and how it intends to respond to emergency calls if it will not conduct operations out of a fixed location or locations.

10. The names, titles and summary of responsibilities of individuals who will be staffing the emergency medical service operation as officers, directors, or other emergency medical service agency officials.

11. A statement attesting to the veracity of the application, which shall be signed by the principal official of the applicant.

History: Effective January 1, 2008; amended effective July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-04. Issuance and renewal of licenses.

1. The department or its authorized agent may inspect the service. If minimum standards for either basic life support ground ambulance services or advanced life support ground ambulance services are met, the department ~~shall~~may issue a license and designate its service area. The department may designate a new ambulance service to operate in a service area if the following conditions are present:

   a. The existing ambulance service has not complied with the performance standards outlined in section 33-11-01.2-14 or 33-11-01.2-17 or chapter 33-11.2-15; or

   b. The county commission or city commission having governing authority within an ambulance service area has petitioned the department requesting another ambulance service to operate in their area due to poor performance. Ambulance service performance issues must be documented, quantifiable, and persistent.

2. A service may request that the department consider it in compliance with this chapter if it is fully accredited by ~~the commission on accreditation of ambulance services or its equivalent~~an ambulance accreditation agency recognized by the department.

3. Services requesting their compliance with this chapter to be verified through an accrediting agency shall submit to the department a copy of the entire accrediting agency survey report. Subsequent accreditation or revisit documentation must be submitted prior to license renewal.

History: Effective January 1, 2008; amended effective July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-05. ~~Special licenses and waivers~~Waivers.

1. ~~An operator of a ground ambulance service intended for industrial site use may be issued a special license by the department.~~

~~2.~~ Based on each individual case, the department may waive any provisions of this chapter.

~~3.~~2. The waiver provision ~~shall~~must only be used for a specific period in specific instances, provided such a waiver does not adversely affect the health and safety of the ~~person~~individual transported, and then only if a nonwaiver would result in unreasonable hardship upon the ambulance service.

History: Effective January 1, 2008; amended effective January 1, 2024.
General Authority: NDCC 23-27-01
Law Implemented: NDCC 23-27-01

33-11-01.2-06. Other requirements for substation ambulance operation.

Repealed effective January 1, 2024.

~~1. A substation ambulance operation and all of its assets must be fully owned and operated by a headquarters ambulance service. A substation ambulance may not establish a separate business structure independent of the headquarters service.~~

~~2. A substation ambulance service may not have its own governing board separate from a governing board of the headquarters ambulance service.~~

~~3. All logos, vehicle lettering, personnel uniforms, and signage on any substation building must reflect the name of the headquarters ambulance service. However, a logo, vehicle lettering, personnel uniforms, or signage on a substation building may include the name of the substation.~~

~~4. A licensed advanced life support ambulance service meeting the requirements of chapter 33-11-03 may operate a substation ambulance that meets the basic life support ambulance standards outlined in chapter 33-11-02.~~

~~5. A substation ambulance service may not be established in a city that has a licensed ambulance service based in that city.~~

~~**History:** Effective January 1, 2008.~~
~~**General Authority:** NDCC 23-27-01~~
~~**Law Implemented:** NDCC 23-27-01~~

33-11-01.2-06.1. Headquarter and substation ambulance requirements.

In addition to requirements as listed in the remainder of chapter 33-11-01.2, the following items apply to headquarter ambulance services and substations:

1. Application for licensure by a headquarter ambulance service shall be made as described in section 33-11-01.2-03 and shall include all information regarding all substations under the control of the headquarters ambulance service.

2. A substation ambulance operation and all of its operational assets must be fully owned or leased and operated by a headquarters ambulance service. A substation ambulance may not establish a separate business structure independent of the headquarters service.

3. A substation ambulance service may not have its own governing board separate from a governing board of the headquarters ambulance service.

4. All logos, vehicle lettering, personnel uniforms, and signage on any substation building must reflect the name of the headquarters ambulance service. However, a logo, vehicle lettering, personnel uniforms, or signage on a substation building may include the name of the substation.

5. A licensed advanced life support ambulance service meeting the requirements of chapter 33-11-03 may operate a substation ambulance that meets the basic life support ambulance standards outlined in chapter 33-11-02.

6. A substation ambulance service may not be established in a city that has a licensed ambulance service based in that city.

7. A substation ambulance service may be available intermittently. The headquarters ambulance service is responsible for responding when the substation ambulance is unavailable. In lieu of responding, the headquarters ambulance service may request that the quickest available ambulance to respond be dispatched when the substation is unavailable. The headquarters ambulance service must inform its dispatching entity as to the time of availability of its substation ambulance service.

History: Effective January 1, 2024.
General Authority: NDCC 23-27-01
Law Implemented: NDCC 23-27-01

33-11-01.2-07. ~~Availability of ground~~Ground ambulance service requirements.

1. A headquarters ambulance service shall be available twenty-four hours per day and seven days per week, except as exempted through waiver by the department.

2. A substation ambulance service may be available intermittently. When the substation ambulance is not available it is the responsibility of the headquarters service to respond to calls within that area if no closer ambulance can respond. The headquarters ambulance service must inform its dispatching entity as to the time of availability of its substation ambulance service.

3. All drivers of ambulance or emergency medical service vehicles shall have a current valid driver's license pursuant to requirements under sections 39-06-01 and 39-06-02 of the North Dakota Century Code.

4. All licensed ambulance services shall keep the ambulance vehicle and other equipment clean and in proper working order.

5. All supplies and other equipment coming in direct contact with the patient must be either a single-use disposable type or cleaned, laundered, or disinfected after each use.

6. When a vehicle has been utilized to transport a patient known to have a communicable disease, the vehicle and all exposed equipment must be disinfected before the transport of another patient.

7. Each ambulance run must be reported to the department electronically via the North Dakota emergency medical services data repository.

8. All ambulance services shall give the receiving health care facility a detailed patient report at the time of patient transfer.

9. All ambulance services shall submit a trauma, stroke, cardiac, and other time-critical condition transport plan to the department upon request.

10. All licensed ambulance services shall keep either an electronic or paper copy of each patient care report on file for a minimum of seven years.

11. All licensed ambulance services shall have current written protocols developed and signed by their medical director. The current version of the protocols must be kept on file with ambulance service management. The ambulance service manager shall keep inactive protocols for a period of seven years after deactivating the protocol.

12. All ambulance services shall report any collision involving an ambulance that results in property damage of four thousand dollars or greater, or personal injury. The report must be made within thirty days of the event and on a form or in a manner provided by the department.

History: Effective January 1, 2008; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-08. Driver's license required.

Repealed effective January 1, 2024.

~~All drivers of ambulance service vehicles shall have a current valid driver's license pursuant to requirements under sections 39-06-01 and 39-06-02 of the North Dakota Century Code.~~

~~**History:** Effective January 1, 2008.~~
~~**General Authority:** NDCC 23-27-04~~
~~**Law Implemented:** NDCC 23-27-04~~

33-11-01.2-09. Number of personnel required.

Repealed effective January 1, 2024.

~~The minimum personnel required on each ambulance run shall be one driver and one primary care provider. Basic life support ambulance services must maintain a file that identifies at least two qualified ambulance service personnel on a written call schedule. Advanced life support ambulances must maintain a file that identifies at least two qualified ambulance service personnel on a written call schedule for each staffed ambulance as required in section 33-11-03-05.~~

~~**History:** Effective January 1, 2008; amended effective July 1, 2010.~~
~~**General Authority:** NDCC 23-27-04~~
~~**Law Implemented:** NDCC 23-27-04~~

33-11-01.2-10. Other requirements.

Repealed effective January 1, 2024.

1. Personnel must be able to identify and locate all equipment items required to be carried in an ambulance.

2. All licensed ambulance services shall keep the ambulance vehicle and other equipment clean and in proper working order.

3. All linens, airways, oxygen masks, nasal cannulas, and other equipment coming in direct contact with the patient must be either a single-use disposable type or cleaned, laundered, or disinfected after each use.

4. When a vehicle has been utilized to transport a patient known to have a communicable disease other than a common cold, the vehicle and all exposed equipment shall be disinfected before the transport of another patient.

5. Each ambulance run must be reported to the department in the manner and in the form determined by the department.

6. All ambulance services must give the receiving licensed health care facility a copy of the run report.

7. All equipment must be stowed in cabinets or securely fastened when not in use.

8. All ambulance services must submit a trauma transport plan to the department upon request.

9. All licensed ambulance services must keep either an electronic or paper copy of each run report on file for a minimum of seven years.

10. All licensed ambulance services must have current written protocols developed and signed by their medical director. The current version of the protocols must be kept on file with ambulance service management. The ambulance service manager must keep inactive protocols for a period of seven years after deactivating the protocol.

11. All ambulance services must report any collision involving an ambulance that results in property damage of one thousand dollars or greater, or personal injury. The report must be made within thirty days of the event and on a form provided by the department.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-11. Out-of-state operators.

1. Operators licensed in another state may pick up patients within this state for transportation to locations within this state under the following circumstances:

   a. When there is a natural disaster, such as a tornado, earthquake, or other disaster, which may require all available ambulances to transport the injured; or

   b. When an out-of-state ambulance is traveling through the state for whatever purpose comes upon an accident or medical emergency where immediate emergency ambulance services are necessary.

2. Out-of-state ambulance services who expect to pick up patients from within this state and transport to locations within this state must meet the North Dakota state standards and become licensed under chapter 23-27 of the North Dakota Century Code and this chapter.

3. Out-of-state fire units responding to North Dakotathis state for the purposes of forest fire or grassland fire suppression may bring their own emergency medical personnel to provide

emergency medical treatment to their own staff. The emergency medical personnel must be certified by the national registry of emergency medical technicians and have physician oversight.

History: Effective January 1, 2008; amended effective January 1, 2024.
General Authority: NDCC 23-27-01
Law Implemented: NDCC 23-27-01

33-11-01.2-13. Ground ambulance service vehicle requirements.

1. All ground ambulances must have a vehicle manufactured to be an ambulance.

2. A ground ambulance must have a patient care compartment that is designed to carry at least one patient on a stretcher that is securely mounted to the ambulance and that enables transportation in both the supine and seated upright positions.

3. A ground ambulance must have a patient care compartment that is designed to provide sufficient access to a patient's body to perform and maintain advanced life support skills, including adequate space for one caregiver to sit superior to the patient's head to perform required advanced life support airway skills, and other emergency medical services skills required by the emergency medical service agency's emergency medical services protocols.

4. A ground ambulance must have a design that does not compromise patient safety during loading, unloading, or patient transport. A ground ambulance must be equipped with a door that will allow loading and unloading of the patient without excessive maneuvering.

5. A ground ambulance must be equipped with permanently installed climate control equipment to provide an environment appropriate for the medical needs of a patient.

6. A ground ambulance must have interior lighting adequate to enable medical care to be provided and patient status monitored without interfering with the vehicle operator's vision.

7. A ground ambulance must be designed for patient safety so that the patient is isolated from the operator's compartment in a manner that minimizes distractions to the vehicle operator during patient transport and prevents interference with the operator's manipulation of vehicle controls.

8. A ground ambulance must be equipped with appropriate patient restraints and with restraints in every seating position within the patient compartment.

9. A ground ambulance must be equipped with two-way radios capable of communication with medical command facilities, receiving facility communications centers, public safety answering points, and ambulances for the purpose of communicating medical information and assuring the continuity of resources for patient care needs.

10. A ground ambulance must carry an oxygen supply that is cable of providing high flow oxygen at twenty-five or more liters per minute to a patient for the anticipated duration of patient transport.

11. All ground ambulance service vehicles must be equipped with a siren and flashing lights as described for class A emergency vehicles in subsection 2 of section 39-10-03 of the North Dakota Century Code.

History: Effective January 1, 2008; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-14. Transporting of patients.

Ambulance services ~~must~~shall transport patients to the nearest appropriate licensed health care facility according to their hospital transport plan except for:

1. Interfacility transports ~~shall~~must be made in accordance with the referring ~~or accepting~~ physician's orders.

2. In the following specific instances transport must be made to a licensed health care facility with specific capabilities or designations. This may result in bypassing a closer licensed health care facility for another located farther away. An ambulance service may deviate from these rules contained in this section on a case-by-case basis if online medical control is consulted and concurs.

   a. ~~Major trauma~~Trauma patients must be transported to a designated trauma center as per article 33-38.

   b. A patient suffering acute chest pain that is believed to be cardiac in nature or an acute myocardial infarction determined by a twelve-lead electrocardiograph must be transported to a licensed health care facility capable of performing primary percutaneous ~~catheter insertion~~coronary intervention or fibrinolytic therapy pursuant to the North Dakota cardiac system ST-elevation myocardial infarction, non-ST elevation myocardial infarction, and acute coronary syndrome guide.

   c. A patient suffering a suspected stroke must be transported to a designated acute stroke ready hospital, primary stroke center, or a comprehensive stoke center pursuant to the North Dakota acute stroke treatment guidelines.

   ~~c.~~d. In cities with multiple hospitals an ambulance service may bypass one hospital to go to another hospital with equal or greater services if the additional transport time does not exceed ten minutes.

3. An officer, employee, or agent of any emergency medical services operation may refuse to transport an individual to a licensed health care facility for which transport is not medically necessary and may recommend an alternative course of action to that individual, including transportation to an alternative destination such as an urgent care center, clinic, physician's office, or other appropriate destination identified by the emergency medical services operation's medical director, if the emergency medical service operation has developed protocols to refuse transport of an individual and recommend an alternative course of action.

History: Effective January 1, 2008; amended effective July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-15. Required advanced life support care.

When it would not delay transport time, basic life support ambulance services ~~must~~shall call for a rendezvous with an advanced life support ~~ground ambulance, or an advanced life support or critical care air ambulance~~capable agency, paramedic, or its equivalent if the basic life support ambulance is unable to provide the advanced life support interventions needed to fully treat a patient exhibiting:

1. Traumatic injuries that meet the trauma code activation criteria as defined in section 33-38-01-03.

2. Cardiac chest pain or acute myocardial infarction.

3. Cardiac arrest.

4. Severe respiratory distress or respiratory arrest.

5. Suspected stroke or stroke-like symptoms.

History: Effective January 1, 2008; amended effective July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-16. Communications.

To ensure responder safety and a seamless integration with the broader public safety response system, ground ambulance services ~~must~~shall have the following elements to their communications system:

1. They ~~must~~shall have a radio call sign issued by state radio.

2. They ~~must~~shall be dispatched directly from a public safety answering point ~~by radio or pager~~.

3. They ~~must~~shall have a radio capable of transmitting and receiving voice communications with the local public safety answering point, law enforcement responders, fire responders, and other public safety agencies ~~on radio frequencies determined by state radio~~.

4. During the response and transport phases of an emergency ambulance run, an ambulance ~~must~~shall notify its dispatch center or public safety answering point when it:

   a. Is en route to the scene.

   b. Has arrived at the scene.

   c. Has left the scene.

   d. Has arrived at the transport destination.

   e. Is available for the next ambulance run.

5. An ambulance may respond to the scene of an emergency with a fragmented crew if:

   a. Any crewmember that is responding to the scene separately from the ambulance has a hand-held radio capable of transmitting and receiving radio traffic on frequencies designated for ambulances ~~by state radio~~.

   b. The crewmembers communicate with each other by radio to ensure that a full crew will ultimately arrive at the scene of an emergency and be able to treat and transport patients.

6. During the transport phase of an emergency ambulance run, the ambulance ~~must~~shall give a radio or telephone report on the patient's condition to the receiving hospital as soon as it is practical. Early notification to the receiving hospital ~~will allow~~allows the hospital more time to prepare for the patient's arrival.

History: Effective July 1, 2010; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-17. Response times.

~~1.~~ Ground ambulances ~~must~~shall meet the following ~~response~~ time standards ninety percent of the time when dispatched to an emergency request as determined by public safety answering point

protocols or to an emergency interfacility transport as determined by the transferring health care provider.~~:~~

~~a.~~ The time of dispatch to the time that the ambulance is en route must not exceed ten minutes to those incidents in which the public safety answering point or transferring health care provider, as appropriate, has determined that a potential life-threat exists.

~~b. Within the city limits of Bismarck, Fargo, Grand Forks, Mandan, Minot, and West Fargo the time from dispatch to the arrival on scene must not exceed nine minutes.~~

~~c. In rural areas as defined by the United States census and frontier area ambulance services that respond to interstate 94, interstate 29, United States highway 2, or United States highway 83 between Bismarck and Minot, the time from dispatch to the arrival on scene must not exceed twenty minutes.~~

~~d. In frontier areas as defined by the United States census, the time from dispatch to the arrival on scene must not exceed thirty minutes.~~

~~2. Failure to meet response time standards when calculated in the two-year licensure period will require the ambulance service to develop a comprehensive plan of correction approved by the department which would include:~~

~~a. An analysis of the barriers to achieving the response time standard.~~

~~b. A plan to remove or minimize all barriers that have been identified.~~

~~c. Placing a notice in the official county newspaper notifying the public of the ambulance service's response time deficiency in the format determined by the department.~~

History: Effective July 1, 2010; amended effective October 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-18. Strike team designation.

Repealed effective January 1, 2024.

~~No ambulance service licensed under this chapter may hold itself out as an ambulance strike team unless it is so designated by the department.~~

~~**History:** Effective July 1, 2010.~~
~~**General Authority:** NDCC 23-27-04~~
~~**Law Implemented:** NDCC 23-27-04~~

33-11-01.2-19. Mutual aid agreements.

Repealed effective January 1, 2024.

~~Each licensed ambulance service must have at least one mutual aid agreement with a neighboring licensed ambulance service that can assist when its operational capacity is exceeded. A copy of each mutual aid agreement shall be maintained in the files of each licensee.~~

~~**History:** Effective July 1, 2010.~~
~~**General Authority:** NDCC 23-27-04~~
~~**Law Implemented:** NDCC 23-27-04~~

33-11-01.2-19.1. Service areas.

To ensure reasonably adequate ambulance service coverage and to prevent competition that would impair the long-term availability of services to the public, the department shall designate service areas when requested or at the department's discretion.

1. Upon request by a licensed ambulance service the department shall designate its service area. The requesting agency shall have a base of operations within that service area, currently be providing ambulance response within that service area, and be in good standing with the department.

2. The geographic area of the service area must be defined by the department based on the reasonableness of a licensed ambulance service to respond to all requests for service within the area.

3. Service area designation may not impede the ability of the designee or health care facility requesting interfacility transportation to utilize other licensed ground ambulance services for mutual aid when the designee is unable to provide services due to capacity, level of service required exceeds what the local ambulance service can provide, or for specialty care transport that the designee cannot provide.

History: Effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-20. ~~Disaster~~Emergency operations plan.

Each licensed ambulance service ~~must complete the disaster plan template as published by the department with appropriate local information. A copy of the completed disaster plan must be placed in each ambulance and one copy must be sent to the department. The disaster plan may include specialized equipment or supplies as required in the state emergency medical services disaster plan as published by the department~~shall be aware of its role as defined by local, county, and state emergency operations plans and shall be able to access the emergency operations plan as needed.

History: Effective July 1, 2010; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-21. ~~Sanctions~~Denials, suspension, or revocation of licensure.

Failure to meet standards outlined in article 33-11 may result in sanctions based on the severity of the noncompliance ~~with standards~~. Based on each individual case, the department may impose the following sanctions on licensed ambulance services:

1. Require the ambulance service to submit a detailed plan of correction that ~~identifies~~acknowledges the deficiencies as designated by the department and outlines the steps needed to become fully compliant with standards.

2. Require the ambulance service to ~~place a public notice in the official county newspaper in each county in which the ambulance service operates outlining the operational deficiencies of the ambulance service. The notice must be approved by the department prior to its publication~~follow sanction requirements as outlined in department policy.

3. ~~Require the~~Revocation or suspension of ambulance service ~~to host a public meeting with stakeholders of the local emergency medical services system to discuss the operational deficiencies and develop a plan of correction and submit that plan to the department.~~

~~Stakeholders must be notified at least thirty days prior to the meeting. The following groups must be invited to attend:~~

~~a. The general public. An invitation to the meeting must be made in the official county newspaper in each county to which the ambulance service provides service.~~

~~b. City and county government officials. An invitation letter must be mailed to each city and county government leaders within the ambulance service's normal service area.~~

~~c. All neighboring emergency medical service agencies. An invitation letter must be mailed to each quick response unit within the ambulance service's area and to each bordering ambulance service.~~

~~d. Hospital officials. An invitation letter must be sent to the hospitals to which the ambulance service routinely transports patients.~~

~~e. Medical director. An invitation letter must be sent to the ambulance service's medical director.~~

~~f. Regional trauma committee. An invitation letter must be sent to the regional trauma committee as defined in article 33-38.~~

~~g. The department. An invitation letter must be sent to the North Dakota department of health division of emergency medical services and trauma~~licensure.

History: Effective July 1, 2010; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-22. Industrial site ambulance services.

An operator of a ground ambulance service intended for industrial site use may be issued a special license by the department.

1. The ambulance service may not advertise or offer service to the general public.

2. The ambulance service may provide advanced life support interventions on an as-needed basis if all requirements of chapter 33-11-03 are satisfied.

History: Effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-23. Government agency ambulance services.

An operator of a ground ambulance service intended for federal or state government emergency operations may be issued a special license by the department.

1. The ambulance service may offer service to the general public and special populations during emergency operations.

2. The ambulance service may provide basic and advanced life support interventions as needed provided the service has met all minimum staffing and equipment requirements of chapters 33-11-02 and 33-11-03, respectively.

History: Effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-24. General operating standards.

1. Documentation requirements for licensure. An applicant for an emergency medical service agency license shall have the following documents available, paper or online, for inspection by the department:

   a. A roster of active personnel, including the emergency medical service agency medical director, with licensure numbers and dates of licensure expiration for each emergency medical service provider.

   b. A record of the age of each emergency medical service provider and emergency medical service vehicle operator and a copy of the driver's license for each emergency medical service vehicle operator.

   c. Documentation, if applicable, of the initial and most recent review of each emergency medical service provider's competence by the emergency medical service agency medical director and the emergency medical service provider licensure level at which each emergency medical service provider is permitted to practice.

   d. The process for scheduling staff to ensure that the minimum staffing requirements as required by this chapter are met.

   e. Identification of individuals who are responsible for making operating and policy decisions for the emergency medical service agency, such as officers, directors, and other emergency medical service agency officials.

   f. Criminal, disciplinary, and exclusion information for all individuals who staff the emergency medical service agency as required under subsection 5.

   g. Copies of the ambulance service's emergency medical services protocols.

   h. Copies of the written policies required under this section.

   i. Emergency medical service patient care records.

   j. Call volume records from the previous year's operations. These records must include a record of each call received requesting the emergency medical service agency to respond to an emergency, as well as a notation of whether it responded to the call and the reason if it did not respond.

   k. A record of the time periods for which the emergency medical service agency notified the public safety answering point, under subdivision a of subsection 6, that it would not be available to respond to a call.

2. Emergency medical service vehicles, equipment and supplies. The department shall publish in administrative rules the vehicle construction and equipment and supply requirements for emergency medical service agencies based upon the types of services they provide and the emergency medical service vehicles they operate. Required equipment and supplies must be carried and readily available in working order.

3. Use of individuals under eighteen years of age. The emergency medical service agency shall comply with chapter 34-07 of the North Dakota Century Code, relating to child labor; chapter 46-02-07; the Fair Labor Standards Act of 1938 [Pub. L. 75-718; 52 Stat. 1060; 29 U.S.S. 201 et seq.], and rules or regulations adopted pursuant to chapter 34-07 of the North Dakota Century Code or Fair Labor Standards Act of 1938 [Pub. L. 75-718; 52 Stat. 1060; 29 U.S.S. 201 et seq.] when it is using individuals under eighteen years of age to staff its operations. The emergency medical service agency shall also ensure that an emergency medical service

provider under eighteen years of age, when providing emergency medical services on behalf of the emergency medical service agency, is directly supervised by an emergency medical service provider who is at least eighteen years of age who has the same or higher-level of emergency medical service provider licensure and at least one year of active practice as an emergency medical service provider.

4. Emergency medical service agency medical director. An emergency medical service agency shall have an emergency medical service agency medical director.

5. Responsible staff. An emergency medical service agency shall ensure that individuals who staff the emergency medical service agency, including its officers, directors and other members of its management team, emergency medical service providers, and emergency medical service vehicle operators, are responsible individuals. In making that determination, an emergency medical service agency shall require each individual who staffs the emergency medical service agency to provide it with the information and documentation related to criminal convictions, disciplinary sanctions, and exclusions and require each emergency medical service vehicle operator to provide it with the information and documentation related to his or her driving record and to update that information if and when additional convictions, disciplinary sanctions, and exclusions occur. The emergency medical service agency shall consider this information in determining whether the individual is a responsible individual. An emergency medical service agency shall also provide the department with notice of any change in its management personnel to include as a new member of its management team an individual who has reported to it information required under this subsection.

6. Communicating with public safety answering points.

a. Responsibility to communicate unavailability. An emergency medical service agency shall apprise the public safety answering point in its area, in advance, as to when it will not be in operation due to inadequate staffing or for another reason and when its resources are committed in a manner that it will not be able to respond with an emergency medical service vehicle, if applicable, and required staff, to a request to provide emergency medical services.

b. Responsibility to communicate delayed response. An emergency medical service agency shall apprise the public safety answering point as soon as practical after receiving a dispatch call from the public safety answering point, if it is not able to have an appropriate emergency medical service vehicle, if applicable, or otherwise provide the requested level of service, including having the required staff en route to an emergency within the time as may be prescribed by a public safety answering point for that type of dispatch.

c. Responsibility to communicate with public safety answering point generally. An emergency medical service agency shall provide a public safety answering point with information, and otherwise communicate with a public safety answering point, as the public safety answering point requests to enhance the ability of the public safety answering point to make dispatch decisions.

d. Response to dispatch by public safety answering point. An emergency medical service agency shall respond to a call for emergency assistance as communicated by the public safety answering point, provided it is able to respond as requested. An emergency medical service agency is able to respond as requested if it has the staff and an operational emergency medical service vehicle, if needed, capable of responding to the dispatch. An emergency medical service agency may not refuse to respond to a dispatch based upon a desire to keep staff or an emergency medical service vehicle in reserve to respond to other calls to which it has not already committed.

7. Patient management. All aspects of patient management are to be handled by an emergency medical service provider with the level of licensure necessary to care for the patient based upon the condition of the patient.

8. Use of lights and other warning devices. Ground emergency medical service vehicles may not use emergency lights or audible warning devices unless they do so in accordance with the standards imposed under chapter 39-10 of the North Dakota Century Code and are transporting or responding to a call involving a patient who presents, or is in good faith perceived to present, a combination of circumstances resulting in a need for immediate medical intervention. Emergency lights and audible warning devices may be used on an ambulance when transporting a patient only when medical intervention is required to receive time-sensitive, lifesaving interventions beyond what can be provided in an ambulance.

9. Explosives. Explosives may not be carried aboard an emergency medical service vehicle. This subsection does not apply to law enforcement officers who are serving in an authorized law enforcement capacity.

10. Accident, injury, and fatality reporting. An emergency medical service agency shall report to the department, in a form or electronically, as prescribed by the department, an emergency medical service vehicle accident that is reportable under chapter 39-08 of the North Dakota Century Code and an accident or injury to an individual that occurs in the line of duty of the emergency medical service agency that results in a fatality or medical treatment by a licensed health care practitioner. The report shall be made within twenty-four hours after the accident or injury. The report of a fatality shall be made within eight hours after the fatality.

11. Safety and quality improvement. An emergency medical service agency shall have a mechanism to address safety issues and quality improvement. This may be in the form of a committee or committees or other format that meets the need of the emergency medical service agency.

12. Emergency medical service provider credentialing. The emergency medical service agency shall maintain a record of the emergency medical service agency medical director's assessments and recommendations for emergency medical service provider credentialing. An emergency medical service agency may not permit an emergency medical service provider at or above the emergency medical technician level to provide emergency medical services at the emergency medical service provider's licensure level if the emergency medical service agency medical director determines that the emergency medical service provider has not demonstrated the knowledge and skills to competently perform the skills within the scope of practice at that level or the commitment to adequately perform other functions relevant to an emergency medical service provider providing emergency medical services at that level. Under these circumstances, an emergency medical service agency may continue to permit the emergency medical service provider to provide emergency medical services for the emergency medical service agency only in accordance with the restrictions as the emergency medical service agency medical director may prescribe. The emergency medical service agency shall notify the department within ten days after it makes a decision to allow an emergency medical service provider to practice at a lower level based upon the assessment of the emergency medical service provider's skills and other qualifications by the emergency medical service agency medical director, or a decision to terminate the emergency medical service agency's use of the emergency medical service provider based upon its consideration of the emergency medical service agency medical director's assessment.

13. Display of license and registration certificates. The emergency medical service agency shall display its license certificate in a public and conspicuous place in the emergency medical service agency's primary operational headquarters.

14. Monitoring compliance. An emergency medical service agency shall monitor compliance with the requirements that the emergency medical services statutes and rules impose upon the emergency medical service agency and its staff. An emergency medical service agency shall file a written report with the department if it determines that an emergency medical service provider or emergency medical service vehicle operator who is on the staff of the emergency medical service agency, or who has recently left the emergency medical service agency, has engaged in conduct not previously reported to the department, for which the department may impose disciplinary action. The duty to report pertains to conduct that occurs during a period of time in which the emergency medical service provider or emergency medical service vehicle operator is functioning for the emergency medical service agency.

15. Policies and procedures. An emergency medical service agency shall maintain policies and procedures ensuring that each of the requirements imposed under this section, as well as any requirements imposed by statute, rules, or internal policy are satisfied by the emergency medical service agency and its staff.

History: Effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-25. General standards for providing emergency medical services.

Regardless of the type of service through which an emergency medical service agency is providing emergency medical services, the following standards apply to the emergency medical service agency and its emergency medical service providers when functioning as an emergency medical service provider on behalf of an emergency medical service agency, except as otherwise provided in this section:

1. An emergency medical service provider who encounters a patient before the arrival of other emergency medical service providers shall attend to the patient and begin providing emergency medical services to the patient at that emergency medical service provider's skill level.

2. An emergency medical responder may not be the emergency medical service provider who primarily attends to a patient unless another higher-level emergency medical service provider is not present or all other emergency medical service providers who are present are attending to other patients. An emergency medical responder may not attend to a patient during transport unless another higher-level emergency medical service provider is present.

3. Except as set forth in subsection 2, or unless there are multiple patients and the emergency medical services needs of other patients require otherwise, among emergency medical service providers who are present, an emergency medical service provider who is certified at or above the emergency medical services skill level required by the patient shall be the emergency medical service provider who primarily attends to the patient.

4. If a patient requires emergency medical services at a higher skill level than the skill level of the emergency medical service providers who are present, unless there are multiple patients and the emergency medical services needs of other patients require otherwise, an emergency medical service provider who is licensed at the highest emergency medical services skill level among the emergency medical service providers who are present shall be the emergency medical service provider who primarily attends to the patient.

5. A member of the emergency medical service vehicle crew with the highest level of emergency medical service provider licensure shall be responsible for the overall management of the emergency medical services provided to the patient or patients by the members of that emergency medical service vehicle crew. If more than one member of the emergency medical

service vehicle crew is an emergency medical service provider above the advanced emergency medical technician level, any of those emergency medical service providers may assume responsibility for the overall management of the emergency medical services provided to the patient or patients by the members of that emergency medical service vehicle crew.

6. If an emergency medical service vehicle crew needs additional assistance in attending to the needs of a patient or patients, it shall contact a public safety answering point or its emergency medical service agency dispatch center to request that assistance.

7. Except as otherwise provided in rule, a ground ambulance service shall operate twenty-four hours per day seven days per week, each type of service it is licensed to provide at each location it is licensed to operate that service.

8. A member of an emergency medical service vehicle crew who responds to a call in a personal vehicle may not transport in that vehicle medications, equipment, or supplies that an emergency medical technician is not authorized to use.

History: Effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-02
BASIC LIFE SUPPORT GROUND AMBULANCE LICENSE

Section
33-11-02-00.1 Purpose
33-11-02-01 ~~Training~~ Standards for ~~Ambulance Driver~~Emergency Medical Service Vehicle Operator
33-11-02-02 ~~Training Standards for Primary Care Provider~~Staffing
33-11-02-03 Minimum Equipment Requirements
33-11-02-04 Medical Direction
33-11-02-05 Basic Life Support Ambulance Performing Advanced Life Support Interventions

33-11-02-00.1. Purpose.

An emergency medical service agency that operates a basic life support ambulance service employs one or more basic life support ambulances staffed by an ambulance crew capable of providing medical assessment, observation, triage, monitoring, treatment, and transportation of patients who require emergency medical services at or below the skill level of an emergency medical technician or equivalent.

History: Effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-02-01. ~~Training standards~~Standards for ~~ambulance driver~~emergency medical service vehicle operator.

~~By July 1, 2011, drivers must have successfully completed an emergency vehicle operations course as defined in chapter 33-36-01. After July 1, 2011, new drivers must complete the~~The emergency medical service vehicle ~~operations course within one year of joining the ambulance service. In addition, the driver~~operator shall have a current driver's license, cardiopulmonary resuscitation certification, ~~unless there are two primary care providers as defined in section 33-11-02-02 or one primary care provider plus one other person with a current cardiopulmonary resuscitation certification providing care to the patient~~and emergency vehicle operators training.

History: Effective March 1, 1985; amended effective January 1, 1986; August 1, 2003; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-02-02. ~~Training standards for primary care provider~~Staffing.

The primary care provider must have current emergency medical technician license or its equivalent and must have current cardiopulmonary resuscitation certification.

1. The minimum staffing for a basic life support ambulance crew when responding to a call to provide emergency medical services and transporting a patient is:

   a. An emergency medical service provider at or above the emergency medical technician level; and

   b. An emergency medical service vehicle operator.

2. For the purposes of this section, an emergency medical service provider at or above the emergency medical technician level includes an emergency medical technician, advanced emergency medical technician, or paramedic or a physician assistant, nurse practitioner, or

registered nurse that has been authorized by the emergency medical service agency medical director to function as an emergency medical service provider.

3. Responding ambulance crew members may arrive at the scene separately, but the ambulance shall be fully staffed at or above the required minimum staffing level before transporting a patient.

4. Providing emergency medical service when dispatched with a higher-level emergency medical service vehicle crew. If a basic life support ambulance and a higher-level emergency medical service vehicle crew are dispatched to provide emergency medical services for a patient, the following shall apply:

   a. Basic life support ambulance crew members shall begin providing emergency medical services to the patient at their skill levels, including transportation of the patient to a receiving facility if the ambulance crew determines transport is needed, until a higher level of emergency medical services is afforded by the arrival of a higher-level emergency medical service provider.

   b. Upon the arrival of a higher-level emergency medical service vehicle crew, the basic life support ambulance shall continue transporting the patient or release the patient to be transported by the higher-level emergency medical service vehicle crew, consistent with local emergency medical service protocols, as directed by the emergency medical service provider exercising primary responsibility for the patient.

   c. The basic life support ambulance crew shall reassume primary responsibility for the patient if that responsibility is relinquished back to that ambulance crew by the emergency medical service provider of the higher-level emergency medical service vehicle crew who had assumed primary responsibility for the patient.

   d. A basic life support ambulance and its ambulance crew may transport from a receiving facility a patient who requires emergency medical services above the skill level at which the ambulance is operating, if the sending or a receiving facility provides a registered nurse, nurse practitioner, physician assistant, or physician to supplement the ambulance crew, that individual brings on board the ambulance equipment and supplies to provide the patient with emergency medical services above the emergency medical service level at which the basic life support ambulance is operating to attend to the emergency medical services needs of the patient during the transport, and that individual attends to the patient during the patient transport.

5. Application. For purposes of this section, the term "higher-level of emergency medical service" means the emergency medical service vehicle crew of a basic life support ambulance performing advanced life support interventions as defined in section 33-11-02-06, an advanced life support ambulance, or air ambulance.

History: Effective March 1, 1985; amended effective January 1, 1986; August 1, 1994; August 1, 2003; January 1, 2006; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-02-03. Minimum equipment requirements.

In addition to a vehicle as described in section 33-11-01-15, the ambulance shall have the following, unless otherwise approved by the department:

1. Patient transport:

   a. Mounted ambulance cot with retaining straps.

~~2.~~b. Stretchers with retaining straps. Vehicle design dictates quantity.

2. Spinal stabilization:

a. One adult long backboard, with retaining straps.

b. One seated spinal immobilization device, with retaining straps.

c. One pediatric-safe transport device.

d. One adult cervical collar.

e. One pediatric cervical collar.

3. Oxygen delivery:

~~3.~~a. Piped oxygen system - with appropriate regulator and flow meter, or two "E" size bottles for minimum oxygen supply with regulator and flowmeter.

~~4.~~b. Portable oxygen unit with carrying ~~case. To include~~device, including one "D" size bottle with another "D" bottle in reserve.

~~5.~~c. Three ~~nasal~~adult cannulas~~, three nonrebreather oxygen masks in adult and pediatric sizes, and three sets of oxygen supply tubing~~.

d. Three pediatric nasal cannulas.

e. Three adult nonrebreather oxygen masks.

f. Three pediatric nonrebreather oxygen masks.

g. Three sets of oxygen supply tubing.

h. Noninvasive positive pressure ventilation device.

i. Nebulizer with tubing.

~~6.~~4. Suction ~~- wall-mounted and portable -~~:

a. Wall-mounted suction capable of achieving ~~400 mmhg/4 seconds or less with one~~a minimum of four hundred millimeters of mercury vacuum within four seconds or less after clamping the suction tube.

b. Portable suction capable of achieving a minimum of four hundred millimeters of mercury vacuum within four seconds or less after clamping the suction tube.

c. One rigid tonsil tip suction catheter~~, one~~.

d. One flexible suction catheter between size six and ten french~~, and one~~.

e. One flexible suction catheter between twelve and sixteen french.

5. Airway adjuncts:

a. One set of adult sizes nasopharyngeal airways.

b. One set of pediatric sizes nasopharyngeal airways.

c. One set of adult sizes oropharyngeal airways.

d. One set of child sizes oropharyngeal airways.

e. One set of infant sizes oropharyngeal airways.

f. Alternative airway devices such as a supraglottic airway as approved by local medical direction.

~~7.~~6. Bag valve masks:

a. One adult bag valve mask resuscitation ~~units in infant child and adult sizes with face masks in adult, child, infant, and neonate sizes~~unit with face mask.

b. One child bag valve mask resuscitation unit with face mask.

c. One infant bag valve mask resuscitation unit with face mask.

~~8. Spine boards - one adult long backboard and one seated spinal immobilization device, with retaining straps. In addition, by July 1, 2011, each ambulance shall have one pediatric long backboard.~~

7. Splinting:

~~9.~~a. ~~Commercial~~Adult commercial fracture splints usable for open and closed fractures, or padded boards ~~usable for pediatric and adult patients~~.

b. Pediatric commercial fracture splints usable for open and closed fractures, or padded boards.

c. Adult lower extremity traction splint.

d. Pediatric lower extremity traction splint.

8. Environmental:

~~10.~~a. ~~Cold~~Four cold packs ~~- four minimum~~.

b. Four hot packs.

~~11. Fire extinguisher - dry chemical, mounted, five pound [2.27 kilogram] minimum.~~

~~12. Head-to-board immobilization devices in adult and pediatric sizes.~~

~~13. Obstetrical kit - disposable or sterilizable that includes an infant bulb suction device and a receiving blanket with head cover.~~

~~14. Activated charcoal.~~

9. Bandaging and bleeding control:

~~15.~~a. Two sterile burn sheets or equivalent.

~~16.~~b. Three triangular bandages or commercial slings.

~~17.~~c. Two trauma dressings - approximately ten inches [25.4 centimeters] by thirty-six inches [91.44 centimeters].

~~18.~~d. Twenty-five sterile gauze pads - approximately four inches [10.16 centimeters] by four inches [10.16 centimeters].

19.e. Twelve soft roller self-adhering type bandages - approximately five yards [4.57 meters] long.

20. One set of nasopharyngeal airways in adult and child sizes.

21. One set of oropharyngeal airways in adult, child, and infant sizes.

22.f. Two sterile occlusive dressings approximately three inches [76.2 millimeters] by nine inches [228.6 millimeters].

g. Two commercial "tactical" tourniquets.

23. Four rolls of tape - assorted sizes.

24. Shears - blunt - two minimum.

25. Bedpan, emesis basin, urinal.

26. One gallon [3.79 liters] of distilled water or saline solution.

27. Intravenous fluid holder - cot mounted or ceiling hooks.

28. Flashlights - two minimum.

29. One sharps container less than half full.

30. Three red biohazard bags.

31. Cervical collars in adult, child, and infant sizes.

32. Two blankets, four sheets, two pillows, four towels.

33. Phenol disinfectant product, such as lystophene or amphyl.

34. Reflectorized flares for securing scene - set of three minimum.

35. Automatic defibrillator.

10. Diagnostic:

36.a. BloodAdult blood pressure manometer, cuff in child, adult, and large adult sizes, and stethoscope.

b. Large adult blood pressure cuff.

c. Child blood pressure cuff.

d. Stethoscope.

e. Pulse oximeter.

f. Glucose measuring device.

g. Penlight.

h. Thermometer.

37. One adult lower extremity traction splint. In addition, by July 1, 2011, each ambulance shall have one pediatric lower extremity traction splint.

~~38. Radio with the capability of meeting state emergency medical services standards as determined by the department.~~

~~39. Glutose or glucose - one dose for oral use.~~

11. Medications:

a. Three oral doses of glutose or glucose.

b. One small bottle, chewable aspirin.

c. Epinephrine, auto-injector for adult and pediatric doses or intramuscular, including syringes and needles for intramuscular delivery, if approved by medical director.

d. Naloxone, auto-injector (0.8 mg) or intranasal (4 mg - nasal spray, or syringe and atomizer).

~~40.~~12. ~~Disposable~~Personal protective equipment:

a. One size small box of nitrile gloves~~ - one box each of small,~~.

b. One size medium~~, and~~ box of nitrile gloves.

c. One size large ~~sizes~~box of nitrile gloves.

~~41. Four disposable hot packs.~~

~~42.~~d. ~~Personal protection equipment including fitted~~Box of surgical masks~~,~~.

e. N95 masks, in small, medium, and large sizes and at least one per crew member.

f. Four nonabsorbent gowns~~, and~~.

g. Four pairs of protective eyeware~~ - minimum of four~~.

13. Cleaning and biological:

a. Three red biohazard bags.

~~43.~~b. Biological fluid cleanup kit.

c. One sharps container, that is less than half full.

d. Medical grade disinfectant.

e. One gallon [3.79 liters] of distilled water or saline solution.

f. One bedpan.

g. One emesis basin.

h. One urinal.

i. One container of nonwater hand disinfectant.

14. Safety:

a. Two reflective vests.

b. A minimum set of three reflectorized flares.

c. Two flashlights.

d. A minimum of two dry chemical, mounted, five-pound [2.27-kilogram] fire extinguishers located in patient compartment and in either cab or exterior compartment.

e. Helmet, protective safety glasses or goggles eyewear, and leather or extrication gloves per crew member.

f. Two window and glass punches located in patient compartment and in cab.

15. Communications:

a. Radio, compatible with local communications system.

b. Portable, hand-held radio, rechargeable, battery-operated, compatible with local communications system.

16. Other:

a. Automated external defibrillator.

~~44.~~b. Twenty-five triage tags.

~~45. Pulse oximeter.~~

~~46.~~c. ~~Appropriate pediatric~~Pediatric reference material ~~or pediatric weight-based and length-based~~for equipment sizing and ~~drug dosage chart or tape~~medication dosing.

~~47. Reflective vests - minimum of two.~~

d. Four assorted sizes rolls of tape.

e. Two blunt shears.

f. Cot-mounted or ceiling hooks intravenous fluid holder.

g. Two blankets.

h. Four sheets.

i. Four towels.

j. Disposable or sterilizable that includes an infant bulb suction and receiving blanket with head cover obstetrical kit.

k. One current edition of the Emergency Response Guidebook.

l. Alcohol or iodine swabs.

m. Water-soluble lubricant.

n. Razor.

History: 33-11-01-11; redesignated effective March 1, 1985; amended effective February 1, 1989; August 1, 1994; August 1, 2003; January 1, 2006; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-03
ADVANCED LIFE SUPPORT GROUND AMBULANCE LICENSE

Section

33-11-03-00.1. Purpose.

An emergency medical service agency that operates an advanced life support ambulance service employs one or more advanced life support ambulances staffed by an ambulance crew capable of providing medical assessment, observation, triage, monitoring, treatment, and transportation of patients who require emergency medical services above the skill level of an advanced emergency medical technician.

History: Effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-01. ~~Minimum standards for personnel~~Staffing.

1. The minimum staffing requirement for an advanced life support licensed ground ambulance must consist of a paramedic or equivalent and an emergency medical technician or equivalent. If the crew consists of three or more personnel, the paramedic and emergency medical technician crew may have ~~a CPR-trained driver. By July 1, 2011, drivers must have successfully completed an emergency vehicle operations course as defined in chapter 33-36-01. After July 1, 2011, new drivers must complete the emergency vehicle operations course within one year of joining the ambulance service~~an emergency medical service vehicle operator as defined in section 33-11-01.2-01 as a third crew member.

2. The primary care provider, whose duties include an assessment of each patient, must hold current cardiopulmonary resuscitation certification and be a licensed paramedic or its equivalent~~, or be a licensed registered nurse currently licensed as an emergency medical technician or its equivalent who has a current American heart association advanced cardiac life support certification or its equivalent,~~ with the following exceptions:

   a. If, based on the paramedic's, or its equivalent's, assessment findings, a patient's condition requires only basic life support, an emergency medical technician or its equivalent may assume primary care of the patient.

   b. For scheduled basic life support transfers with a crew of two personnel, the driver and the primary care provider must be at least licensed emergency medical technicians or its equivalent.

   ~~c. For scheduled basic life support transfers with a crew of three or more personnel, the crew may have a CPR-trained driver.~~

3. Responding ambulance crew members may arrive at the scene separately, but the ambulance shall be fully staffed at or above the minimum staffing level before transporting a patient.

4. Providing emergency medical services when dispatched with a lower-level emergency medical service vehicle crew. If an advanced life support ambulance and a lower-level emergency

medical service vehicle crew are dispatched to provide emergency medical services for a patient, the following shall apply:

a. Upon arrival of an emergency medical service provider from the advanced life support ambulance crew who is a higher-level emergency medical service provider than the highest-level emergency medical service provider of the lower-level emergency medical service vehicle crew who is present, that emergency medical service provider shall assume primary responsibility for the patient.

b. If the patient is assessed by the advanced life support ambulance crew to require emergency medical services above the skill level at which the lower-level emergency medical service vehicle crew is operating, and requires transport to a receiving facility, the emergency medical service provider who is responsible for the overall management of the emergency medical services provided to the patient shall decide, consistent with local emergency medical service protocols, who will transport the patient. An appropriately licensed member of the advanced life support ambulance crew shall attend to the patient during the transport. If the lower-level emergency medical service vehicle is used to transport the patient, that emergency medical service provider shall use the equipment and supplies on the lower-level emergency medical service vehicle, supplemented with the additional equipment and supplies, including medications, from the advanced life support ambulance.

c. If at the scene or during patient transport by the lower-level emergency medical service vehicle crew, the emergency medical service provider of the advanced life support ambulance crew who has assumed primary responsibility for the patient determines that the lower-level emergency medical service vehicle crew is operating at the skill level needed to attend to the patient's emergency medical services needs, consistent with local emergency medical service protocols, that emergency medical service provider may relinquish responsibility for the patient to the lower-level emergency medical service vehicle crew.

History: Effective March 1, 1985; amended effective January 1, 1986; August 1, 1994; August 1, 2003; January 1, 2006; January 1, 2008; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-02. Minimum equipment standards.

The ambulance must contain all the equipment requirements as found in section 33-11-02-03, except ~~oral glutose or glucose~~for having an automated external defibrillator, unless the required manual cardiac monitor is not able to function as an automated external defibrillator, plus the following, unless otherwise approved by the department:

1. ~~Manual cardiac monitor defibrillator with transcutaneous pacer and pediatric capabilities.~~

~~2. Portable radio. Rechargeable battery operated capable of reaching law enforcement and hospitals.~~

~~3. Nebulizer with tubing.~~

~~4. Endotracheal airway equipment in pediatric and adult sizes.~~

~~5. Laryngoscope with straight blade sizes zero, one, two, and three or four. Also curved blade sizes two and three or four.~~

~~6. Stylettes, one pediatric and one adult.~~

~~7. Meconium aspirator adaptor.~~

~~8. Magill forceps, one pediatric and one adult.~~

~~9. Intravenous therapy equipment. Catheters, intraosseouss needles, tubing solutions, for both pediatric and adult patients as approved by medical director.~~

~~10. Glucose measuring device.~~

~~11. Syringes and needles.~~

~~12. Alcohol swabs. Betadine swabs.~~

~~13. Electrocardiogram supplies. Rolls of electrocardiogram paper, monitor electrodes and defibrillator pads.~~

~~14. Pediatric weight and length based drug dosage chart or tape~~Oxygen delivery. End-tidal carbon dioxide detectors with pediatric and adult capability.

2. Suction. One meconium aspirator adaptor.

3. Airway adjuncts:

a. Adult endotracheal airway equipment.

b. Pediatric endotracheal airway equipment.

c. One size zero straight laryngoscope blade.

d. One size one straight laryngoscope blade.

e. One size two straight laryngoscope blade.

f. One size three or four straight laryngoscope blade.

g. One size two curved laryngoscope blade.

h. One size three or four curved laryngoscope blade.

i. One adult stylette.

j. One pediatric stylette.

k. One pair of adult Magill forceps.

l. One pair of pediatric Magill forceps.

m. One adult laryngoscope handle with extra batteries.

n. One pediatric laryngoscope handle with extra batteries.

4. Diagnostic:

a. Manual cardiac monitor defibrillator with transcutaneous pacing, waveform capnography and pediatric capabilities.

b. Monitor electrocardiogram paper rolls.

c. Monitor electrodes.

d. Adult defibrillator pads.

e. Pediatric defibrillator pads.

5. Medication delivery:

a. Intravenous therapy equipment, including venous restriction device, micro and macro drip administration sets, catheters from sixteen gauge to twenty-four gauge, intraosseous needles, tubing, solutions, and intravenous arm boards for both pediatric and adult patients, as approved by local medical direction.

b. Syringes and needles.

History: Effective March 1, 1985; amended effective August 1, 1994; August 1, 2003; January 1, 2008; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-03. Minimum medication requirements.

The ambulance must carry the following functional classification of medications in pediatric and adult dosages:

1. Alkalinizer agent.
2. Bronchodilator - adrenergic intravenous or subcutaneous.
3. Bronchodilator for nebulized delivery.
4. Antidysrhythmic or antiarrhythmic.
~~4.~~5. Anticholinergen parasympatholitic.
~~5.~~6. Opioid antagonist.
~~6.~~7. Coronary vasodilator, antianginal.
~~7.~~8. ~~Antianxiety~~Anxiolytic.
~~8.~~9. ~~Caloric~~Dextrose containing solution.
~~9.~~10. Anticonvulsant.
~~10. Bronchodilator.~~
11. ~~Narcotic~~Analgesic.
12. Antiemetic.

History: Effective March 1, 1985; amended effective August 1, 1994; August 1, 2003; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-05. Number of ambulances staffed.

~~Unless the advanced life support ambulance service has a system status management program as defined in this chapter in place that is approved by the department, the number of advanced life support ambulances staffed, either by on-call or in-house staff, by the licensed ambulance service is dependent upon the population of the city in which the ambulance is based.~~

~~1. For cities with a population less than fifteen thousand, one advanced life support ambulance must be staffed. Additional ambulances may be required to meet the response time standards as defined in section 33-11-01.2-17 and may be staffed and equipped at the basic life support level.~~

~~2. For cities with populations between fifteen thousand one and fifty-five thousand, two advanced life support ambulances must be staffed. Additional ambulances may be required to meet the response time standards as defined in section 33-11-01.2-17 and may be staffed and equipped at the basic life support level.~~

~~3. For cities with populations greater than fifty-five thousand, three advanced life support ambulances must be staffed. Additional ambulances may be required to meet the response time standards as defined in section 33-11-01.2-17 and may be staffed and equipped at the basic life support level~~One advanced life support ambulance must be staffed. Additional ambulances may be required to meet community needs, demand, or the response time standards as defined in section 33-11-01.2-17 and may be staffed and equipped at the basic life support level.

History: Effective March 1, 1985; amended effective January 1, 1986; August 1, 1994; August 1, 2003; January 1, 2006; January 1, 2008; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-04

33-11-04-01. Definitions.

1. "Air ambulance run" means the response of an aircraft and personnel to an emergency or nonemergency for the purpose of rendering medical care or transportation, or both, to someone who is sick or injured. Includes canceled calls, no transports, and standby events where medical care may be rendered.

2. "Aircraft" means either an airplane also known as a fixed-wing, or a helicopter also known as a rotor-wing.

3. ~~"Cardiopulmonary resuscitation" means the American heart association health care provider standards or its equivalent, which includes the following skills: adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.~~

~~4.~~ "Commission on accreditation of medical transport systems" means ~~the commission on accreditation of medical transport systems located in Anderson, South Carolina~~a nationally recognized body for accreditation of air medical transportation systems.

~~5.~~4. "Department" means the ~~state~~ department of health ~~as defined in North Dakota Century Code chapter 23-01~~and human services.

~~6. "Emergency medical technician" means a person who meets the requirements of the state emergency medical technician program and is licensed by the department.~~

~~7.~~5. "Equivalent" means ~~training or equipment of equal or greater value which accomplishes the same results as determined by the department~~qualifications reasonably comparable to those specifically listed as required for training, certification, licensure, credentialing, or recognition.

~~8. "Paramedic" means a person who is certified by the national registry of emergency medical technicians and licensed by the department as a paramedic.~~

~~9.~~6. "Personnel" means ~~qualified primary care providers within an air ambulance service~~an individual maintained on an air ambulance roster.

~~10. "Primary care provider" means a qualified individual responsible for care of the patient while on an air ambulance run.~~

History: Effective August 1, 2003; amended effective January 1, 2006; January 1, 2008; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-02. License required - Fees.

1. No air ambulance service as defined in North Dakota Century Code chapter 23-27 shall be advertised or offered to the public or any person unless the operator of such air ambulance service is licensed by the department.

2. The license shall expire midnight on October thirty-first of the even year following issuance. ~~License renewal shall be on a biennial basis~~The department shall relicense for a two-year period, expiring on October thirty-first, an air ambulance service successfully meeting the requirements of the North Dakota air ambulance licensure program.

3. A license is valid only for the service for which it is issued. A license may not be sold, assigned, or transferred.

4. The license shall be displayed in a conspicuous place inside the patient compartment of the aircraft. An operator operating more than one aircraft out of a town, city, or municipality will be issued duplicate licenses for each aircraft at no additional charge.

5. The biennial license fee shall be fifty dollars for each air ambulance service operated.

History: Effective August 1, 2003; amended effective January 1, 2008; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-03. Application for license.

An application for an air ambulance service license shall be submitted on a form or through an electronic process, as prescribed by the department. The application must contain the following information as well as additional information and documents that may be solicited by the application form:

1. ~~Application for the license shall be made in the manner prescribed by the department.~~

~~2. The application must be made for either basic life support air ambulance service as defined in chapter 33-11-05, advanced life support air ambulance service as defined in chapter 33-11-06, or for critical care air ambulance service as defined in chapter 33-11-07~~Contact information:

   a. The name, mailing address, and electronic mail address of the applicant.

   b. A primary contact person, including telephone number, to be reached twenty-four hours per day seven days per week.

2. The name under which the applicant will be holding itself out to the public in conducting its emergency medical service operations and the address of its primary location in this state out of which it will be conducting its emergency medical service operations.

   a. If the applicant seeks to conduct emergency medical service agency operations out of more than one location, the address of its primary operational headquarters and each other location out of which it intends to operate must also be provided.

   b. If the applicant will be holding itself out to the public under different fictitious names for the emergency medical service operations it will conduct at different locations, the fictitious name under which it intends to operate at each location.

3. The manner in which the applicant is organized.

4. The tax status of the applicant.

5. An up-to-date roster of active personnel.

6. The number and types of aircraft to be operated by the applicant and identifying information for each aircraft.

7. The communication access and capabilities of the applicant.

8. A full description of the emergency medical service agency services that it intends to provide out of each location and how it intends to respond to flight transport requests.

9. The names, titles, and summary of responsibilities of individuals who will be staffing the emergency medical service operation as officers, directors, or other emergency medical service agency officials.

10. A statement attesting to the veracity of the application, which must be signed by the principal official of the applicant.

History: Effective August 1, 2003; amended effective January 1, 2006; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-04. Issuance and renewal of licenses.

1. The department or its authorized agent may inspect the air ambulance service. If minimum standards ~~for either basic life support air ambulance services, advanced life support air ambulance services, or critical care air ambulance services~~ are met, the department shall issue a license.

2. A service may request that the department consider it in compliance with this chapter if it is fully accredited by the commission on accreditation of medical transport systems or its equivalent.

3. Services requesting their compliance with this chapter be verified through an accrediting agency shall submit to the department a copy of the entire accrediting agency survey report. Subsequent accreditation or revisit documentation must be submitted prior to license renewal.

History: Effective August 1, 2003; amended effective January 1, 2006; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-05. Availability of air ambulance services.

~~Basic life support air ambulance services may be available as needed per licensee's discretion. Advanced life support air ambulance services and critical~~Critical care air ambulance services shall be available twenty-four hours per day and seven days per week, except as limited by weather or aircraft maintenance or by unscheduled pilot duty limitations in accordance with federal aviation administration regulations.

History: Effective August 1, 2003; amended effective March 24, 2004; January 1, 2006; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-06. Number of personnel required.

~~For a licensed basic life support air ambulance service, the minimum number of personnel required is one primary care provider as defined in chapter 33-11-05. For a licensed advanced life support air ambulance service, the minimum number of personnel required is one primary care provider as defined in chapter 33-11-06, except when either the transferring or receiving physician believes the patient's status requires a minimum of two providers.~~ For a licensed critical care air ambulance service, the minimum number of personnel required is two providers as defined in chapter 33-11-07 and one pilot.

History: Effective August 1, 2003; amended effective March 24, 2004; January 1, 2006; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-07. Out-of-state operators.

1. Operators ~~from~~licensed in another state may pick up patients within ~~this state~~North Dakota for transportation to locations within this state ~~when there is a natural disaster such as a tornado, flood, or other disaster which may require available air ambulances to transport the injured~~under the following circumstances:

   a. When there is a disaster or incident which may require elevated response to transport the injured.

   b. When an out-of-state air ambulance is traveling through the state for whatever purpose comes upon an accident or medical emergency where immediate emergency air ambulance services are necessary.

2. Out-of-state air ambulance services that expect to pick up patients from within this state and transport to locations within this state shall meet the North Dakota standards and become licensed under North Dakota Century Code chapter 23-27 and this chapter.

History: Effective August 1, 2003; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-09. Securing of equipment.

All equipment and materials used in an air ambulance must be secured in accordance with ~~federal aviation administration regulation~~ title 14, Code of Federal Regulations, part 135.

History: Effective August 1, 2003; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-14. Medical direction.

1. Each air ambulance service shall have a signed agreement on file with the department with a North Dakota licensed physician who shall serve as official medical director and whose duties include establishing written medical protocols, recommending optional equipment, oversight of a quality assurance program, and maintaining current training requirements for personnel.

2. Each air ambulance service must have written treatment protocols for adult and pediatric medical conditions approved by the medical director and available for reference when providing patient care.

3. Air ambulance services must have a written process for accessing adult and pediatric online medical control that includes contacting a medical practitioner at a hospital that has continual in-house emergency room coverage or having the ability to directly contact the on-call emergency room medical practitioner while the practitioner is not at the hospital.

History: Effective August 1, 2003; amended effective January 1, 2006; January 1, 2008; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-15. Other requirements.

1. The aircraft ~~shall~~must have sufficient space to accommodate at least one pilot, one patient on a stretcher, two medical personnel, and the medical equipment required.

2. The aircraft must be configured to allow medical personnel to have a good patient view and access to equipment and supplies in order to initiate both basic and advanced life support.

3. All licensed air ambulance services shall keep the aircraft and other equipment clean and in proper working order.

4. All linens, and all equipment and supplies coming in direct contact with the patient, must be either a single-use disposable type or cleaned, laundered, or disinfected after each use.

5. When an aircraft has been utilized to transport a patient known to have a communicable disease ~~other than a common cold~~, the aircraft and all exposed equipment shall be disinfected before the transport of another patient.

6. Each air ambulance run must be reported to the department ~~in the manner and in the form determined by the department~~electronically via an electronic patient care record that is compatible with the North Dakota emergency medical service data repository within seventy-two hours.

History: Effective August 1, 2003; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-05
BASIC LIFE SUPPORT AIR AMBULANCE LICENSE

[Repealed effective January 1, 2024]

~~Section~~
~~33-11-05-01 Training Standards for Primary Care Provider~~
~~33-11-05-02 Minimum Equipment Requirements~~

CHAPTER 33-11-06
ADVANCED LIFE SUPPORT AIR AMBULANCE LICENSE

[Repealed effective January 1, 2024]

~~Section~~
~~33-11-06-01 Training Standards for Primary Care Provider~~
~~33-11-06-02 Minimum Equipment Requirements~~
~~33-11-06-03 Advertising Restrictions~~

CHAPTER 33-11-07

33-11-07-01. Training standards for care providers.

~~1.~~ Both care providers shall be critical care providers as listed in subsection 3 of section 33-11-01.2-12.

~~2. Notwithstanding subsection 1, elective transports for patients that are in stable condition who do not require specialized interventions or equipment as described in section 33-11-01.2-12 may be staffed at a lesser level that meets the patient's care requirements and is at least at the level of basic life support air ambulance defined in section 33-11-05-01.~~

History: Effective January 1, 2006; amended effective April 1, 2009; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-07-02. Minimum equipment requirements.

~~All equipment required for a basic life support air ambulance as found in section 33-11-05-02 and all equipment required for an advanced life support air ambulance found in section 33-11-06-02 plus the following equipment must be available at the base station~~In addition to an aircraft as described in subsection 3 of section 33-11-04-01, the air ambulance shall have the following, unless otherwise approved by the department:

1. ~~Ventilator.~~

~~2. Intravenous infusion pumps.~~

~~3. Any specialized equipment ordered by a physician~~Patient litter or stretcher for patient transport.

2. Spinal immobilization:

   a. One pediatric-safe transport device.

   b. One adult cervical collar.

   c. One pediatric cervical collar.

3. Oxygen delivery:

   a. An onboard oxygen system, with the following:

      (1) Cylinders with a capacity of one thousand two hundred liters.

      (2) The cylinders must have at least one thousand six hundred fifty pounds per square inch [11376.35 kilopascals] at the time of inspection.

      (3) A flow meter with a range of zero to twenty-five liters per minute delivery.

   b. Two D size oxygen cylinders or one D size oxygen cylinder and an onboard system capable of providing, at a minimum, an additional four hundred fifteen liters of oxygen.

   c. Nonsparking wrench or tank opening device.

   d. Gauge or flow meter not gravity dependent and can deliver between zero and twenty-five liters per minute.

e. Three adult nasal cannulas.

f. Three pediatric nasal cannulas.

g. Three adult nonrebreather oxygen masks.

h. Three pediatric nonrebreather oxygen masks.

i. Three sets of oxygen supply tubing.

j. Noninvasive positive pressure ventilation device.

k. Nebulizer with tubing.

l. End-tidal carbon dioxide detectors with pediatric and adult capability.

m. Multifunction mechanical ventilator.

4. Suction:

a. Portable suction unit with wide-bore tubing that is capable of achieving a minimum of three hundred millimeters of mercury vacuum within four seconds or less after clamping the suction tube or an aircraft suction system meeting the same or similar performance standards and a portable manual suction device.

b. One rigid tonsil tip suction catheter.

c. One flexible suction catheter between size six and ten french.

d. One flexible suction catheter between twelve and sixteen french.

5. Airway adjuncts:

a. One set of adult sizes nasopharyngeal airways.

b. One set of pediatric sizes nasopharyngeal airways.

c. One set of adult sizes oropharyngeal airways.

d. One set of child sizes oropharyngeal airways.

e. One set of infant sizes oropharyngeal airways.

f. Alternative airway devices such as a supraglottic airway as approved by local medical direction.

g. Adult endotracheal airway equipment.

h. Pediatric endotracheal airway equipment.

i. One size zero straight laryngoscope blade.

j. One size one straight laryngoscope blade.

k. One size two straight laryngoscope blade.

l. One size three or four straight laryngoscope blade.

m. One size two curved laryngoscope blade.

n. One size three or four curved laryngoscope blade.

o. One adult stylette.

p. One pediatric stylette.

q. One pair of adult Magill forceps.

r. One pair of pediatric Magill forceps.

s. One adult laryngoscope handle with extra batteries.

t. One pediatric laryngoscope handle with extra batteries.

6. Bag valve masks:

a. One adult bag valve mask resuscitation unit with face mask.

b. One child bag valve mask resuscitation unit with face mask.

c. One infant bag valve mask resuscitation unit with face mask.

7. One pelvic stabilization device for splinting.

8. Environmental:

a. Four cold packs.

b. Four hot packs.

9. Bandaging and bleeding control:

a. Two sterile burn sheets or equivalent.

b. Three triangular bandages or commercial slings.

c. Two trauma dressings approximately ten by thirty-six inches [25.4 by 91.44 centimeters].

d. Twenty-five sterile gauze pads approximately four by four inches [10.16 by 10.16 centimeters].

e. Twelve soft roller self-adhering type bandages approximately five yards [4.57 meters] long.

f. Two sterile occlusive dressings approximately three by nine inches [76.2 by 228.6 millimeters].

g. Two commercial tactical tourniquets.

10. Diagnostic:

a. Manual cardiac monitor defibrillator with transcutaneous pacing, waveform capnography, and pediatric capabilities.

b. Monitor electrocardiogram paper rolls.

c. Monitor electrodes.

d. Adult defibrillator pads.

e. Pediatric defibrillator pads.

f. Adult blood pressure cuff.

g. Large adult blood pressure cuff.

h. Child blood pressure cuff.

i. Stethoscope.

j. Pulse oximeter.

k. Glucose measuring device.

l. Penlight.

m. Thermometer.

11. Medication delivery:

a. Four of each size and individually wrapped and sterile hypodermic needles size sixteen to eighteen gauge, twenty to twenty-two gauge, twenty-three to twenty-five gauge, and two hypodermic needles of assorted sizes, including at least one with a one milliliter volume.

b. Intravenous therapy equipment, including venous restriction device, micro and macro drip administration sets, catheters size sixteen gauge to twenty-four gauge, intraosseous needles, tubing, solutions, and intravenous arm boards for both pediatric and adult patients, as approved by local medical direction.

c. Two three and one-quarter inch [8.26 centimeters] over the needle catheter in ten, twelve, or fourteen gauge.

d. Three intravenous infusion pumps or one multichannel unit capable of managing three simultaneous infusions.

e. Two intravenous bag holders with straps.

12. Medications:

a. Alkanilizing agent.

b. Anxiolytic.

c. Anticholinergen parasympatholytic.

d. Anticonvulsants.

e. Antidysrhythmic/antiarrhythmic.

f. Antiemetic.

g. Antihistamine.

h. One small bottle of chewable aspirin.

i. Adrenergic intravenous or subcutaneous bronchodilator or sympathomimetic.

j. Adult and pediatric doses of epinephrine administered through an autoinjector or intramuscular, if approved by medical director. If epinephrine is administered

intramuscular the air ambulance shall have syringes and needles for intramuscular delivery.

k. Bronchodilator for nebulized delivery.

l. Dextrose containing solution.

m. Coronary vasodilator, antianginal.

n. Corticosteroid or glucocorticoid.

o. Opioid antagonist.

p. Analgesic.

q. Other medications may be carried as approved by the medical director.

13. Personal protective equipment:

a. Personal infection control kit, which includes the following:

(1) Eye protection, clear, and disposable for each crew member.

(2) Gown or coat for each crew member.

(3) Disposable surgical cap and foot coverings, for each crew member.

(4) Exam gloves for each crew member.

(5) Sharps containers and red bags per infectious control plan.

(6) N95 respirator for each crew member.

(7) Hand disinfectant for each crew member.

(8) Ten alcohol sponges.

14. Two liters of sterile water or normal saline.

15. Safety:

a. For rotor-wing aircraft, flight helmet with built-in communication for each crew member.

b. One survival bag.

c. One fully charged fire extinguisher rated at least 5 B:C securely mounted where it can be reached by the pilot or crew members. The fire extinguisher must be intact with safety seal, have been inspected within the previous twelve calendar months, and have the appropriate inspection tag attached.

16. Communications:

a. Two-way radio communications for the pilot to be able to communicate with hospitals, public safety answering points, and ground ambulances in areas to which the air ambulance routinely provides service.

b. For fixed-wing aircraft, at least one headset per crew member with built-in communication among the crew when the aircraft is operating and noise levels prevent normal conversation.

17. Other:

a. Four assorted rolls of adhesive tape, with at least one hypoallergenic roll.

b. One bandage shears.

c. Pediatric length-based drug dosing and equipment sizing tape, most current version available.

d. One sterile obstetrical kit.

e. One separate sterile bulb syringe.

f. One silver swaddler sterile thermal blanket or one roll of sterile aluminum foil for use on infants and newborns.

g. Appropriate patient coverings capable of maintaining body temperature based on anticipated weather conditions.

h. Two sterile water-soluble lubrication, two cubic centimeter or larger tubes.

i. Copy of most current version of agency protocols, as approved by medical director.

History: Effective January 1, 2006; amended effective January 1, 2024.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-33-04.1
FOOD CODE

Section
33-33-04.1-01 Adoption of the United States Food and Drug Administration ~~2013~~2017 Model Food Code by Reference

33-33-04.1-01. Adoption of the United States food and drug administration ~~2013~~2017 Model Food Code by reference.

The provisions of the United States food and drug administration ~~2013~~2017 Model Food Code and its supplement are adopted by reference into this chapter, with the following modifications:

1. Paragraph 1-201.10 Statement of Application for Listing of Terms. For purposes of this chapter, subparagraph (3)(f) of the food establishment definition is revised as follows:

(f) A kitchen in a private home, such as a self-declared child care provider or an early childhood program licensed for thirty or fewer children pursuant to North Dakota Century Code chapter 50-11.1; or a bed-and-breakfast operation that prepares and offers food to guests if the home is owner occupied, the number of available guests bedrooms does not exceed six, breakfast is the only meal offered, the number of guests served does not exceed eighteen, and the consumer is informed by statements contained in published advertisements, mailed brochures, and placards posted at the registration area that the food is prepared in a kitchen that is not regulated and inspected by the regulatory authority; or

2. Paragraph 2-102.12 Certified Food Protection Manager. For the purposes of this chapter, is excluded.

3. Paragraph 2-102.20 (B) Food Protection Manager Certification. For the purposes of this chapter, is excluded.

~~2.~~4. Paragraph 8-401.10 Establishing Inspection Interval. For the purposes of this chapter, is revised as follows:

a. Except as specified in subdivisions b and c of this subsection, the regulatory authority, at any time during operation, may inspect a food establishment. The department shall determine the frequency of inspection based on the level of risk categorization, complaints, and previous compliance history.

b. The regulatory authority may increase the interval between inspections if:

(1) The food establishment is fully operating under an approved and validated hazard analysis critical control point plan as specified under section 8-201.14 and paragraphs 8-103.12 (A) and (B);

(2) The food establishment is assigned a less frequent inspection frequency based on a written risk-based inspection schedule that is being uniformly applied throughout the jurisdiction. The food establishment may be contacted by telephone or other means by the regulatory authority to ensure the establishment manager and the nature of food operation are not changed; or

(3) The establishment's operation involves only coffee service and other unpackaged or prepackaged food that is not time/temperature control for safety food, such as carbonated beverages and snack food, such as chips, nuts, popcorn, and pretzels.

c. The regulatory authority periodically shall inspect throughout its permit period a temporary food establishment that prepares, sells, or serves unpackaged time/temperature control for safety food and that:

(1) Has improvised rather than permanent facilities or equipment for accomplishing functions, such as handwashing, food preparation and protection, food temperature control, warewashing, providing drinking water, waste retention and disposal, and insect and rodent control; or

(2) Has inexperienced food employees.

~~3.~~5. Paragraph 8-405.11 Timely Correction. For the purpose of this chapter, is revised as follows:

a. Except as specified in subdivision b of this subsection, a permitholder at the time of inspection shall correct a violation of a priority item or priority foundation item of this code and implement corrective actions for a hazard analysis critical control point plan provision that is not in compliance with its critical limit.[Pf]

b. Considering the nature of the potential hazard involved and the complexity of the corrective action needed, the regulatory authority may agree to or specify a longer time frame and approve a compliance schedule.

~~4.~~6. Paragraph 8-406.11 Time Frame for Correction. For the purpose of this chapter, is revised as follows:

a. Except as specified in subdivision b of this subsection, the permitholder shall correct core items by a date and time agreed to or specified by the regulatory authority.

b. The regulatory authority may approve a compliance schedule that extends beyond the time limits specified under subdivision a of this subsection if a written schedule of compliance is submitted by the permitholder and no health hazard exists or will result from allowing an extended schedule for compliance.

History: Effective January 1, 2018; amended effective January 1, 2024.
General Authority: NDCC 23-09
Law Implemented: NDCC 23-09

CHAPTER 33-36-01
EMERGENCY MEDICAL SERVICES PERSONNEL TRAINING, TESTING, CERTIFICATION, AND LICENSURE

33-36-01-01. Definitions.

Words defined in North Dakota Century Code chapter 23-27 have the same meaning in this chapter.

1. "~~Accrediting agency~~Advanced emergency medical technician" means ~~the commission on accreditation on allied health education programs or its equivalent~~an individual certified by the national registry as an advanced emergency medical technician. An advanced emergency medical technician is eligible for licensure as an advanced emergency medical technician upon completion of a license application and approval by the department.

2. "Cardiopulmonary resuscitation", initial and refresher, means the American heart association health care provider standards or its equivalent which includes the following skills: adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant one-person and two-person cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.

3. ~~"Certification scope enhancement programs" means those certification programs which add additional skills to or refresh existing skills obtained from the primary certification programs.~~

~~4.~~ ~~"Continuing education coordinator" means an individual who is licensed to conduct limited courses including continuing education courses, refresher courses, and scope enhancement courses~~"Clinical and field internship preceptor" means a qualified individual designated by an emergency medical services instructor or emergency medical services training institute to supervise a student during clinical or field internship training.

~~5.~~4. "Department" means the ~~state~~ department of health and human services.

5. "Emergency medical services instructor" means an individual who is licensed to conduct emergency medical services courses, including continuing education courses.

6. "Emergency medical ~~services instructor~~technician" means an individual ~~who is licensed to conduct the full scope of courses including continuing education courses, refresher courses,~~

~~and scope enhancement courses, as well as initial primary education courses that include emergency medical responder,~~certified by the national registry as an emergency medical technician~~, emergency medical technician-intermediate/85, advanced~~. An emergency medical technician~~, emergency medical technician-intermediate/99, and paramedic~~ is eligible for licensure as an emergency medical technician upon completion of a license application and approval by the department.

7. "Equivalent" means training of equal or greater value which accomplishes the same results ~~as determined by the department~~.

8. ~~"Field internship preceptor" means a qualified person designated by an emergency medical services instructor to supervise a student during field internship training.~~

~~9.~~ "National registry" means the national registry of emergency medical technicians located in Columbus, Ohio.

~~10.~~9. "On call" means that an individual is expected to be available for emergency response when called by telephone, mobile communications application, radio, or pager and report after notification.

~~11. "Prehospital emergency medical services personnel" are those persons certified or licensed under the programs defined in this chapter.~~

~~12. "Primary certification programs" means those certification programs which integrate a broad base of skills necessary to perform within a level of the emergency medical services system as determined by the department.~~

History: Effective April 1, 1992; amended effective August 1, 2003; January 1, 2006; January 1, 2008; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-02. Emergency medical services training courses.

The department ~~shall establish training, testing, and certification requirements for~~acknowledges the following emergency medical services courses and personnel:

1. ~~Primary certification courses~~Courses leading to national registry certification:

   a. Emergency medical responder;

   b. Emergency medical technician;

   c. ~~Emergency medical technician-intermediate/85;~~

   ~~d. Emergency medical technician-intermediate/99;~~

   ~~e.~~ Advanced emergency medical technician; and

   ~~f. Advanced first-aid ambulance attendant;~~

   ~~g. Emergency vehicle operations;~~

   ~~h. Emergency medical dispatch; and~~

   ~~i. Automobile extrication~~

   d. Paramedic.

2. ~~Certification scope enhancement courses:~~

~~a. Intravenous maintenance;~~

~~b. Automobile extrication instructor;~~

~~c. Emergency medical services instructor;~~

~~d. Epinephrine administration;~~

~~e. Dextrose administration;~~

~~f. Bronchodilator/nebulizer administration;~~

~~g. Limited advanced airway insertion;~~

~~h. Emergency vehicle operations instructor; and~~

~~i. Continuing education coordinator.~~

~~3. Certification refresher courses~~Courses requiring current department licensure that provide supplementary qualifications by the department:

a. ~~Emergency medical responder-refresher;~~

~~b. Emergency medical technician-basic refresher;~~

~~c. Emergency medical technician-intermediate/85 refresher;~~

~~d. Emergency medical technician-intermediate/99 refresher;~~

~~e. Advanced emergency medical technician refresher; and~~

~~f. Paramedic refresher~~Emergency medical services instructor;

b. Community emergency medical technician;

c. Community advanced emergency medical technician; and

d. Community paramedic.

History: Effective April 1, 1992; amended effective October 1, 1992; August 1, 1994; August 1, 2003; August 1, 2004; January 1, 2006; January 1, 2008; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-03. Training, testing, certification, and licensure standards for ~~primary certification courses~~emergency medical services personnel.

The department shall authorize ~~the conduct of~~all courses~~, the testing of students, and the certification or licensure of personnel when application has been made on forms requested from and provided~~ leading to approval, certification, or licensure by the department prior to ~~conducting~~ the course ~~and in the manner specified by the department~~being conducted in North Dakota contingent upon the course being offered by a licensed emergency medical services training institute and on the following requirements:

1. Emergency medical responder:

a. ~~Curriculum~~Course. ~~The~~A course ~~curriculum~~conducted in North Dakota must ~~be that issued~~adhere to the national emergency medical services education standards for emergency medical responders as published by the United States department of transportation, national highway traffic safety administration~~, in the edition specified by the department~~. Prior to student eligibility for certification by the national registry, competency in the required knowledge and skills must be verified by a North Dakota emergency medical services instructor or North Dakota licensed emergency medical services training institute.

b. ~~Textbooks. The department shall approve textbooks.~~

~~c.~~ Course ~~coordinator~~instructors. ~~The course coordinator~~Course instructors must be ~~licensed~~approved by the ~~department as an~~licensed emergency medical services ~~instructor~~training institute and ~~must~~ be ~~currently certified as an emergency medical responder or its equivalent~~knowledgeable in course content, effective in teaching their assigned subjects, and capable through academic preparation, training, and experience to teach courses or topics to which they are assigned.

~~d.~~c. An emergency medical responder student may practice all ~~of~~ the skills defined in the ~~core~~ scope of practice for emergency medical responder while in the classroom and during a clinical or field internship while under direct supervision of an instructor or clinical and field internship preceptor and if registered with the department as an emergency medical responder student.

~~e. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department or the national registry cognitive knowledge examination and pass all stations of a practical examination conducted by the course coordinator. The practical examination must consist of no less than one medical, one cardiopulmonary resuscitation, and one trauma station.~~

~~f.~~d. Initial certification. ~~The department shall issue initial certification to persons who meet the physical requirements described in the functional job analysis for emergency medical responder as published by the national highway traffic safety administration and are over the age of sixteen~~Individuals sixteen years of age and older who ~~have completed an authorized course and passed the testing process, or~~ are certified as an emergency medical responder by the national registry are eligible for certification by the department. ~~Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year, or ninety days past their national registry expiration date if they are nationally registered. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year, or ninety days past their national registry expiration date if they are nationally registered~~Upon completion and department approval of an application, eligible applicants may be certified by the department for a two-year period until June thirtieth of the second year.

~~g.~~e. Recertification. ~~The department shall recertify for a two-year period expiring on June thirtieth, or ninety days past their national registry expiration date if they are nationally registered, to those persons that meet the physical requirements described in the functional job analysis for emergency medical responder as published by the national highway traffic safety administration and who have met one of the following requirements:~~

~~(1) Completion of an approved North Dakota emergency medical responder refresher course.~~

~~(2) Completion of a twenty-four-hour emergency medical technician refresher course~~An individual that maintains certification from the national registry is eligible for recertification. Upon completion and approval of an application, eligible applicants may be recertified by the department for a two-year period until June thirtieth of the second year.

f. Individuals certified as emergency medical responders as of January 1, 2024, and those attending emergency medical responder courses approved before January 1, 2024, and certified by June 30, 2024, will not be required to obtain national registry certification.

(1) Prior to student eligibility for initial certification by the department under the conditions identified in this subdivision, competency in the required knowledge and skills must be verified by a North Dakota emergency medical services instructor or North Dakota licensed emergency medical services training institute.

(2) Prior to eligibility for recertification by the department under the conditions identified in this subdivision, individuals must complete recertification requirements equivalent to those required by the national registry.

2. Emergency medical technician:

a. ~~Curriculum~~Course. ~~The~~A course ~~curriculum~~conducted in North Dakota must ~~be that issued~~adhere to the national emergency medical services education standards for emergency medical technicians as published by the United States department of transportation, national highway traffic safety administration~~, in the edition specified by the department~~. Prior to student eligibility for certification by the national registry, competency in the required knowledge and skills must be verified by a North Dakota emergency medical services instructor or North Dakota licensed emergency medical services training institute.

b. ~~Textbooks. The department shall approve textbooks.~~

~~c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician or its equivalent.~~

d. Course instructors. ~~The primary course instructor~~Course instructors must be ~~licensed~~approved by the ~~department as an~~licensed emergency medical services ~~instructor~~training institute and ~~must~~ be ~~currently licensed as an emergency medical technician or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as an emergency medical technician or its equivalent~~knowledgeable in course content, effective in teaching their assigned subjects, and capable through academic preparation, training, and experience to teach courses or topics to which they are assigned.

~~e.~~c. An emergency medical technician student may practice all ~~of~~ the skills defined in the ~~core~~ scope of practice for emergency medical technician while in the classroom and during a clinical or field internship while under direct supervision of an instructor or the clinical and field internship preceptor and if registered with the department as an emergency medical technician student.

~~f. Testing. Students must pass the national registry cognitive knowledge examination and a practical examination specified by the department which meets the national registry's standards or its equivalent in order to be eligible for licensure. The content of the practical examination must be determined by the department, and the department shall establish policies regarding retesting of failed written and practical examinations.~~

g.d. Emergency medical technician initial licensure. The department shall issue initial licensure as an emergency medical technician to persons that meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and are over the age of sixteenIndividuals sixteen years of age and older who have completed an authorized course and passed the testing process or those who have requested reciprocity from another state with equivalent training. Persons passing the testing process between January first and June thirtieth shall be licensed until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be licensed until June thirtieth of the third yearare certified as emergency medical technicians by the national registry are eligible for licensure. Upon completion and department approval of a license application, eligible applicants may be licensed by the department. The applicant must be affiliated with a North Dakota licensed emergency medical services operation or obtain medical direction from a North Dakota licensed physician. Licensure will expire ninety days after the national registry emergency medical technician expiration date.

h.e. Relicensure of emergency medical technicians. The department shall relicense for a two-year period expiring June thirtieth those persons that meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and who have met the following requirements:

(1) Completion of a twenty-four hour emergency medical technician-basic refresher course which includes a cardiopulmonary resuscitation health care provider refresher, answering correctly at least seventy percent of the questions on a written examination specified by the department and passing a local practical examination meeting the department's requirements; and

(2) Completion of forty-eight hours of continuing education as approved by the department or the national registry; or

(3) If currently licensed as an emergency medical technician, successful completion of the practical examination for emergency medical technician as established by the department. The practical examination must be administered by a licensed emergency medical services training institution in accordance with section 33-36-02-10 or by the departmentAn individual that maintains certification from the national registry as an emergency medical technician is eligible for relicensure. Upon completion and approval of a license application, eligible applicants may be relicensed by the department. The applicant must be affiliated with a North Dakota licensed emergency medical services operation or obtain medical direction from a North Dakota licensed physician. Licensure will expire ninety days after the national registry expiration date.

3. Emergency medical technician-intermediate/85:

a. Student prerequisite certification. Students must be licensed as an emergency medical technician or its equivalent prior to testing.

b. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

c. Textbooks. The department shall approve textbooks.

d. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician-intermediate/85 or its equivalent.

e. Course instructors. The primary course instructor must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician-intermediate/85 or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as an emergency medical technician-intermediate/85 or its equivalent.

f. An emergency medical technician-intermediate/85 student may practice all of the skills defined in the core scope of practice for emergency medical technician-intermediate/85 while in the classroom and during field internship while under direct supervision of an instructor or field internship preceptor and if registered with the department as an emergency medical technician-intermediate/85 student.

g. Testing. Students must pass the cognitive knowledge and practical examinations as provided by the national registry and approved by the department in order to be eligible for licensure.

h. Emergency medical technician-intermediate/85 initial licensure. A person eighteen years of age or older that meets the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and who has completed an authorized course and passed the testing process shall obtain certification from the national registry. Persons obtaining national registry certification and in compliance with chapter 50-03-03 will be licensed by the department expiring ninety days after their national registry expiration date.

i. Relicensure of emergency medical technician-intermediate/85. Emergency medical technician-intermediate/85 must be recertified by the national registry recertification policies and meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration. Persons recertified by the national registry and in compliance with chapter 50-03-03 will be relicensed by the department for a two-year period expiring ninety days after their national registry expiration date.

j. Transition to new licensure level. When the national registry discontinues certifying personnel at the emergency medical technician-intermediate/85 level, personnel currently licensed as an emergency medical technician-intermediate/85 must transition to a new licensure level. To remain licensed as an emergency medical services provider, each person must do one of the following options:

(1) Complete a state-authorized transition course for emergency medical technician-intermediate/85 to advanced emergency medical technician and license as an advanced emergency medical technician as described in subsection 4.

(2) Complete a state-authorized transition course for emergency medical technician-intermediate/85 to advanced emergency medical technician, as well as completing all of the certification requirements of the national registry for advanced emergency medical technician and license as an advanced emergency medical technician as described in subsection 4.

(3) Complete the national registry requirements for emergency medical technician and license as an emergency medical technician as described in subsection 2.

~~4.~~ Advanced emergency medical technician:

a. Student prerequisite ~~certification~~. Students must be ~~licensed~~certified as an emergency medical technician by the national registry or licensed as an emergency medical technician or its equivalent ~~prior to testing~~.

b. ~~Curriculum~~Course. The course ~~curriculum~~ must ~~be that issued~~adhere to the national emergency medical services education standards for advanced emergency medical technicians as published by the United States department of transportation, national highway traffic safety administration~~, in the edition specified by the department~~. Prior to student eligibility for certification by the national registry, competency in the required knowledge and skills must be verified by a North Dakota emergency medical services instructor or North Dakota licensed emergency medical services training institute.

c. ~~Textbooks. The department shall approve textbooks.~~

~~d. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an advanced emergency medical technician or its equivalent.~~

~~e. Course instructors. The primary course instructor must be licensed by the department as an emergency medical services instructor and must be currently licensed as an advanced emergency medical technician or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as an advanced emergency medical technician or its equivalent.~~

~~f.~~ An advanced emergency medical technician student may practice all ~~of~~ the skills defined in the ~~core~~ scope of practice for advanced emergency medical technician while in the classroom and during a clinical or field internship while under direct supervision of an instructor or clinical and field internship preceptor and if registered with the department as an advanced emergency medical technician student.

~~g. Testing. Students must pass the cognitive knowledge and practical examinations as provided by the national registry and approved by the department in order to be eligible for licensure.~~

~~h.~~d. Advanced emergency medical technician initial licensure. ~~Except as otherwise provided under subdivision j of subsection 3, a person~~An individual eighteen years of age or older ~~that meets the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and~~ who ~~has completed an authorized course and passed the testing process shall obtain certification from the national registry. Persons obtaining national registry certification and in compliance with chapter 50-03-03 will be licensed by the department expiring~~is certified as an advanced emergency medical technician by the national registry is eligible for licensure. Upon completion and department approval of a license application, eligible applicants may be licensed by the department. The applicant must be affiliated with a North Dakota licensed emergency medical services operation or obtain medical direction from a North Dakota licensed physician. Licensure will expire ninety days after ~~their~~the national registry advanced emergency medical technician expiration date.

~~i.~~e. Relicensure of advanced emergency medical technician. ~~Except as otherwise provided under subdivision j of subsection 3, an advanced emergency medical technician must be recertified by the national registry recertification policies and meet the physical requirements described in the functional job analysis for emergency medical technician~~

~~as published by the national highway traffic safety administration. Persons recertified by the national registry and in compliance with chapter 50-03-03 will be relicensed by the department for a two-year period expiring~~An individual that maintains certification from the national registry as an advanced emergency medical technician is eligible for relicensure. Upon completion and approval of a license application, eligible applicants may be relicensed by the department. The applicant must be affiliated with a North Dakota licensed emergency medical services operation or obtain medical direction from a North Dakota licensed physician. Licensure will expire ninety days after ~~their~~the national registry advanced emergency medical technician expiration date.

~~j. Transitioning from emergency medical technician-intermediate/85. Notwithstanding subdivisions h and i of subsection 3, an emergency medical technician-intermediate/85 licensee may be licensed or relicensed as an advanced emergency medical technician without obtaining national registry certification if the requirements in subsection 3 have been met as well as maintaining compliance with chapter 50-03-03.~~

~~5. Emergency medical technician-intermediate/99:~~

~~a. Student prerequisite certification or license. A student must be licensed as an emergency medical technician or its equivalent prior to testing.~~

~~b. Curriculum. The course curriculum shall be that issued by the United States department of transportation, national highway traffic safety administration, in the addition specified by the department.~~

~~c. Textbooks. The department shall approve textbooks.~~

~~d. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician-intermediate/99 or its equivalent.~~

~~e. Course instructors. The primary course instructor must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician-intermediate/99 or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as an emergency medical technician-intermediate/99 or its equivalent.~~

~~f. An emergency medical technician-intermediate/99 student may practice all of the skills defined in the core scope of practice for emergency medical technician-intermediate/99 while in the classroom and during field internship while under direct supervision of an instructor or field internship preceptor and if registered with the department as an emergency medical technician-intermediate/99 student.~~

~~g. Testing. Students must pass the cognitive knowledge and practical examinations as provided by the national registry and approved by the department in order to be eligible for licensure.~~

~~h. Emergency medical technician-intermediate/99 initial licensure. A person eighteen years of age or older that meets the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and who has completed an authorized course and passed the testing process shall obtain certification from the national registry. Persons obtaining national registry certification and in compliance with chapter 50-03-03 will be licensed by the department expiring ninety days after their national registry expiration date.~~

~~i. Relicensure of emergency medical technician-intermediate/99. An emergency medical technician-intermediate/99 must be recertified by the national registry recertification policies and meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration. Persons recertified by the national registry and in compliance with chapter 50-03-03 will be relicensed by the department for a two-year period expiring ninety days after their national registry expiration date.~~

~~6.~~4. Paramedic:

a. Student prerequisite ~~certification~~. Students must be certified ~~or licensed~~at minimum as an emergency medical technician or licensed at minimum as an emergency medical technician or its equivalent ~~prior to testing~~.

b. ~~Curriculum~~Course. The course ~~curriculum~~ must ~~be that issued~~adhere to the national emergency medical services education standards for paramedics as published by the United States department of transportation, national highway traffic safety administration~~, in the edition specified by the department~~ and be conducted by a commission on accreditation of allied education programs accredited paramedic education program.

c. ~~Textbooks. The department shall approve textbooks.~~

~~d. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as a paramedic or its equivalent. Course coordinators that are not affiliated with a licensed training institution must have their paramedic course accredited by an accrediting agency by January 1, 2012.~~

~~e. Course instructors. The primary course instructor must be licensed by the department as an emergency medical services instructor and must be currently licensed as a paramedic or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as a paramedic or its equivalent.~~

~~f.~~ A paramedic student may practice all ~~of~~ the skills defined in the ~~core~~ scope of practice for paramedic while in the classroom and during a clinical or field internship while under direct supervision of an instructor or clinical and field internship preceptor and if registered with the department as a paramedic student.

~~g. Field internship. Courses must provide field internship experience based on the curriculum requirements for patient contacts with a paramedic preceptor.~~

~~h. Testing. A student must pass the cognitive knowledge and practical examinations as provided by the national registry and approved by the department in order to be eligible for licensure.~~

~~i.~~d. Paramedic initial licensure. ~~A person~~An individual eighteen years of age or older ~~that meets the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and~~ who ~~has completed an authorized course and passed the testing process shall obtain certification from the national registry. Persons obtaining~~is certified as a paramedic by the national registry ~~certification and in compliance with chapter 50-03-03 will be~~is eligible for licensure. Upon completion and department approval of a licensed application, eligible applicants may be licensed by the department ~~expiring~~. The applicant must be affiliated with a North Dakota licensed emergency medical services operation or obtain medical

direction from a North Dakota licensed physician. Licensure will expire ninety days after ~~their~~the national registry paramedic expiration date.

~~j.~~e. Relicensure of paramedic. ~~A paramedic must be recertified by~~An individual that maintains certification from the national registry ~~recertification policies and meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration. Persons recertified by the national registry and in compliance with chapter 50-03-03 will~~as a paramedic is eligible for relicensure. Upon completion and approval of a license application, eligible applicants may be relicensed by the department ~~for a two-year period expiring~~. The applicant must be affiliated with a North Dakota licensed emergency medical services operation or obtain medical direction from a North Dakota licensed physician. Licensure will expire ninety days after ~~their~~the national registry paramedic expiration date.

~~7. Advanced first aid ambulance attendant:~~

~~a. Advanced first aid ambulance attendant initial certification. The department shall issue initial certification to persons currently certified in American national red cross advanced first aid and who demonstrate a minimum of two years experience with a North Dakota licensed ambulance service as evidenced by North Dakota ambulance service license application personnel rosters.~~

~~b. Recertification of advanced first aid ambulance attendants. The department shall recertify for a three-year period, expiring on June thirtieth, those persons who meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and have completed a twenty-four-hour emergency medical technician-basic refresher course, which includes a cardiopulmonary resuscitation refresher, answering correctly at least seventy percent of the questions on a written examination specified by the department and passing a local practical examination meeting the department's requirements.~~

~~8. Emergency vehicle operations:~~

~~a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.~~

~~b. Course coordinator. The course coordinator must be certified by the department as an emergency vehicle operation instructor.~~

~~c. Testing. The students must correctly answer at least seventy percent of the questions on a written examination and pass a practical examination specified by the department.~~

~~d. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth must be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first must be certified until June thirtieth of the third year.~~

~~9. Emergency medical dispatch:~~

~~a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.~~

~~b. Course coordinator. The course coordinator must be approved by the department as an emergency medical dispatch instructor.~~

~~c. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department.~~

~~d. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth must be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first must be certified until June thirtieth of the third year.~~

~~10. Automobile extrication:~~

~~a. Curriculum. The course curriculum must be approved by the department.~~

~~b. Course coordinator. The course coordinator must be certified by the department as an automobile extrication instructor.~~

~~c. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department.~~

~~d. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth must be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first must be certified until June thirtieth of the third year.~~

5. Emergency medical services instructor:

a. Student prerequisite. A candidate for certification as an emergency medical services instructor must be at least eighteen years of age and licensed for at least two years as an emergency medical technician, advanced emergency medical technician, or paramedic.

b. Course. The course must be approved by the department.

c. Initial certification. The department shall issue initial certification to individuals who have successfully completed an approved course and meet the prerequisites. Individuals possessing a bachelor's degree in education, a teacher's certification in education, a master's degree or doctorate and meeting the student prerequisites are eligible for initial certification upon application to the department. Emergency medical services instructor certification is concurrent with emergency medical services licensure.

d. Recertification. The department may recertify as emergency medical services instructors those individuals who maintain emergency medical services licensure and:

(1) Are employed or affiliated with a licensed emergency medical services training institution and submit documentation of eight hours of adult instructional education approved by the licensed emergency medical services training institute; and

(2) Instruct or coordinate a minimum of one authorized emergency medical responder, emergency medical technician, advanced emergency medical technician, or paramedic education program every two years.

6. Community emergency medical technician:

a. The department shall certify as a community emergency medical technician an individual who meets the following qualifications:

(1) Has a current license as an emergency medical technician issued by the department.

(2) Has two years of service as an emergency medical technician.

(3) Has successfully completed a community emergency medical technician education program from a college or university that has been approved by the department or accredited by a department approved accreditation organization. The education program must include clinical experience that is provided under the supervision of a physician, advanced practice registered nurse, physician assistant, or public health nurse operating under the direct authority of a local unit of government.

b. A community emergency medical technician shall practice in accordance with protocols and standards established by a medical director and provide services as directed by a patient care plan developed by a patient's primary or specialty care physician, advanced practice registered nurse, or physician assistant. In the absence of a primary or specialty care provider, the patient care plan may be directed by the medical director.

c. A community emergency medical technician must be employed by a licensed ground ambulance or licensed hospital.

d. In addition to the relicensure requirements in subdivision e of subsection 2, a community emergency medical technician shall complete an additional twelve hours of continuing education in clinical topics approved by the medical director.

e. No individual shall hold themself out as a community emergency medical technician or provide the services of a community emergency medical technician unless such individual is certified by the department.

7. Community advanced emergency medical technician:

a. The department shall certify as a community advanced emergency medical technician an individual who meets the following qualifications:

(1) Has a current license as an advanced emergency medical technician issued by the department.

(2) Has two years of service as an advanced emergency medical technician.

(3) Has successfully completed a community advanced emergency medical technician education program from a college or university that has been approved by the department or accredited by a department approved accreditation organization. The education program must include clinical experience that is provided under the supervision of a physician, advanced practice registered nurse, physician assistant, or public health nurse operating under the direct authority of a local unit of government.

b. A community advanced emergency medical technician shall practice in accordance with protocols and standards established by a medical director and provide services as directed by a patient care plan developed by a patient's primary or specialty care physician, advanced practice registered nurse, or physician assistant. In the absence of a primary or specialty care provider, the patient care plan may be directed by the medical director.

c. A community advanced emergency medical technician must be employed by a licensed ground ambulance or licensed hospital.

d. In addition to the relicensure requirements in subdivision e of subsection 3, a community advanced emergency medical technician shall complete an additional twelve hours of continuing education in clinical topics approved by the medical director.

e. No individual shall hold themself out as an community advanced emergency medical technician or provide the services of an community advanced emergency medical technician unless such individual is certified by the department.

8. Community paramedic:

a. The department shall certify as a community paramedic an individual who meets the following qualifications:

(1) Has a current license as a paramedic issued by the department.

(2) Has two years of service as a paramedic.

(3) Has successfully completed a community paramedic education program from a college or university that has been approved by the department or accredited by a department approved accreditation organization. The education program must include clinical experience that is provided under the supervision of a physician, advanced practice registered nurse, physician assistant, or public health nurse operating under the direct authority of a local unit of government.

b. A community paramedic shall practice in accordance with protocols and standards established by a medical director and provide services as directed by a patient care plan developed by a patient's primary or specialty care physician, advanced practice registered nurse, or physician assistant. In the absence of a primary or specialty care provider, the patient care plan may be directed by the medical director.

c. A community paramedic must be employed by a licensed ground ambulance or licensed hospital.

d. In addition to the relicensure requirements in subdivision e of subsection 4, a community paramedic shall complete an additional eighteen hours of continuing education in clinical topics approved by the medical director.

e. No individual shall hold themself out as a community paramedic or provide the services of a community paramedic unless such individual is certified by the department.

9. Emergency medical dispatch. An individual authorized to provide prearrival emergency medical instructions for a public safety answering point shall satisfactorily complete an emergency medical dispatch course of instruction approved by the department. A certificate indicating satisfactory completion of the emergency medical dispatch course of instruction must be submitted to the department by the public safety answering point prior to the individual providing prearrival emergency medical instructions for a public safety answering point.

History: Effective April 1, 1992; amended effective August 1, 1994; August 1, 2003; January 1, 2006; January 1, 2008; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-03.1. Limited temporary certification or licensure of emergency medical services training course graduates.

Repealed effective January 1, 2024.

~~1. An individual that has graduated from a department-authorized emergency medical services training course as an emergency medical technician, emergency medical technician - intermediate, or paramedic and has submitted a completed application signed by a physician~~

and an official transcript verifying program completion may be issued a limited certification or license one time. A limited temporary certification or licensure allows the graduate to be employed while awaiting results of the graduate's national registry examination. The limited temporary certification or licensure expires ninety days after the date of issue.

2. The graduate must practice under the direct supervision of a person certified or licensed at an equal or greater level. Direct supervision means close physical and visual proximity. The graduate may not be the primary care provider.

History: Effective January 1, 2006; amended effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-03.2. Continuing education.

Continuing education means ongoing professional education that is based on current emergency medical services textbooks, emergency medical services educational principles, or topics that expand the professional knowledge to stay up to date with emergency medical services standards. An entity or individual that offers continuing education must:

1. Have the course approved as continuing education by:

   a. The department;

   b. An emergency medical services training institution licensed in accordance with chapter 33-36-02;

   c. The continuing education coordinating board for emergency medical services located in Dallas, Texas;

   d. A licensed continuing education coordinator in consultation with a licensed physician;

   e. A licensed instructor in consultation with a licensed physician; or

   f. A licensed physician.

2. Maintain the continuing education course records for at least two years.

3. Issue certificates to attendees that list the title of the course, date, number of hours awarded rounded to the nearest half hour, location, name of instructor, and the name of the person or entity that approved the courseshall follow the continuing education policy as published in the department's emergency medical services instructor handbook.

History: Effective July 1, 2010; amended effective January 1, 2024.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-04. Training, testing, and certification standards for certification scope enhancement courses.

Repealed effective January 1, 2024.

The department shall authorize the conduct of courses, the testing of students, and the certification or licensure of personnel when application has been made on forms provided prior to conducting the course and in the manner specified by the department contingent on the following requirements:

1. Intravenous therapy maintenance:

a. Student prerequisite certification. A student must be licensed as an emergency medical technician or its equivalent.

b. Curriculum. The course curriculum must be that issued by the department entitled "EMT IV Maintenance Module".

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator, and currently certified in intravenous therapy maintenance, or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all portions of a practical examination specified by the department. The practical examination must consist of performing intravenous maintenance skills on a mannequin.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

2. Automobile extrication instructor:

a. Curriculum. The course curriculum must be approved by the department.

b. Student prerequisite. The candidate for this course must be currently certified in automobile extrication with at least two years of certified automobile extrication experience.

c. Course coordinator. The department shall designate the course coordinator.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department.

e. Initial certification. The department shall issue initial certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

f. Recertification. The department shall recertify for a two-year period those persons who have satisfactorily conducted an automobile extrication course or have audited eight hours of an automobile extrication instructor course before the expiration date of their certification.

3. Emergency medical services instructor:

a. Student prerequisite. An individual must be at least eighteen years of age and certified or licensed for at least two years as a patient care provider at the level the individual will instruct at, in order to be licensed.

b. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department or its equivalent.

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor.

d. Initial licensure. The department shall issue initial licensure to persons who have completed an authorized course. Persons completing the course between January first and June thirtieth shall be licensed until June thirtieth of the second year. Persons completing the course between July first and December thirty-first shall be licensed until June thirtieth of the third year.

e. Relicensure. The department shall relicense for a two-year period those persons who have participated in at least one initial training course as a course coordinator or primary instructor, and:

(1) Completed the department's eight-hour relicensure course;

(2) Those persons that are employed or affiliated with a licensed training institution, may submit documentation of eight hours of adult education training to satisfy the relicensure requirements;

(3) Within the current two-year licensure period the instructor has had at least a seventy percent pass rate in both cognitive and practical examinations for the following primary certification courses; emergency medical technician, emergency medical technician-intermediate/85, emergency medical technician-intermediate/99, or paramedic; and

(4) In addition, failure to achieve a seventy percent pass rate for these courses would require the instructor to retake the entire initial licensure process for emergency medical services instructor or require the instructor to be affiliated with a licensed training institution for a period of two years.

4. Continuing education coordinator:

a. Student prerequisite. An individual must be at least eighteen years of age and certified or licensed for at least two years as a patient care provider at the level at which the individual will instruct.

b. Curriculum. The course curriculum must be that issued by the division of emergency medical services and trauma.

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor.

d. Initial licensure. The department shall issue initial licensure to persons who have completed an authorized course. Persons completing the course between January first and June thirtieth shall be licensed until June thirtieth of the second year. Persons completing the course between July first and December thirty-first shall be licensed until June thirtieth of the third year.

e. Relicensure. The department shall relicense for a two-year period those persons:

(1) Who have completed the department's relicensure course; or

(2) Who are employed or affiliated with a licensed training institution, upon submission of documentation of continued affiliation with a licensed training institution.

5. Epinephrine administration:

a. Student prerequisite certification. A student must be certified as an emergency medical responder or its equivalent.

b. Curriculum. The course curriculum must be that issued by the department entitled "Epinephrine Administration Module".

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator and must be currently certified in epinephrine administration or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all portions of a practical examination specified by the department. The practical examination must consist of performing subcutaneous injection of epinephrine with the use of a preloaded, self-injecting device such as the epipen trainer.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

6. Dextrose administration:

a. Student prerequisite licensure. A student must be licensed as an emergency medical technician-intermediate or its equivalent.

b. Curriculum. The course curriculum must be that issued by the department entitled "EMT-I -- 50% Dextrose Administration Module".

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator and must be licensed as a paramedic or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all portions of a practical examination specified by the department. The practical examination must consist of administration of the drug by aseptic injection into intravenous administration tubing.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

7. Bronchodilator/nebulizer administration:

a. Student prerequisite licensure. A student must be licensed as an emergency medical technician or its equivalent.

b. Curriculum. The course curriculum must be the general pharmacology and the respiratory emergencies sections of the curriculum issued by the United States department of transportation, national highway traffic safety administration, for emergency medical technicians-basic, in the edition specified by the department, or its equivalent.

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator and be licensed as a paramedic or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination and pass a practical examination specified by the department.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

8. Limited advanced airway insertion:

a. Student prerequisite licensure. A student must be licensed as an emergency medical technician or its equivalent.

b. Curriculum. The course curriculum must be that issued by the department entitled "Limited Advanced Airway Module".

c. Course coordinator. The course coordinator must be licensed as an emergency medical services instructor or continuing education coordinator and must be currently licensed as a paramedic or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination and pass a practical examination specified by the department.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

9. Emergency vehicle operations instructor:

a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

b. Course instructor. The department shall designate the course instructor.

c. Testing. The students must correctly answer at least seventy percent of the questions on a written examination and pass a practical examination specified by the department.

d. Initial certification. The department shall issue initial certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

e. Recertification. The department shall recertify for a two-year period those persons who have satisfactorily conducted an emergency vehicle operations course or have audited eight hours of an emergency vehicle operator's course.

History: Effective April 1, 1992; amended effective October 1, 1992; August 1, 1994; August 1, 2003; August 1, 2004; January 1, 2006; January 1, 2008; July 1, 2010.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-04.1. Training, testing, and certification standards for certification refresher courses.

Repealed effective January 1, 2024.

~~The department shall authorize the conduct of courses, the testing of students, and the certification of personnel when application has been made on forms requested from and provided by the department prior to conducting the course and in the manner specified by the department contingent on the following requirements:~~

~~1. Emergency medical responder refresher:~~

~~a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.~~

~~b. Textbooks. The department shall approve textbooks.~~

~~c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator and must be currently certified as an emergency medical responder or its equivalent.~~

~~d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all stations of a practical examination conducted by the course coordinator. The practical examination must consist of no less than one medical, one cardiopulmonary resuscitation, and one trauma station.~~

~~2. Emergency medical technician refresher:~~

~~a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.~~

~~b. Textbooks. The department shall approve textbooks.~~

~~c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator and must be currently licensed as an emergency medical technician or its equivalent.~~

~~d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all stations of a practical examination conducted by the course coordinator.~~

~~3. Emergency medical technician-intermediate/85 refresher:~~

~~a. Curriculum. The course coordinator shall select topics consistent with the reregistration requirements of the national registry.~~

~~b. Textbooks. The department shall approve textbooks.~~

~~c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator and must be currently licensed as an emergency medical technician-intermediate/85 or its equivalent.~~

~~4. Emergency medical technician-intermediate/99 refresher:~~

~~a. Curriculum. The course coordinator shall select topics consistent with the reregistration requirements of the national registry.~~

~~b. Textbooks. The department shall approve textbooks.~~

~~c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator and must be currently licensed as an emergency medical technician-intermediate/99 or its equivalent.~~

~~5. Paramedic refresher:~~

~~a. Curriculum. The course curriculum must be consistent with the reregistration requirements of the national registry.~~

~~b. Textbooks. The department shall approve textbooks.~~

~~c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor or continuing education coordinator and must be currently licensed as a paramedic or its equivalent.~~

~~**History:** Effective August 1, 2003; amended effective January 1, 2006; January 1, 2008; July 1, 2010.~~
~~**General Authority:** NDCC 23-27-04.3~~
~~**Law Implemented:** NDCC 23-27-04.3~~

33-36-01-05. Denial, suspension, or revocation of certification or licensure.

The department may deny, suspend, or revoke the certification or licensure ~~for a period of time determined by the department~~ of ~~a person~~an individual who:

1. Has misrepresented to others that the ~~person~~individual is a physician, nurse, or health care provider other than the highest level for which they are certified or licensed.

2. Is incapable of properly performing the skills for which the individual has been certified or licensed.

3. Performs a skill which exceeds those allowed by the individual's level of certification or licensure.

4. Is under indictment for or has been convicted of a misdemeanor or felony which has a direct bearing upon the ~~person's~~individual's ability to serve the public in a capacity certified or licensed by this chapter, or has been convicted of a crime that requires the ~~person~~individual to register as a sex offender in any state. ~~Persons~~Individuals certified or licensed who are under indictment for or have been convicted of a misdemeanor or felony or required to register as a sex offender in any state must report the information to the department within two business days.

5. Has been found by a court of law to be mentally incompetent.

6. Failure to follow examination policies as a student, instructor, or course coordinator.

7. Diversion of drugs for personal or unauthorized use.

8. Performance of care in a manner inconsistent with acceptable standards or protocols.

9. Has attempted to obtain by fraud or deceit a certification or license or has submitted to the department any information that is fraudulent, deceitful, or false.

10. Has had the ~~person's~~individual's national registry or other health care certification or license encumbered for any reason. ~~Persons~~Individuals certified or licensed as described in this chapter must report any encumbrance of their national registry or other health care certification or licensure to the department within two business days.

11. Has misrepresented to others that the ~~person~~individual is an employee, volunteer, or agent of an ambulance service, quick response unit, or rescue squad to offer emergency medical services.

12. Unprofessional conduct, which may give a negative impression of the emergency medical services system to the public~~, as determined by the department~~.

13. As an instructor has failed to have emergency medical services training authorized as required ~~in section 33-36-01-03, 33-36-01-04, or 33-36-01-04.1~~or has not met required education standards.

14. Providing emergency medical or community emergency medical technician, community advanced emergency medical technician, or community paramedic services without authorization from a physician.

15. Has been found to be under the influence of alcohol or mind-altering drugs while on call, on duty, or during an emergency medical or community emergency medical technician, community advanced emergency medical technician, or community paramedic response or interfacility transfer.

16. Failing to respond to an emergency while on call or on duty. The failure to respond must be caused by the individual's willful disregard and not caused by a good-faith error or circumstances beyond the individual's control as determined by the department.

History: Effective April 1, 1992; amended effective August 1, 2003; January 1, 2006; January 1, 2008; July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-05.1. Criminal history background checks.

The department may perform criminal history background checks on any applicant requesting a certification or license or ~~a person~~an individual requesting to be listed on an ambulance service or quick response unit's roster as a driver. A driver may be denied participation in any emergency medical services operation based on the driver's criminal background history or any occurrence listed in section 33-36-01-05.

History: Effective January 1, 2008; amended effective January 1, 2024.
General Authority: NDCC ~~12-60-24.2~~12-60-24, 23-27-04.3
Law Implemented: NDCC ~~12-60-24.2~~12-60-24, 23-27-04.3

33-36-01-08. Waivers.

Based on each individual case, the department may waive any provisions of this chapter that may result in unreasonable hardship upon the individual or the individual's emergency medical service ~~agency~~operation, provided such a waiver does not adversely affect the health and safety of patients. The department ~~will~~may consider waivers for the following situations and conditions:

1. ~~A person~~An individual had completed all the requirements for recertification or relicensure and a good-faith effort was made by that ~~person~~individual to recertify with the national registry and by no fault of the ~~person~~individual recertification was not granted.

2. ~~A person~~An individual who was current in the ~~person's~~individual's certification or license was called to active duty in the United States armed forces and deployed to an area without the resources to maintain the ~~person's~~individual's certification or license resulting in a lapse of the ~~person's~~individual's certification or license.

3. Other reason as determined by the department.

4. A waiver may be granted for a specific period of time not to exceed one year and shall expire on June thirtieth of each year.

History: Effective January 1, 2006; amended effective July 1, 2010; January 1, 2024.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

TITLE 33.1

DEPARTMENT OF ENVIRONMENTAL QUALITY

JANUARY 2024

CHAPTER 33.1-16-02.1

33.1-16-02.1-02. Purpose.

1. The purposes of this chapter are to establish a system for classifying waters of the state; provide standards of water quality for waters of the state; and protect existing and potential beneficial uses of waters of the state.

2. The state and public policy is to maintain or improve, or both, the quality of the waters of the state and to maintain and protect existing uses. Classifications and standards are established for the protection of public health and environmental resources and for the enjoyment of these waters, to ensure the propagation and well-being of resident fish, wildlife, and all biota associated with, or dependent upon, these waters; and to safeguard social, economical, and industrial development. Waters not being put to use shall be protected for all reasonable uses for which these waters are suitable. All known and reasonable methods to control and prevent pollution of the waters of this state are required, including improvement in quality of these waters, when feasible.

   a. The "quality of the waters" shall be the quality of record existing at the time the first standards were established in 1967, or later records if these indicate an improved quality. Waters with existing quality that is higher than established standards will be maintained at the higher quality unless affirmatively demonstrated, after full satisfaction of the intergovernmental coordination and public participation provisions of the continuing planning process, that a change in quality is necessary to accommodate important social or economic development in the area in which the waters are located. In allowing the lowering of existing quality, the department shall assure that existing uses are fully protected and that the highest statutory and regulatory requirements for all point sources and cost-effective and reasonable best management practices for nonpoint sources are achieved.

   b. Waters of the state having unique or high-quality characteristics that may constitute an outstanding state resource shall be maintained and protected.

   c. Any public or private project or development which constitutes a source of pollution shall provide the best degree of treatment as designated by the department in the North Dakota pollutant discharge elimination system. If review of data and public input indicates any detrimental water quality changes, appropriate actions will be taken by the department following procedures approved by the environmental protection agency. (North Dakota Antidegradation Implementation Procedure, Appendix IV.)

History: Effective January 1, 2019; amended effective January 1, 2024.

General Authority: NDCC 61-28-04~~, 61-28-05~~; S.L. 2017, ch. 199, § 1
Law Implemented: NDCC 23.1-11, 61-28-04; S.L. 2017, ch. 199, § 26

33.1-16-02.1-04. Definitions.

The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 61-28, except:

1. "Acute standard" means the one-hour average concentration does not exceed the listed concentration more than once every three years.

2. "Best management practices" are methods, measures, or procedures selected by the department to control nonpoint source pollution. Best management practices include structural and nonstructural measures and operation and maintenance procedures.

3. "Chronic standard" means the four-day average concentration does not exceed the listed concentration more than once every three years.

4. "Consecutive thirty-day average" is the average of samples taken during any consecutive thirty-day period. It is not a requirement for thirty consecutive daily samples.

5. "Department" means the department of environmental quality.

6. A standard defined as "dissolved" means the total quantity of a given material present in a filtered water sample, regardless of the form or nature of its occurrence.

7. "Eutrophication" means the process of enrichment of rivers, streams, lakes, reservoirs, and wetlands with nutrients needed to maintain primary production.

8. "Nutrients" mean the chemical elements, primarily nitrogen and phosphorus, which are critical to the growth of aquatic plants and animals.

9. "Pollution" means such contamination, or other alteration of the physical, chemical, or biological properties, of any waters of the state, including change in temperature, taste, color, turbidity, or odor. Pollution includes discharge of any liquid, gaseous, solid, radioactive, or other substance into any waters of the state that will or is likely to create a nuisance or render such waters harmful, detrimental, or injurious to public health, safety, or welfare; domestic, commercial, industrial, agricultural, recreational, or other legitimate beneficial uses; or livestock, wild animals, birds, fish, or other aquatic biota.

10. "Site-specific standards" mean water quality criteria developed to reflect local environmental conditions to protect the uses of a specific water body.

11. A standard defined as "total" means the entire quantity of a given material present in an unfiltered water sample regardless of the form or nature of its occurrence. This includes both dissolved and suspended forms of a substance, including the entire amount of the substance present as a constituent of the particulate material. Total recoverable is the quantity of a given material in an unfiltered aqueous sample following digestion by refluxing with hot dilute mineral acid.

12. "Water usage". The best usage for the waters shall be those uses determined to be the most consistent with present and potential uses in accordance with the economic and social development of the area. Present principal best uses are those defined in subdivisions a, b, c, d, and e. These are not to be construed to be the only possible usages.

    a. Municipal and domestic water. Waters suitable for use as a source of water supply for drinking and culinary purposes after treatment to a level approved by the department.

b. Fish and aquatic biota. Waters suitable for the propagation and support of fish and other aquatic biota and waters that will not adversely affect wildlife in the area. Low flows or natural physical and chemical conditions in some waters may limit their value for fish propagation or aquatic biota.

c. Recreation. Primary recreational waters are suitable for recreation where direct body contact is involved, such as bathing and swimming, and where secondary recreational activities such as boating, fishing, and wading are involved. Natural high turbidities in some waters and physical characteristics of banks and streambeds of many streams are factors that limit their value for bathing.

d. Agricultural uses. Waters suitable for irrigation, stock watering, and other agricultural uses, but not suitable for use as a source of domestic supply for the farm unless satisfactory treatment is provided.

e. Industrial water. Waters suitable for industrial purposes, including food processing, after treatment. Treatment may include that necessary for prevention of boiler scale and corrosion.

History: Effective January 1, 2019; amended effective January 1, 2024.
General Authority: NDCC 61-28-04~~, 61-28-05~~; S.L. 2017, ch. 199, § 1
Law Implemented: NDCC 23.1-11, 61-28; S.L. 2017, ch. 199, § 26

33.1-16-02.1-05. Variances and compliance schedules.

Upon written application by the responsible discharger, the department finds that by reason of substantial and widespread economic and social impacts the strict enforcement of state water quality criteria is not feasible, the department can permit a variance to the water quality standard for the affected segment. The department can set conditions and time limitations with the intent that progress toward improvements in water quality will be made. This can include interim criteria which must be reviewed at least once every three years. A variance will be granted only after fulfillment of the approved requirements at 40 CFR section 131.14, including public participation requirements and environmental protection agency approval. A variance will not preclude an existing use.

A North Dakota pollutant discharge elimination system permit may contain a schedule to return a permittee to compliance with water quality based effluent limits consistent with federal and state regulations. Compliance schedules in North Dakota pollutant discharge elimination system permits are subject to the requirements of section 33.1-16-01-15 and cannot be issued for new discharges or sources.

History: Effective January 1, 2019; amended effective January 1, 2024.
General Authority: NDCC 61-28-04~~, 61-28-05~~; S.L. 2017, ch. 199, § 1
Law Implemented: NDCC 23.1-11, 61-28; S.L. 2017, ch. 199, § 26

33.1-16-02.1-08. General water quality standards.

1. **Narrative standards.**

a. The following minimum conditions are applicable to all waters of the state except for class II ground waters. All waters of the state shall be:

(1) Free from substances attributable to municipal, industrial, or other discharges or agricultural practices that will cause the formation of putrescent or otherwise objectionable sludge deposits.

(2) Free from floating debris, oil, scum, and other floating materials attributable to municipal, industrial, or other discharges or agricultural practices in sufficient amounts to be unsightly or deleterious.

(3) Free from materials attributable to municipal, industrial, or other discharges or agricultural practices producing color, odor, or other conditions to such a degree as to create a nuisance or render any undesirable taste to fish flesh or, in any way, make fish inedible.

(4) Free from substances attributable to municipal, industrial, or other discharges or agricultural practices in concentrations or combinations which are toxic or harmful to humans, animals, plants, or resident aquatic biota. For surface water, this standard will be enforced in part through appropriate whole effluent toxicity requirements in North Dakota pollutant discharge elimination system permits.

(5) Free from oil or grease residue attributable to wastewater, which causes a visible film or sheen upon the waters or any discoloration of the surface of adjoining shoreline or causes a sludge or emulsion to be deposited beneath the surface of the water or upon the adjoining shorelines or prevents classified uses of such waters.

(6) Free from nutrients attributed to municipal, industrial, or other discharges or agricultural practices, in concentrations or loadings which will cause accelerated eutrophication resulting in the objectionable growth of aquatic vegetation or algae or other impairments to the extent that it threatens public health or welfare or impairs present or future beneficial uses.

b. There shall be no materials such as garbage, rubbish, offal, trash, cans, bottles, drums, or any unwanted or discarded material disposed of into the waters of the state.

c. There shall be no disposal of livestock or domestic animals in waters of the state.

d. The department shall propose and submit to the state engineer the minimum streamflows of major rivers in the state necessary to protect the public health and welfare. The department's determination shall address the present and prospective future use of the rivers for public water supplies, propagation of fish and aquatic life and wildlife, recreational purposes, and agricultural, industrial, and other legitimate uses.

e. No discharge of pollutants, which alone or in combination with other substances, shall:

(1) Cause a public health hazard or injury to environmental resources;

(2) Impair existing or reasonable beneficial uses of the receiving waters; or

(3) Directly or indirectly cause concentrations of pollutants to exceed applicable standards of the receiving waters.

f. If the department determines that site-specific criteria are necessary and appropriate for the protection of designated uses, procedures described in the environmental protection agency's Water Quality Standards Handbook 1994 or other defensible methods may be utilized to determine maximum limits. Where natural chemical, physical, and biological characteristics result in exceedances of the limits set forth in this section, the department may derive site-specific criteria based on the natural background level or condition. All available information shall be examined, and all possible sources of a contaminant will be identified in determining the naturally occurring concentration. All site-specific criteria shall be noticed for public comment and subjected to other applicable public participation requirements prior to being adopted.

2. **Narrative biological goal.**

a. Goal. The biological condition of surface waters shall be similar to ~~that of~~ sites or water bodies determined by the department to be regional reference sites.

b. Definitions.

(1) "Assemblage" means an association of aquatic organisms of similar taxonomic classification living in the same area. Examples of assemblages include fish, macroinvertebrates, algae, and vascular plants.

(2) "Aquatic organism" means any plant or animal which lives at least part of its life cycle in water.

(3) "Biological condition" means the taxonomic composition, richness, and functional organization of an assemblage of aquatic organisms at a site or within a water body.

(4) "Functional organization" means the number of species or abundance of organisms within an assemblage which perform the same or similar ecological functions.

(5) "Metric" means an expression of biological community composition, richness, or function which displays a predictable, measurable change in value along a gradient of pollution or other anthropogenic disturbance.

(6) "Regional reference sites" are sites or water bodies which are determined by the department to be representative of sites or water bodies of similar type (e.g., hydrology and ecoregion) and are least impaired with respect to habitat, water quality, watershed land use, and riparian and biological condition.

(7) "Richness" means the absolute number of taxa in an assemblage at a site or within a water body.

(8) "Taxonomic composition" means the identity and abundance of species or taxonomic groupings within an assemblage at a site or within a water body.

c. Implementation. The intent of the state in adopting a narrative biological goal is solely to provide an additional assessment method that can be used to identify impaired surface waters. Regulatory or enforcement actions based solely on a narrative biological goal, such as the development and enforcement of North Dakota pollutant discharge elimination system permit limits, are not authorized. However, ~~adequate and~~ representative biological assessment information may be used in combination with other information to assist in determining whether designated uses are attained and to assist in determining whether new or revised chemical-specific permit limitations may be needed. Implementation will be based on the comparison of current biological conditions at a particular site to the biological conditions deemed attainable based on regional reference sites. In implementing a narrative biological goal, biological condition may be expressed through an index composed of multiple metrics or through appropriate statistical procedures.

History: Effective January 1, 2019; amended effective July 1, 2021; January 1, 2024.
General Authority: NDCC 61-28-04; S.L. 2017, ch. 199, § 1
Law Implemented: NDCC 23.1-11, 61-28; S.L. 2017, ch. 199, § 26

33.1-16-02.1-09. Surface water classifications, mixing zones, and numeric standards.

1. **Surface water classifications.** Procedures for the classifications of streams and lakes of the state shall follow this subsection. Classifications of streams and lakes are listed in appendix I and appendix II, respectively.

   a. Class I streams. The quality of the waters in this class shall be suitable for the propagation or protection, or both, of resident fish species and other aquatic biota and for swimming, boating, and other water recreation. The quality of the waters shall be suitable for irrigation, stock watering, and wildlife without injurious effects. After treatment consisting of coagulation, settling, filtration, and chlorination, or equivalent treatment processes, the water quality shall meet the bacteriological, physical, and chemical requirements of the department for municipal or domestic use.

   b. Class IA streams. The quality of the waters in this class shall be the same as the quality of class I streams, except that where natural conditions exceed class I criteria for municipal and domestic use, the availability of softening or other treatment methods may be considered in determining whether ambient water quality meets the drinking water requirements of the department.

      The Sheyenne River from its headwaters to one-tenth mile downstream from Baldhill Dam is not classified for municipal or domestic use.

   c. Class II streams. The quality of the waters in this class shall be the same as the quality of class I streams, except that additional treatment may be required to meet the drinking water requirements of the department. Streams in this classification may be intermittent in nature which would make these waters of limited value for beneficial uses such as municipal water, fish life, irrigation, bathing, or swimming.

   d. Class III streams. The quality of the waters in this class shall be suitable for agricultural and industrial uses. Streams in this class generally have low average flows with prolonged periods of no flow. During periods of no flow, they are of limited value for recreation and fish and aquatic biota. The quality of these waters must be maintained to protect secondary contact recreation uses (e.g., wading), fish and aquatic biota, and wildlife uses.

   e. Wetlands. These water bodies, including isolated ponds, sloughs, and marshes, are to be considered waters of the state and will be protected under section 33.1-16-02.1-08.

   f. Lakes and reservoirs. The type of fishery a lake or reservoir may be capable of supporting is based on the lake's or reservoir's geophysical characteristics. The capability of a lake or reservoir to support a fishery may be affected by seasonal or climatic variability or other natural occurrences, which may alter the physical and chemical characteristics of the lake or reservoir.

Class	Characteristics
1	Cold water fishery. Waters capable of supporting growth of cold water fish species (e.g., salmonids) and associated aquatic biota.
2	Cool water fishery. Waters capable of supporting natural reproduction and growth of cool water fishes (e.g., northern pike and walleye) and associated aquatic biota. These waters are also capable of supporting the growth and marginal survival of cold water species and associated biota.
3	Warm water fishery. Waters capable of supporting natural reproduction and growth of warm water fishes (e.g., largemouth bass and bluegill) and

associated aquatic biota. Some cool water species may also be present.

4 Marginal fishery. Waters capable of supporting a fishery on a short-term or seasonal basis (generally a "put and take" fishery).

5 Not capable of supporting a fishery due to high salinity.

2. **Mixing zones.** North Dakota mixing zone and dilution policy is contained in appendix III.

3. **Numeric standards.**

a. Class I streams. The physical and chemical criteria for class I streams are listed in table 1 and table 2.

b. Class IA streams. The physical and chemical criteria shall be those for class I streams, with the exceptions for chloride, percent sodium, and sulfate as listed in table 1.

c. Site-specific sulfate standard. The physical and chemical criteria for the Sheyenne River from its headwaters to one-tenth of a mile downstream from Baldhill Dam shall be those for class IA streams, with the exception of sulfate as listed in table 1.

d. Class II streams. The physical and chemical criteria shall be those for class IA, with the chloride and pH and sulfates as listed in table 1.

e. Class III streams. The physical and chemical criteria shall be those for class II, with the exceptions for sulfate as listed in table 1.

f. Wetlands, including isolated ponds, class 4 lakes not listed in appendix II, sloughs and marshes. The physical and chemical criteria shall be those for class III streams, with exceptions for temperature, dissolved oxygen as listed in paragraph 6 of subdivision g, and other conditions not attributable to municipal, industrial, domestic, or agricultural sources.

g. Lakes and reservoirs.

(1) The physical and chemical criteria for class I streams shall apply to all classified lakes or reservoirs listed in appendix II.

(2) In addition, a guideline for use as a goal in any lake or reservoir improvement or maintenance program is a growing season (April through November) average chlorophyll-a concentration of twenty µg/l.

(3) The temperature standard for class I streams does not apply to Nelson Lake in Oliver County. The temperature of any discharge to Nelson Lake shall not have an adverse effect on fish, aquatic biota, recreation, and wildlife.

(4) A numeric temperature standard of not greater than fifty-nine degrees Fahrenheit [15 degrees Celsius] shall be maintained in the hypolimnion of class I lakes and reservoirs during periods of thermal stratification.

(5) The numeric dissolved oxygen standard of five mg/l as a daily minimum does not apply to the hypolimnion of class III and IV lakes and reservoirs during periods of thermal stratification.

(6) The numeric dissolved oxygen standard of five mg/l as a daily minimum and the maximum temperature of eighty-five degrees Fahrenheit [29.44 degrees Celsius] shall not apply to wetlands and class 4 lakes.

(7) Lake Sakakawea must maintain a minimum volume of water of five hundred thousand-acre feet [61,674-hectare meters] that has a temperature of fifty-nine degrees Fahrenheit [15 degrees Celsius] or less and a dissolved oxygen concentration of not less than five mg/l.

History: Effective January 1, 2019; amended effective July 1, 2021; January 1, 2024.
General Authority: NDCC 61-28-04; S.L. 2017, ch. 199, § 1
Law Implemented: NDCC 23.1-11, 61-28; S.L. 2017, ch. 199, § 26

TABLE 1

MAXIMUM LIMITS FOR SUBSTANCES IN
OR CHARACTERISTICS OF CLASSES I, IA, II, AND III STREAMS

~~CAS[1] No.~~	~~Substance or Characteristic (a = aquatic life) (b = municipal & domestic drinking water) (c = agricultural, irrigation, industrial) (d = recreation)~~	~~Maximum Limit~~
CAS[1] No.	Substance or Characteristic (a = aquatic life) (b = municipal & domestic drinking water) (c = agricultural, irrigation, industrial) (d = recreation)	Maximum Limit
7429905	Aluminum[2] (a)	**Acute Standard** 750 micrograms per liter (µg/l) **Chronic Standard** 87 µg/l Where the pH is equal to or greater than 7.0, and the hardness is equal to or greater than 50 mg/l as $CaCO_3$ in the receiving water after mixing, the 87 µg/l chronic total recoverable aluminum criterion will not apply, and aluminum will be regulated based on compliance with the 750 µg/l acute total recoverable aluminum criterion.
7446-41-7	Ammonia (Total as N) (a)	**Acute Standard** The one-hour average concentration of total ammonia as nitrogen in mg/l does not exceed, more often than once every three years on the average, the numerical value given by the following: $0.7249 \times \left(\frac{0.0114}{1+10^{7.204-pH}} + \frac{1.6181}{1+10^{pH-7.204}}\right) \times MIN\left(51.93, 23.12 \times 10^{0.036\times(20-T)}\right)$ Where Oncorhynchus are absent; or

		$$\text{MIN}\left(\left(\frac{0.275}{1+10^{7.204-pH}}+\frac{39.0}{1+10^{pH-7.204}}\right),\left(0.7249\times\left(\frac{0.0114}{1+10^{7.204-pH}}+\frac{1.6181}{1+10^{pH-7.204}}\right)\times\left(23.12\times10^{0.036\times(20-T)}\right)\right)\right)$$ Where Oncorhynchus are present **Chronic Standard** The 30-day rolling average concentration of total ammonia as nitrogen expressed in mg/l is not to exceed, more than once every three years on average, the chronic criteria magnitude calculated using the following formula: $$0.8876\times\left(\frac{0.0278}{1+10^{7.688-pH}}+\frac{1.1994}{1+10^{pH-7.688}}\right)\times\left(2.126\times10^{0.028\times(20-MAX(T,7))}\right)$$ In addition, the highest four-day average within the 30-day averaging period should not be more than 2.5 times the criteria more than once in three years on average.
7440-39-3	Barium (Total) (b)	1.0 mg/l (1-day arithmetic average)
7440-42-8	Boron (Total) (c)	0.75 mg/l (30-day arithmetic average)
16887-00-6	Chloride (Total) (a, b, c)	**Class I:** 100 mg/l (30-day arithmetic average) **Class IA:** 175 mg/l (30-day arithmetic average) **Class II and Class III:** 250 mg/l (30-day arithmetic average)
7782-50-5	Chlorine Residual (Total) (a)	**Acute:** 0.019 mg/l **Chronic:** 0.011 mg/l
None	Cylindrospermopsin (d)	15 µ/l For Clean Water Act water quality criterion, no more than 3 excursions (10-day assessment periods) within a single recreational season in a single year.
None	Microcystins (d)	8 µ/l For Clean Water Act water quality criterion, no more than 3 excursions (10-day assessment periods) within a single recreational season in a single year.
7782-44-7	Dissolved Oxygen (a)	5 mg/l as a daily minimum (up to 10% of representative samples collected during any 3-year period may be less than this value provided that lethal conditions are avoided)
14797-55-8	Nitrate as N^{23} (a, b)	1.0 mg/l (up to 10% of samples may exceed)

14797-65-0	Nitrite as N (b)	1.0 mg/l
None	E. coli[3][4] (d)	Not to exceed 126 organisms per 100 ml as a geometric mean of representative samples collected during any 30-day consecutive period, nor shall more than 10 percent of samples collected during any 30-day consecutive period individually exceed 409 organisms per 100 ml. For assessment purposes, the 30-day consecutive period shall follow the calendar month. This standard shall apply only during the recreation season May 1 to September 30.
None	pH (a)	**Class I and IA:** 6.5 - 9.0 (up to 10% of representative samples collected during any 3-year period may exceed this range, provided that lethal conditions are avoided). **Class II and Class III:** 6.0 - 9.0 (up to 10% of representative samples collected during any 3-year period may exceed this range, provided that lethal conditions are avoided).
108-95-2	Phenols (Total) (b)	0.3 mg/l (organoleptic criterion) (one-day arithmetic average)
7782-49-2	Selenium in Fish[4] Flesh[5] (a)	**Egg-Ovary:** 15.1 mg/kg Dry Weight **Whole Body:** 8.5 mg/kg Dry Weight **Muscle:** 11.3 mg/kg Dry Weight
7440-23-5	Sodium (b, c)	**Class I:** 50 percent of total cations as milliequivalents per liter (mEq/l) **Class IA, II, and III:** 60 percent of total cations as mEq/l
18785-72-3	Sulfates (Total as SO_4) (b)	**Class I:** 250 mg/l (30-day arithmetic average) **Class IA and II:** 450 mg/l (30-day arithmetic average) **Class III:** 750 mg/l (30-day arithmetic average)
	Sulfates (Total as SO_4) (a, b)	**Site Specific:** 750 mg/l (maximum) applies to the Sheyenne River from its headwaters to 0.1 mile downstream from Baldhill Dam **131.10(b) requirement:** The water quality standards for the Red River and the portions of the Sheyenne River located downstream from the segment of the Sheyenne River to which the site-specific sulfate standard applies must continue to be maintained. The Sheyenne River from 0.1 mile downstream from Baldhill Dam to the confluence with the Red River shall not exceed 450 mg/l sulfate (total) 30-day arithmetic average, and the Red River shall not exceed 250 mg/l sulfate (total) 30-day arithmetic average after mixing downstream from the confluence of the Sheyenne River. Regulated pollution control efforts must be developed to achieve compliance with these water quality standards.
None	Temperature (a)	Eighty-five degrees Fahrenheit [29.44 degrees Celsius]. The maximum increase shall not be greater than five degrees Fahrenheit [2.78 degrees Celsius] above natural background conditions.
None	Combined radium 226 and radium 228 (Total) (b)	5 pCi/l (30-day arithmetic average)
None	Gross alpha particle activity, including	15 pCi/l (30-day arithmetic average)

	radium 226, but excluding radon and uranium (b)	

[1] CAS No. is the chemical abstract service registry number. The registry database contains records for specific substances identified by the chemical abstract service.

[2] The US EPA 2018 recommended national criteria (304(a) criteria) for aluminum can be used for site-specific chronic and acute criteria when appropriate and data is available. The criteria is based upon multiple linear regression (MLR) models for fish and invertebrate species. Data requirements are pH, DOC, and total hardness to quantify the effects of these water chemistry parameters on the bioavailability and associated toxicity of aluminum to aquatic organisms.

[23] The standard for nitrates (N) is intended as benchmark concentration when stream or lake specific data is insufficient to determine the concentration that will cause excessive plant growth (eutrophication). However, in no case shall the concentration for nitrate plus nitrite N exceed 10 mg/l for any waters used as a municipal or domestic drinking water supply.

[3] [4] Where the E. Coli criteria are exceeded and there are natural sources, the criteria may be considered attained, provided there is reasonable basis for concluding that the indicator bacteria density attributable to anthropogenic sources is consistent with the level of water quality required by the criteria. This may be the situation, for example, in headwater streams that are minimally affected by anthropogenic activities.

[4] [5] Fish tissue elements are expressed as steady-state instantaneous measurement not to exceed the criteria in the table. When fish egg/ovary concentrations are measured, the egg/ovary criterion element supersedes any whole-body, or muscle criterion element. The fish flesh values in Table 1 and the water column criteria in Table 2 are independently applicable. Water column criterion elements that are derived site-specifically using an empirical bioaccumulation factor approach or a bioaccumulation mechanistic model approach, once duly established under the provisions of 40 CFR 131 will supersede the criteria in Table 2 and will be subordinate to fish tissue criterion elements when both fish and water concentrations are measured. Any site-specific water column criterion element established under the provisions of 40 CFR 131 is the applicable criterion in the absence of fish tissue measurement, or in waters with new discharges of selenium where steady state has not been achieved between water and fish tissue at the site.

TABLE 2

WATER QUALITY CRITERIA[1]
(MICROGRAMS PER LITER)

		Aquatic Life Value Classes I, IA, II, III		Human Health Value	
CAS No.	Pollutant (Compounds)	Acute	Chronic	Classes I, IA, II[2]	Class III[3]
71-55-6	1,1,1-Trichloroethane			10,000[7]	200,000
79-00-5	1,1,2-Trichloroethane[4]			0.55	8.9
79-34-5	1,1,2,2-Tetrachloroethane[4]			0.2	3
75-35-4	1,1-Dichloroethylene[4]			300	20,000
156-60-5	1,2-trans-Dichloroethylene[7]			100	4,000
120-82-1	1,2,4-Trichlorobenzene			0.071	0.076
95-50-1	1,2-Dichlorobenzene[7]			1,000	3,000
541-73-1	1,3-Dichlorobenzene			7	10
106-46-7	1,4-Dichlorobenzene[7]			300	900
107-06-2	1,2-Dichloroethane[4]			9.9	650
78-87-5	1,2-Dichloropropane			0.90	31
542-75-6	1,3-Dichloropropylene (1,3-Dichloropropene) (cis and trans isomers)			0.27	12
122-66-7	1,2-Diphenylhydrazine[4]			0.03	0.20
121-14-2	2,4-Dinitrotoluene[4]			0.049	1.7
95-57-8	2-Chlorophenol			30	800
120-83-2	2,4-Dichlorophenol			10	60
88-06-2	2,4,6-Trichlorophenol[4]			1.5	2.8
91-58-7	2-Chloronaphthalene			800	1,000
91-94-1	3,3'-Dichlorobenzidine[4]			0.049	0.15
105-67-9	2,4-Dimethylphenol			100	3,000
51-28-5	2,4-Dinitrophenol			10	300
94-75-7	2,4-D			1,300	12,000
72-54-8	4,4'-DDD[4]			0.00012	0.00012
75-55-9	4,4'-DDE[4]			0.000018	0.000018
50-29-3	4,4'-DDT[4]	0.55[12]	0.001[12]	0.000030	0.000030
534-52-1	2-Methyl-4,6-Dinitrophenol			2	30
59-50-7	3-Methyl-4-Chlorophenol			500	2,000
83-32-9	Acenaphthene			70	90
107-02-8	Acrolein	3	3	3	400
107-13-1	Acrylonitrile[4]			0.061	7.0
15972-60-8	Alachlor			2[7]	
309-00-2	Aldrin[4]	1.5		7.7E-07	7.7E-07
319-84-6	alpha-BHC[4] (Hexachlorocyclohexane-alpha)			0.00036	0.00039
319-85-7	beta-BHC[4] (Hexachlorocyclohexane-beta)			0.008	0.014
58-89-9	gamma-BHC (Lindane)[4] (Hexachlorocyclohexane-gamma)	0.95		4.2[7]	4.4
959-98-8	alpha-Endosulfan	0.11[11]	0.056[11]	20	30

33213-65-9	beta-Endosulfan	0.11[11]	0.056[11]	20	40
120-12-7	Anthracene (PAH)[5]			300	400
1332-21-4	Asbestos[4,7]			7,000,000 f/l	7,000,000 f/l
1912-24-9	Atrazine			3[7]	
71-43-2	Benzene[4]			2.1	58
92-87-5	Benzidine[4]			0.00014	0.011
56-55-3	Benzo(a)anthracene (PAH)[4] (1,2-Benzanthracene)			0.0012	0.0013
50-32-8	Benzo(a)pyrene (PAH)[4] (3,4-Benzopyrene)			0.00012	0.00013
205-99-2	Benzo(b)fluoranthene (PAH)[4] (3,4-Benzofluoranthene)			0.0012	0.0013
207-08-9	Benzo(k)fluoranthene (PAH)[4] (11,12-Benzofluoranthene)			0.012	0.013
12587-47-2	Beta/photon emitters			4 mrem/yr[7]	
111-44-4	Bis(2-chloroethyl) ether[4]			0.030	2.2
108-60-1	Bis(2-chloro-1-Methylethyl) ether			200	4,000
117-81-7	Bis(2-ethylhexyl) phthalate[4]			0.32	0.37
15541-45-4	Bromate			10[7]	
75-25-2	Bromoform (HM)[5] (Tribromomethane)			7.0	120
85-68-7	Butyl benzyl phthalate			0.10	0.10
63-25-2	Carbaryl (1-naphthyl-N-methycarbamate)	2.1	2.1		
1563-66-2	Carbofuran			40[7]	
56-23-5	Carbon tetrachloride[4] (Tetrachloromethane)			0.40	5
57-74-9	Chlordane[4]	1.2	0.0043	0.00031	0.00032
14998-27-7	Chlorite			1,000[7]	
108-90-7	Chlorobenzene (Monochlorobenzene)			100[7]	800
124-48-1	Chlorodibromomethane (HM)[5]			0.80	21
67-66-3	Chloroform (HM)[4] (Trichloromethane)			60	2,000
2921-88-2	Chlorpyrifos	0.083	0.041		
218-01-9	Chrysene (PAH)[4]			0.12	0.13
57-12-5	Cyanide (total)	22	5.2	4	400
75-99-0	Dalapon			200[7]	
103-23-1	Di(2-ethylhexyl)adipate			400[7]	
333-41-5	Diazinon	0.17	0.17		
53-70-3	Dibenzo(a,h)anthracene (PAH)[4] (1,2,5,6-Dibenzanthracene)			0.00012	0.00013
67708-83-2	Dibromochloropropane			0.2[7]	
75-27-4	Dichlorobromomethane (HM)[5]			0.95	27
156-59-2	Dichloroethylene (cis-1,2-)			70[7]	
60-57-1	Dieldrin[4]	0.24	0.056	1.2E-06	1.2E-06
84-66-2	Diethyl phthalate			600	600
131-11-3	Dimethyl phthalate			2,000	2,000
84-74-2	Di-n-butyl phthalate			20	30
88-85-7	Dinoseb			7[7]	
1746-01-6	Dioxin (2,3,7,8-TCDD)[4]			5.00E-09	5.10E-09

85-00-7	Diquat			20[7]	
1031-07-8	Endosulfan sulfate			20	40
145-73-3	Endothall			100[7]	
72-20-8	Endrin	0.086	0.036	0.03	0.03
7421-93-4	Endrin aldehyde			1	1
100-41-4	Ethylbenzene[7]			68	130
106-93-4	Ethylene dibromide (EDB)			0.05[7]	
206-44-0	Fluoranthene			20	20
86-73-7	Fluorene (PAH)[5]			50	70
1071-83-6	Glyphosate			700[7]	
	Halocetic acids[14]			60[7]	
1024-57-3	Heptachlor epoxide[4]	0.26	0.0038	0.000032	0.000032
76-44-8	Heptachlor[4]	0.26	0.0038	0.0000059	0.0000059
118-74-1	Hexachlorobenzene[4]			0.000079	0.000079
87-68-3	Hexachlorobutadiene[4]			0.01	0.01
77-47-4	Hexachlorocyclopentadiene			4	4
67-72-1	Hexachloroethane[4]			0.10	0.10
193-39-5	Indeno(1,2,3-cd) pyrene (PAH)[4]			0.0012	0.0013
78-59-1	Isophorone[4]			34	1,800
72-43-5	Methoxychlor			0.02	0.02
74-83-9	Methyl bromide (HM) (Bromomethane)			100	10,000
75-09-2	Methylene chloride (HM)[4] (Dichloromethane)			20	1,000
98-95-3	Nitrobenzene			10	600
62-75-9	N-Nitrosodimethylamine[4]			0.00069	3
621-64-7	N-Nitrosodi-n-propylamine[4]			0.005	0.51
86-30-6	N-Nitrosodiphenylamine[4]			3.3	6
84852-15-3	Nonylphenol (Isomer mixture)[13]	28	6.6		
23135-22-0	Oxamyl (Vydate)			200[7]	
56-38-2	Parathion	0.065	0.013		
53469-21-9	PCB-1242 (Arochlor 1242)[4]		0.014[10]	0.000064[10]	0.000064[10]
126764-11-2	PCB-1016 (Arochlor 1016)[4]		0.014[10]	0.000064[10]	0.000064[10]
11104-28-2	PCB-1221 (Arochlor 1221)[4]		0.014[10]	0.000064[10]	0.000064[10]
11141-16-5	PCB-1232 (Arochlor 1232)[4]		0.014[10]	0.000064[10]	0.000064[10]
12672-29-6	PCB-1248 (Arochlor 1248)[4]		0.014[10]	0.000064[10]	0.000064[10]
11097-69-1	PCB-1254 (Arochlor 1254)[4]		0.014[10]	0.000064[10]	0.000064[10]
11096-82-5	PCB-1260 (Arochlor 1260)[4]		0.014[10]	0.000064[10]	0.000064[10]
87-86-5	Pentachlorophenol	19[8]	15[8]	0.03	0.04
108-95-2	Phenol			4,000	300,000
1918-02-1	Picloram			500[7]	
129-00-0	Pyrene (PAH)[5]			20	30
122-34-9	Simazine			4[7]	
100-42-5	Styrene			100[7]	
127-18-4	Tetrachloroethylene[4]			10	29
108-88-3	Toluene			57	520

8001-35-2	Toxaphene[4]	0.73	0.0002	0.0007	0.00071
688-73-3	Tributyltin	0.46	0.072		
79-01-6	Trichloroethylene[4]			0.60	7
75-01-4	Vinyl chloride[4] (Cloroethylene)			0.022	1.6
1330-20-7	Xylenes			10,000[7]	
		Aquatic Life Value Classes I, IA, II, III		Human Health Value	
CAS No.	Pollutant (Elements)	Acute	Chronic	Classes I, IA, II[2]	Class III[3]
7440-36-0	Antimony			5.6	640
7440-38-2	Arsenic[7]	340[9]	150[9]	10[7]	
7440-41-7	Beryllium[4]			4[7]	
7440-43-9	Cadmium	7.38[6,15]	2.39[6,15]	5[7]	
16065-83-1	Chromium (III)	5,611.70[6,15]	268.22[6,15]	100(total)[7]	
18540-29-9	Chromium (VI)	16	11	100(total)[7]	
7440-50-8	Copper	51.68[6,15,16]	30.50[6,15,16]	1000	
7782-41-4	Fluoride			4,000[7]	
7439-92-1	Lead	476.82[6]	18.58[6]	15[7]	
7439-97-6	Mercury	1.7	~~0.88~~0.012	0.050	0.051
7440-02-0	Nickel	1,516.92[6,15]	168.54[6,15]	100[7]	4,200
7782-49-2	Selenium	20	5	50[7]	
7440-22-4	Silver	41.07[6,15]			
7440-28-0	Thallium			0.24	0.47
7440-61-1	Uranium			30[7]	
7440-66-6	Zinc	387.83[6,15]	387.82[6,15]	7,400	26,000

[1] Except for the aquatic life values for metals, the values given in this appendix refer to the total (dissolved plus suspended) amount of each substance unless otherwise noted. For the aquatic life values for metals, the values refer to the total recoverable method for ambient metals analyses.

[2] Based on two routes of exposure - ingestion of contaminated aquatic organisms and drinking water.

[3] Based on one route of exposure - ingestion of contaminated aquatic organisms only.

[4] Substance classified as a carcinogen, with the value based on an incremental risk of one additional instance of cancer in one million persons.

[5] Chemicals which are not individually classified as carcinogens but which are contained within a class of chemicals, with carcinogenicity as the basis for the criteria derivation for that class of chemicals; an individual carcinogenicity assessment for these chemicals is pending.

[6] Hardness dependent criteria. Value given is an example ~~only and is~~ based on a $CaCO_3$ hardness of 400 mg/l. Criteria for each case must be calculated using the following formula:

For the Criterion Maximum Concentration (CMC):

Cadmium	$CMC = e^{0.9789[\ln(\text{hardness})]-3.866}$
~~Chromum~~Chromium (III)	$CMC = e^{0.8190[\ln(\text{hardness})]+3.7256}$
Copper	$CMC = e^{0.9422[\ln(\text{hardness})]-1.7000}$
Lead	$CMC = e^{1.2730[\ln(\text{hardness})]-1.4600}$
Nickel	$CMC = e^{0.8460[\ln(\text{hardness})]+2.2550}$
Silver	$CMC = e^{1.7200[\ln(\text{hardness})]-6.5900}$
Zinc	$CMC = e^{0.8473[\ln(\text{hardness})]+0.8840}$

CMC = Criterion Maximum Concentration (acute exposure value)
The threshold value at or below which there should be no unacceptable effects to freshwater aquatic organisms and their uses if the one-hour concentration does not exceed that CMC value more than once every three years on the average.

For the Criterion Continuous Concentration (CCC):

Cadmium	$CCC = e^{0.7977[\ln(\text{hardness})]-3.909}$
Chromium (III)	$CCC = e^{0.8190[\ln(\text{hardness})]+0.6848}$
Copper	$CCC = e^{0.8545[\ln(\text{hardness})]-1.7020}$
Lead	$CCC = e^{1.2730[\ln(\text{hardness})]-4.7050}$
Nickel	$CCC = e^{0.8460[\ln(\text{hardness})]+0.0584}$
Silver	No CCC criterion for silver
Zinc	$CCC = e^{0.8473[\ln(\text{hardness})]+0.8840}$

CCC = Criterion Continuous Concentration (chronic exposure value)
The threshold value at or below which there should be no unacceptable effects to freshwater aquatic organisms and their uses if the four-day concentration does not exceed that CCC value more than once every three years on the average.

[7] Safe Drinking Water Act (MCL).

[8] Freshwater aquatic life criteria for pentachlorophenol are expressed as a function of pH. Values displayed in the table correspond to a pH of 7.8 and are calculated as follows:

$CMC = \exp[1.005(pH) - 4.869]$ $CCC = \exp[1.005(pH) - 5.134]$

[9] This criterion applies to total arsenic.

[10] This criterion applies to total PCBs (i.e., the sum of all congener or all isomer or homolog or Arochlor analyses).

[11] This criterion applies to the sum of alpha-endosulfan and beta-endosulfan.

[12] This criterion applies to DDT and its metabolites (i.e., the total concentration of DDT and its metabolites should not exceed this value).

[13] The nonylphenol criteria address CAS numbers 84852-15-3 and 25154-52-3.

[14] The criterion is for a total measurement of 5 haloacetic acids, dichloroacetic acid, trichloroacetic acid, monochloroacetic acid, bromoacetic acid, and dibromoacetic acid.

[15] Hardness values shall be no greater than 400 mg/l. For waters with hardness concentrations greater than 400 mg/l, the actual ambient hardness may be used where a site-specific water effect ratio has been determined consistent with the environmental protection agency's water effect ratio procedure.

[16] The department will recognize the biotic ligand model as an appropriate tool for developing site-specific limits for copper as well as the water-effects ratio (WER) method.

33.1-16-02.1-10. Ground water classifications and standards.

1. Class I ground waters. Class I ground waters are those with a total dissolved solids concentration of less than 10,000 mg/l. The minimum conditions described in subsection 1 of section 33.1-16-02.1-08 apply. Class I ground waters are not exempt under the North Dakota underground injection control program in section 33.1-25-01-05.

2. Class II ground waters. Class II ground waters are those with a total dissolved solids concentration of 10,000 mg/l or greater. Class II ground waters are exempt under the North Dakota underground injection control program in section 33.1-25-01-05.

History: Effective January 1, 2019; amended effective January 1, 2024.
General Authority: NDCC 61-28-04~~, 61-28-05~~; S.L. 2017, ch. 199, § 1
Law Implemented: NDCC 61-28-04

APPENDIX I

STREAM CLASSIFICATIONS

The following intrastate and interstate streams are classified as the class of water quality which is to be maintained in the specified stream or segments noted. All tributaries, minor or intermittently flowing watercourse, unnamed creeks, or draws not specifically mentioned are classified as class III streams.

RIVER BASINS SUBBASINS TRIBUTARIES	CLASSIFICATION
Missouri River, including Lake Sakakawea and Oahe Reservoir	I
Yellowstone	I
Little Muddy ~~Creek~~River near Williston	II
White Earth River	II
Little Missouri River	II
Knife River	II
Spring Creek	IA
Square Butte Creek below Nelson Lake	IA
Heart River	IA
Green River	IA
Antelope Creek	II
Muddy Creek	II
Apple Creek	II
Cannonball River	II
Cedar Creek	II
Beaver Creek near Linton	II
Grand River	IA
Spring Creek	II
Souris River	IA
Des Lacs River	II
Willow Creek	II
Deep River	III
Mauvais Coulee	I
James River	IA
Pipestem	IA
Cottonwood Creek	II
Beaver Creek	II
Elm River	II
Maple River	II

RIVER BASINS SUBBASINS TRIBUTARIES	CLASSIFICATION
Bois de Sioux	I
Red River	I
Wild Rice River	II
Antelope Creek	III
Sheyenne River (except as noted below)	IA
Baldhill Creek	II
Maple River	II
Rush River	III
Elm River	II
Goose River	IA
Turtle River	II
Forest River	II
North Branch of Forest River	III
Park River	II
North Branch	III
South Branch	II
Middle Branch	III
Cart Creek	III
Pembina River	IA
Tongue River	II

The Sheyenne River from its headwaters to 0.1 mile downstream from Baldhill Dam is not classified for municipal or domestic use.

APPENDIX II

LAKE AND RESERVOIR CLASSIFICATION

Lakes and reservoirs are classified according to the water characteristics which are to be maintained in the specified lakes and reservoirs. The physical and chemical criteria for class I streams shall apply to all classified lakes and reservoirs listed. For lakes and other lentic water bodies not listed, the physical and chemical criteria designated for class III streams shall apply.

COUNTY	LAKE	CLASSIFICATION
Adams	Mirror Lake	3
Adams	N. Lemmon Lake	1
Barnes	Lake Ashtabula	3
Barnes	Moon Lake	2
Barnes	Clausen Springs	3
Benson	Wood Lake	2
Benson	Graves	3
Benson	Reeves	3
Bottineau	Lake Metigoshe	2
Bottineau	Long Lake	2
Bottineau	Pelican Lake	3
Bottineau	Carbury Dam	2
Bottineau	Cassidy Lake	4
Bottineau	Strawberry Lake	2
Bowman	Bowman-Haley Dam	3
Bowman	Gascoyne Lake	3
Bowman	Kalina Dam	3
Bowman	Lutz Dam	2
Bowman	Spring Lake	3
Burke	Powers Lake	3
Burke	Short Creek Dam	2
Burke	Smishek Dam	2
Burke	Northgate Dam	2
Burleigh	McDowell Dam	3
Burleigh	Mitchell Lake	3
Burleigh	New Johns Lake	2
Cass	Casselton Reservoir	3
Cass	Brewer Lake	2
Cavalier	Mt. Carmel Dam	2
Dickey	Moores Lake	3

COUNTY	LAKE	CLASSIFICATION
Dickey	Pheasant Lake	3
Dickey	Wilson Dam	3
Divide	Baukol-Noonan Dam	2
Divide	Baukol-Noonan East Mine Pond	2
Divide	Skjermo Dam	2
Dunn	Lake Ilo	3
Eddy	Battle Lake	3
Eddy	Warsing Dam	3
Emmons	Braddock Dam	3
Emmons	Nieuwsma Dam	2
Emmons	Rice Lake	3
Foster	Juanita Lake	3
Golden Valley	South Buffalo Gap Dam	4
Golden Valley	Camel Hump Dam	1
Golden Valley	Odland Dam	3
Grand Forks	Fordville Dam	2
Grand Forks	Kolding Dam	3
Grand Forks	Larimore Dam	2
Grand Forks	Niagara Dam	3
Grant	Heart Butte Dam (Lake Tschida)	2
Grant	Niagara Dam	3
Grant	Raleigh Reservoir	2
Grant	Sheep Creek Dam	2
Griggs	Carlson-Tande Dam	3
Griggs	Red Willow Lake	2
Hettinger	Blickensderfer Dam	2
Hettinger	Castle Rock Dam	4
Hettinger	Indian Creek	2
Hettinger	Larson Lake	3
Hettinger	Mott Watershed Dam	3
Kidder	Alkaline Lake	2
Kidder	Cherry Lake	3
Kidder	Crystal Springs	3
Kidder	Frettim Lake	2
Kidder	George Lake	5

COUNTY	LAKE	CLASSIFICATION
Kidder	Horsehead Lake	2
Kidder	Lake Isabel	3
Kidder	Lake Josephine	2
Kidder	Lake Williams	3
Kidder	Round Lake	2
LaMoure	Heinrich-Martin Dam	3
LaMoure	Kalmbach Lake	3
LaMoure	Kulm-Edgeley Dam	3
LaMoure	Lake LaMoure	3
LaMoure	Lehr Dam	3
LaMoure	Limesand-Seefeldt Dam	3
LaMoure	Schlecht-Thom Dam	3
LaMoure	Schlecht-Weix Dam	3
Logan	Beaver Lake	3
Logan	Mundt Lake	3
Logan	Rudolph Lake	3
McHenry	Cottonwood Lake	3
McHenry	George Lake	3
McHenry	Round Lake	3
McHenry	Buffalo Lodge Lake	3
McIntosh	Blumhardt Dam	2
McIntosh	Clear Lake	3
McIntosh	Coldwater Lake	3
McIntosh	Dry Lake	2
McIntosh	Green Lake	2
McIntosh	Lake Hoskins	3
McKenzie	Arnegard Dam	4
McKenzie	Leland Dam	2
McKenzie	Sather Dam	2
McLean	Brush Lake	3
McLean	Crooked Lake	3
McLean	Custer Mine Pond	2
McLean	East Park Lake	2
McLean	Lake Audubon	2
McLean	Lake Brekken	2
McLean	Lake Holmes	2

COUNTY	LAKE	CLASSIFICATION
McLean	Lightning Lake	1
McLean	Long Lake	4
McLean	Riverdale Spillway Lake	1
McLean	Strawberry Lake	3
McLean	West Park Lake	2
Mercer	Harmony Lake	3
Morton	Crown Butte Dam	3
Morton	Danzig Dam	3
Morton	Fish Creek Dam	1
Morton	Harmon Lake	3
Morton	Nygren Dam	2
Morton	Sweetbriar Dam	2
Mountrail	Clearwater Lake	3
Mountrail	Stanley City Pond	3
Mountrail	Stanley Reservoir	3
Mountrail	White Earth Dam	2
Nelson	McVille Dam	2
Nelson	Tolna Dam	2
Nelson	Whitman Dam	2
Oliver	East Arroda Lake	2
Oliver	Nelson Lake	3
Oliver	West Arroda Lake	2
Pembina	Renwick Dam	3
Pierce	Balta Dam	3
Pierce	Buffalo Lake	3
Ramsey	Cavanaugh Lake	3
Ramsey	Devils Lake	2
Ransom	Dead Colt Creek Dam	3
Renville	Lake Darling	2
Richland	Lake Elsie	3
Richland	Mooreton Pond	3
Rolette	Belcourt Lake	2
Rolette	Carpenter Lake	2
Rolette	Dion Lake	2
Rolette	Gordon Lake	2
Rolette	Gravel Lake	2

COUNTY	LAKE	CLASSIFICATION
Rolette	Hooker Lake	2
Rolette	Island Lake	3
Rolette	Jensen Lake	3
Rolette	School Section Lake	2
Rolette	Upsilon Lake	2
Rolette	Shutte Lake	2
Sargent	Alkali Lake	3
Sargent	Buffalo Lake	3
Sargent	Lake Tewaukon	3
Sargent	Silver Lake	3
Sargent	Sprague Lake	3
Sheridan	Hecker Lake	2
Sheridan	South McClusky Lake (Hoffer Lake)	2
Sioux	Froelich Dam	2
Slope	Cedar Lake	3
Slope	Davis Dam	2
Slope	Stewart Lake	3
Stark	Belfield Pond	1
Stark	Dickinson Dike	1
Stark	Patterson Lake	3
Steele	North Golden Lake	3
Steele	North Tobiason Lake	3
Steele	South Golden Lake	3
Stutsman	Arrowwood Lake	4
Stutsman	Bader Lake	3
Stutsman	Barnes Lake	3
Stutsman	Clark Lake	3
Stutsman	Crystal Springs	3
Stutsman	Hehn-Schaffer Lake	3
Stutsman	Jamestown Reservoir	3
Stutsman	Jim Lake	4
Stutsman	Spiritwood Lake	3
Stutsman	Pipestem Reservoir	3
Towner	Armourdale Dam	2
Towner	Bisbee Dam	2
Walsh	Bylin Dam	3

COUNTY	LAKE	CLASSIFICATION
Walsh	Homme Dam	3
Walsh	Matejcek Dam	3
Ward	Hiddenwood Lake	3
Ward	Makoti Lake	4
Ward	North-Carlson Lake	3
Ward	Rice Lake	3
Ward	Velva Sportsmans Pond	1
Wells	Harvey Dam	3
Wells	Lake Hiawatha (Sykeston Dam)	4
Williams	Blacktail Dam	3
Williams	Cottonwood Lake	3
Williams	East Spring Lake Pond	3
Williams	Epping-Springbrook Dam	3
Williams	Iverson Dam	2
Williams	Kettle Lake	2
Williams	Kota-Ray Dam	1
Williams	McCleod (Ray) Reservoir	3
Williams	McGregor Dam	1
Williams	Tioga Dam	3
Williams	Trenton Lake	2
Williams	West Spring Lake Pond	3
~~Burliegh~~Burleigh, Emmons, Morton, Sioux	Lake Oahe	1
Dunn, McKenzie, McLean, Mercer, Mountrail, Williams	Lake Sakakawea	1

APPENDIX III

MIXING ZONE AND DILUTION POLICY AND IMPLEMENTATION PROCEDURE

PURPOSE

This policy addresses how mixing and dilution of point source discharges with receiving waters will be addressed in developing chemical-specific and whole effluent toxicity discharge limitations for point source discharges. Depending upon site-specific mixing patterns and environmental concerns, some pollutants/criteria may be allowed a mixing zone or dilution while others may not. In all cases, mixing zone and dilution allowances shall be limited, as necessary, to protect the integrity of the receiving water's ecosystem and designated uses.

MIXING ZONES

Where dilution is available and the discharge does not mix at a near instantaneous and complete rate with the receiving water (incomplete mixing), an appropriate mixing zone may be designated. In addition, a mixing zone may only be designated if it is not possible to achieve chemical-specific standards and whole effluent toxicity objectives at the end-of-pipe with no allowance for dilution. The size and shape of a mixing zone will be determined on a case-by-case basis. At a maximum, mixing zones for streams and rivers shall not exceed one-half the cross-sectional area or a length ten times the stream width at critical low flows, whichever is more limiting. Also, at a maximum, mixing zones in lakes shall not exceed five percent of lake surface area or two hundred feet in radius, whichever is more limiting. Individual mixing zones may be limited or denied in consideration of designated beneficial uses or presence of the following concerns in the area affected by the discharge:

1. There is the potential for bioaccumulation in fish tissues or wildlife.
2. The area is biologically important, such as fish spawning/nursery areas.
3. The pollutant of concern exhibits a low acute to chronic ratio.
4. There is a potential for human exposure to pollutants resulting from drinking water use or recreational activities.
5. The effluent and resultant mixing zone results in an attraction of aquatic life to the effluent plume.
6. The pollutant of concern is extremely toxic and persistent in the environment.
7. The mixing zone would prohibit a zone of passage for migrating fish or other species (including access to tributaries).
8. There are cumulative effects of multiple discharges and their mixing zones.

Within the mixing zone designated for a particular pollutant, certain numeric water quality criteria for that substance may not apply. However, all mixing zones shall meet the general conditions set forth in section 33-16-02-08 of the state water quality standards.

While exceedances of acute chemical specific numeric standards are not allowed within the entire mixing zone, a portion of the mixing zone (the zone of initial dilution or ZID) may exceed acute chemical-specific numeric standards established for the protection of aquatic life. The ZID shall be determined on a case-by-case basis where the statement of basis for the discharge permit includes a rationale for concluding that a zone of initial dilution poses no unacceptable risks to aquatic life. Acute whole effluent toxicity (WET) limits shall be achieved at the end-of-pipe with no allowance for a ZID.

DILUTION ALLOWANCES

An appropriate dilution allowance may be provided in calculating chemical-specific acute and chronic and WET discharge limitations where: 1) the discharge is to a river or stream, 2) dilution is available at low-flow conditions, and 3) available information is sufficient to reasonably conclude that there is near instantaneous and complete mixing of the discharge with the receiving water (complete mixing). The basis for concluding that such near instantaneous and complete mixing is occurring shall be documented in the statement of basis for the North Dakota pollutant discharge elimination system permit. In the case of field studies, the dilution allowance for continuous dischargers shall be based on the critical low flow (or some portion of the critical low flow). The requirements and environmental concerns identified in the paragraphs above may be considered in deciding the portion of the critical low flow to provide as dilution. The following critical low flows shall be used for streams and effluents:

Stream Flows	
Aquatic life, chronic	4-day, 3-year flow (biologically based*)**
Aquatic life, acute	1-day, 3-year flow (biologically based)
Human health (carcinogens)	Harmonic mean flow
Human health (noncarcinogens)	4-day, 3-year flow (biologically based) or 1-day, 3-year flow (biologically based)

Effluent Flows	
Aquatic life, chronic	Mean daily flow
Aquatic life, acute	Maximum daily flow
Human health (all)	Mean daily flow

* Biologically based refers to the biologically based design flow method developed by the environmental protection agency. It differs from the hydrologically based design flow method in that it directly uses the averaging periods and frequencies specified in the aquatic life water quality criteria for individual pollutants and whole effluents for determining design flows.

** A 30-day, 10-year flow (biologically based) can be used for ammonia or other chronic standard with a 30-day averaging period.

For chemical-specific and chronic WET limits, an appropriate dilution allowance may also be provided for certain minor publicly owned treatment works where allowing such dilution will pose insignificant environmental risks. For acute WET limits, an allowance for dilution is authorized only where dilution is available and mixing is complete.

For controlled discharges, such as lagoon facilities that discharge during high ambient flows, the stream flow to be used in the mixing zone analysis should be the lowest statistical flow expected to occur during the period of discharge.

Where a discharger has installed a diffuser in the receiving water, all or a portion of the critical low stream flow may be provided as a dilution allowance. The determination shall depend on the diffuser design and on the requirements and potential environmental concerns identified in the above paragraphs. Where a diffuser is installed across the entire river/stream width (at critical low flow), it will generally be presumed that near instantaneous and complete mixing is achieved and that providing the entire critical low flow as dilution is appropriate.

OTHER CONSIDERATIONS

Where dilution flow is not available at critical conditions (i.e., the water body is dry), the discharge limits will be based on achieving applicable water quality criteria (i.e., narrative and numeric, chronic and acute) at the end-of-pipe; neither a mixing zone or an allowance for dilution will be provided.

All mixing zone dilution assumptions are subject to review and revision as information on the nature and impacts of the discharge becomes available (e.g., chemical or biological monitoring at the mixing zone boundary). At a minimum, mixing zone and dilution decisions are subject to review and revision, along with all other aspects of the discharge permit upon expiration of the permit.

For certain pollutants (e.g., ammonia, dissolved oxygen, metals) that may exhibit increased toxicity or other effects on water quality after dilution and complete mixing is achieved, the waste load allocation shall address such effects on water quality, as necessary, to fully protect designated and existing uses. In other words, the point of compliance may be something other than the mixing zone boundary or the point where complete mixing is achieved.

The discharge will be consistent with the Antidegradation Procedure.

IMPLEMENTATION PROCEDURE

This procedure describes how dilution and mixing of point source discharges with receiving waters will be addressed in developing discharge limitations for point source discharges. For the purposes of this procedure, a mixing zone is defined as a designated area or volume of water surrounding or downstream of a point source discharge where the discharge is progressively diluted by the receiving water and numerical water quality criteria may not apply. Based on site-specific considerations, such a mixing zone may be designated in the context of an individual permit decision. Discharges may also be provided an allowance for dilution where it is determined that the discharge mixes with the receiving water in near instantaneous and complete fashion. Such mixing zones and allowances for dilution will be granted on a parameter-by-parameter and criterion-by-criterion basis as necessary to fully protect existing and designated uses.

The procedure to be followed is composed of six individual elements or steps. The relationship of the six steps and an overview of the mixing zone/dilution procedure is shown in figure 1.

Step 1 - No dilution available during critical low-flow conditions

Where dilution flow is not available at critical low-flow conditions, discharge limitations will be based on achieving applicable narrative and numeric water quality criteria at the end-of-pipe during critical low-flow conditions.

Step 2 - Dilution categorically prohibited for wetland discharges

Permit limitations for discharges to a wetland shall be based on achieving all applicable water quality criteria (i.e., narrative and numeric, chronic and acute) at end-of-pipe.

Step 3 - Procedure for certain minor publicly owned treatment works

Minor publicly owned treatment works that discharge to a lake or to a river/stream at a dilution greater than a 50-to-1 ratio qualify for this procedure. Minor publicly owned treatment works with dilution ratios less than a 50-to-1 ratio may also qualify (at the discretion of the permit writer) where it can be adequately demonstrated that this procedure poses insignificant environmental risks. For the purposes of this procedure, the river/stream dilution ratio is defined as the chronic low flow of the segment upstream of the publicly owned treatment works discharge divided by the mean daily flow of the publicly owned treatment works. For controlled discharges from lagoon facilities (discharging during high flows), the river/stream dilution ratio is defined as the lowest upstream flow expected during the period of discharge divided by the mean daily flow of the discharge.

For minor publicly owned treatment works that qualify for this procedure and discharge to lakes, the allowance for dilution for chemical-specific and chronic WET limits will be determined on a case-by-case basis. Dilution up to a 19-to-1 ratio (five percent effluent) may be provided.

For minor publicly owned treatment works that qualify for this procedure and discharge to a river/stream segment, dilution up to the full chronic aquatic life, acute aquatic life, and human health critical flows may be provided.

Step 4 - Site-specific risk considerations

Where allowing a mixing zone or a dilution allowance would pose unacceptable environmental risks, the discharge limitations will be based on achieving applicable narrative and numeric water quality criteria at the end-of-pipe. The existence of environmental risks may also be the basis for a site-specific mixing zone or dilution allowance. Such risk determinations will be made on a case-by-case and parameter-by-parameter basis. These decisions will take into account the designated and existing uses and all relevant site-specific environmental concerns, including the following:

1. ~~Bioaccummulation~~Bioaccumulation in fish tissues or wildlife.
2. Biologically important areas such as fish spawning areas.
3. Low acute to chronic ratio.
4. Potential human exposure to pollutants resulting from drinking water or recreational areas.
5. Attraction of aquatic life to the effluent plume.
6. Toxicity/persistence of the substance discharged.
7. Zone of passage for migrating fish or other species (including access to tributaries).
8. Cumulative effects of multiple discharges and mixing zones.

Step 5 - Complete mix procedures

For point source discharges to rivers/streams where available data are adequate to support a conclusion that there is near instantaneous and complete mixing of the discharge with the receiving water (complete mix) the full critical low flow or a portion thereof may be provided as dilution for chemical-specific and WET limitations. Such determinations of complete mixing will be made on a case-by-case basis using best professional judgement. Presence of an effluent diffuser that covers the entire river/stream width at critical low flow will generally be assumed to provide complete mixing. Also, where the mean daily flow of the discharge exceeds the chronic low stream flow of the receiving water, complete mixing will generally be assumed. In addition, where the mean daily flow of the discharge is less than or equal to the chronic low flow of the receiving water, it will generally be assumed that complete mixing does not occur unless otherwise demonstrated by the permittee. Demonstrations for complete mixing should be consistent with the study plan developed in cooperation with the states/tribes and environmental protection agency region VIII. Near instantaneous and complete mixing is defined as no more than a ten percent difference in bank-to-bank concentrations within a longitudinal distance not greater than two river/stream widths. For controlled discharges (lagoon facilities), the test of near instantaneous and complete mixing will be made using the expected rate of effluent discharge and the lowest upstream flow expected to occur during the period of discharge.

The following critical low flows shall be applied for streams and effluents:

Stream Flows	
Aquatic life, chronic	4-day, 3-year flow (biologically based*)**
Aquatic life, acute	1-day, 3-year flow (biologically based)

Human health (carcinogens)	Harmonic mean flow
Human health (noncarcinogens)	4-day, 3-year flow (biologically based) or 1-day, 3-year flow (biologically based)

Effluent Flows

Aquatic life, chronic	Mean daily flow
Aquatic life, acute	Maximum daily flow
Human health (all)	Mean daily flow

* Biologically based refers to the biologically based design flow method developed by the environmental protection agency. It differs from the hydrologically based design flow method in that it directly uses the averaging periods and frequencies specified in the aquatic life water quality criteria for individual pollutants and whole effluents for determining design flows.

** A 30-day, 10-year flow (biologically based) can be used for ammonia or other chronic standard with a 30-day averaging period.

Where complete mixing can be concluded and the environmental concerns identified in step 4 do not justify denying dilution, but are nevertheless significant, some portion of the critical low flows identified above may be provided as dilution. Such decisions will take site-specific environmental concerns into account as necessary to ensure adequate protection of designated and existing uses.

Step 6 - Incomplete mix procedures

This step addresses point source discharges that exhibit incomplete mixing. Because acute WET limits are achieved at the end-of-pipe in incomplete mix situations, this step provides mixing zone procedures for chronic aquatic life, human health, and WET limits, and ZID procedures for acute chemical-specific limits. Where a ZID is allowed for chemical limits, the size of the ZID shall be limited as follows:

Lakes:	The ZID volume shall not exceed ten percent of the volume of the chronic mixing zone.
Rivers and Streams:	The ZID shall not exceed ten percent of the chronic mixing zone volume or flow, nor shall the ZID exceed a maximum downstream length of one hundred feet, whichever is more restrictive.

The following provides guidelines for determining the amount of dilution available for dischargers that exhibit incomplete mixing.

Default Method

This method addresses situations where information needed for modeling is not available or there are concerns about potential environmental impacts of allowing a mixing zone. The default method provides a conservative dilution allowance.

Stream/river dischargers: Dilution calculation which uses up to ten percent of the critical low flow for chronic aquatic life limits or human health limits. However, this allowance may be adjusted downward on a case-by-case basis depending upon relevant site-specific information, designed and existing uses of the segment, and especially the uses of the segment portion affected by the discharge.

Lake/reservoir dischargers: Dilution up to a 4-to-1 ratio (twenty percent effluent) may be provided for chronic aquatic life analyses or human health analyses. However, this allowance may be adjusted downward on a case-by-case basis depending upon discharge flow, lake size, lake

flushing potential, designated and existing uses of the lake, and uses of the lake portion affected by the discharge.

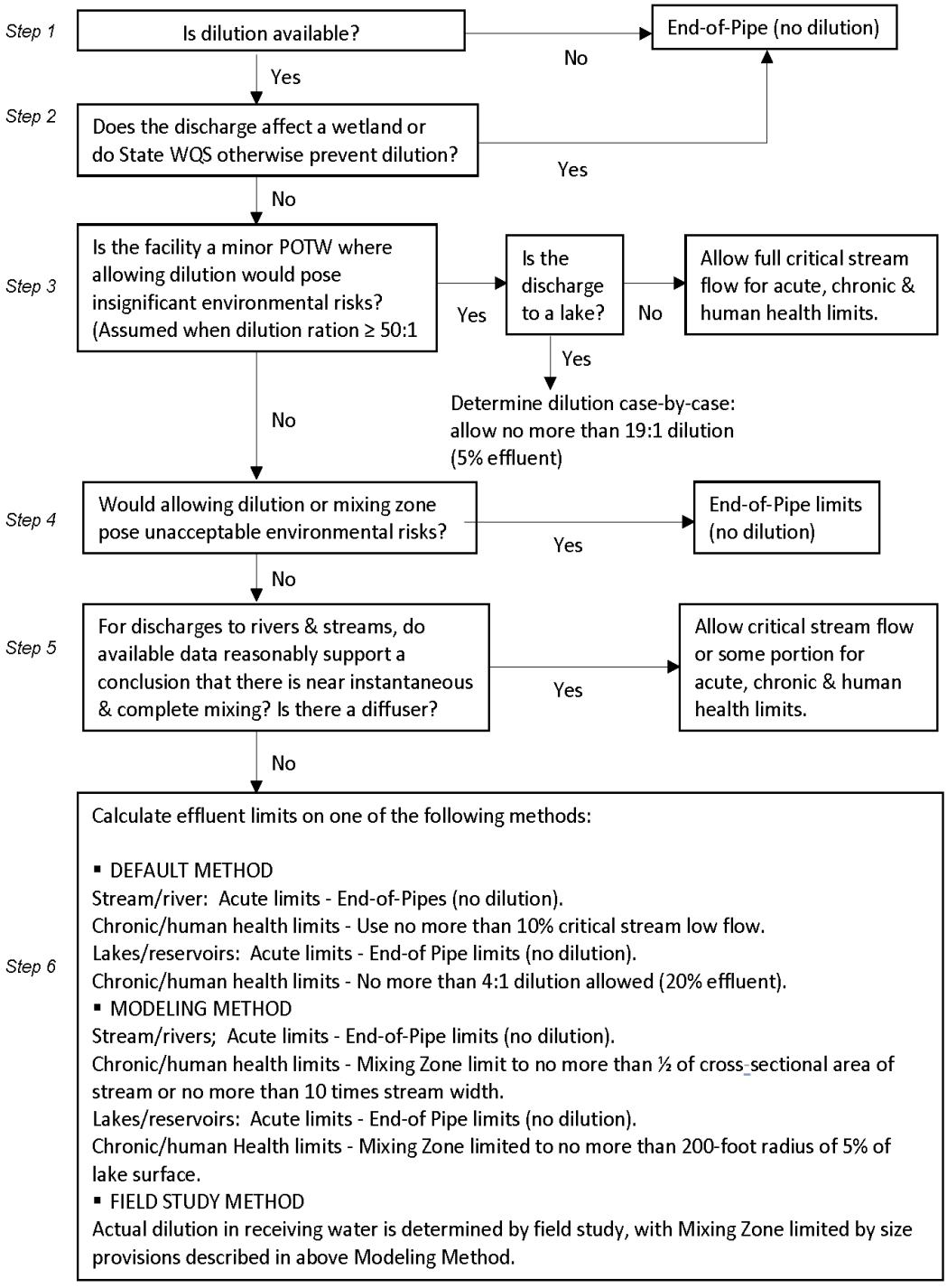
Modeling Method

An appropriate mixing zone model is used to calculate the dilution flow that will allow mixing zone limits to be achieved at the critical low flow. Prior to initiating modeling studies, it should be determined that compliance with criteria at the end-of-pipe is not practicable.

Field Study Method

Field studies which document the actual mixing characteristics in the receiving water are used to determine the dilution flow that will allow mixing zone size limits to be achieved at the critical low flow. For the purposes of field studies, "near instantaneous and complete mixing" is operationally defined as no more than a ten percent difference in bank-to-bank concentrations within a longitudinal distance not greater than two stream/river widths.

FIGURE 1
NORTH DAKOTA MODEL MIXING ZONE/DILUTION PROCEDURE*



*The procedure is applied to both chemical-specific and WET limits. In the case of complex discharges, the dilution of mixing zone may vary parameter-by parameter.

TITLE 45

INSURANCE, COMMISSIONER OF

JANUARY 2024

CHAPTER 45-01-01

45-01-01-01. Organization of insurance department.

1. **History and functions**. Section 12 of article V of the Constitution of North Dakota provides for the office of insurance commissioner. North Dakota Century Code title 26.1 contains statutes pertaining to the commissioner and the department. Besides administering and regulating all matters pertaining to insurance, the commissioner manages the state bonding fund, administers the state fire and tornado fund, ~~administers the petroleum tank release compensation fund, and administers the unsatisfied judgment fund~~and manages the state fire marshal.

2. **State fire marshal.** The state fire marshal is appointed by the insurance commissioner and supervises the operation of the fire marshal division. The division is responsible for enforcing state laws for prevention of fires; coordinating resources for large rural wild-land fires; storage, sale, and use of combustibles and explosives; installation and maintenance of fire alarms and fire extinguishing equipment; adequacy of exits from public buildings; investigation of arson and the cause and origin of fires and education on hazards of fire. The division also has responsibility for the state's emergency response to hazardous materials incidents and hazardous materials training.

3. **Inquiries**. Inquiries regarding the insurance department may be addressed to the commissioner:

   Commissioner
   Insurance Department
   600 East Boulevard Avenue
   Bismarck, North Dakota 58505

History: Amended effective January 1, 1982; August 1, 1983; March 1, 1986; January 1, 1992; February 1, 1993; April 1, 1994; June 1, 2003; January 1, 2009; October 1, 2019; January 1, 2024.
General Authority: NDCC 28-32-02.1
Law Implemented: NDCC 28-32-02.1

CHAPTER 45-03-15

45-03-15-01. Accounting practices and procedures.

Every insurance company doing business in this state shall file with the commissioner, pursuant to North Dakota Century Code section 26.1-03-07, the appropriate national association of insurance commissioners annual statement blank, prepared in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the March ~~2019~~2023 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance.

History: Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001; March 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; April 1, 2014; January 1, 2016; October 1, 2019; January 1, 2024.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-26, 26.1-03-07, 26.1-03-11.1

45-03-15-02. Reporting of financial information.

Every insurance company licensed to do business in this state shall transmit to the commissioner and to the national association of insurance commissioners its most recent financial statements compiled on a quarterly basis, within forty-five days following the calendar quarters ending March thirty-first, June thirtieth, and September thirtieth. The financial statements must be prepared and filed in the form prescribed by the commissioner and in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the March ~~2019~~2023 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance. The commissioner may exempt any company or category or class of companies from the filing requirement.

History: Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001; March 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; April 1, 2014; January 1, 2016; October 1, 2019; January 1, 2024.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-03, 26.1-02-26, 26.1-03-07, 26.1-03-11.1

CHAPTER 45-06-06.1

45-06-06.1-11. Rules related to fair marketing.

1. a. A small employer carrier shall actively market each of its health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of a health benefit plan unless the carrier has good cause and has received the prior approval of the commissioner.

   b. In marketing the basic and standard health benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state shall also be authorized to market the basic and standard health benefit plans.

2. a. A small employer carrier shall offer to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier all health benefit plans it actively markets to small employers. The offer shall be in writing and shall include at least the following information:

      (1) A general description of the benefits contained in the health benefit plans being offered to small employers in this state; and

      (2) Information describing how the small employer may enroll in the plans. The offer may be provided directly to the small employer or delivered through a producer.

   b. In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer is required to make reasonable disclosure to the employer, as a part of its solicitation and sales materials, of the availability of information described in this subsection; and upon request provide that information to the employer.

      Subject to the above, the information that must be provided is the provisions of coverage relating to the following:

      (1) The issuer's right to change premium rates and the factors that may affect changes in premium rates.

      (2) Renewability of coverage.

      (3) Any preexisting condition exclusion, including use of the alternative method of counting creditable coverage.

      (4) The geographic areas served by HMOs.

   c. (1) A small employer carrier shall provide a price quote to a small employer, directly or through an authorized producer, within ten working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer, directly or through an authorized producer, within five working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

      (2) A small employer carrier may not apply more stringent or detailed requirements related to the application process for the basic and standard health benefit plans than are applied for other health benefit plans offered by the carrier.

3. The small group carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer

carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of paragraph 2 of subdivision b of subsection 1 of North Dakota Century Code section 26.1-36.3-06.

4. A small employer carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

5. a. Carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this chapter. Carriers shall elicit the following information from applicants for such plans at the time of application:

   (1) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

   (2) Whether or not the prospective policyholder, certificate holder, or any prospective insured individual intends to treat the health benefit plan as part of plan or program under section 162 (other than section 162(1)), section 125, or section 106 of the United States Internal Revenue Code.

   b. If a small employer carrier fails to comply with subdivision a, the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with subdivision a.

~~6. a. A small employer carrier shall file annually the following information with the commissioner related to health benefit plans issued by the small employer carrier to small employers in this state:~~

~~(1) The number of small employers that were issued health benefit plans in the previous calendar year, separated as to newly issued plans and renewals;~~

~~(2) The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year, separated as to newly issued plans and renewals and as to class of business;~~

~~(3) The number of small employer health benefit plans in force in each county or by zip code of the state as of December thirty-first of the previous calendar year;~~

~~(4) The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;~~

~~(5) The number of small employer health benefit plans that were terminated or nonrenewed for reasons other than nonpayment of premium by the carrier in the previous calendar year; and~~

~~(6) The number of small employer health benefit plans that were issued to small employers that were uninsured for at least the three months prior to issue.~~

~~b. The information described in subdivision a shall be filed no later than March fifteenth of each year.~~

History: Effective August 1, 1994; amended effective December 1, 1997; January 1, 2024.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-36.3-11

CHAPTER 45-09-01

45-09-01-03. Surplus lines insurance producer must conduct search.

The licensed surplus lines insurance producer seeking the placement of nonadmitted insurance must conduct a diligent search to ascertain whether the insurance, indemnity contract, or surety bond can be procured from a company authorized to do business in this state. The surplus lines insurance producer may rely on a diligent search done by a licensed insurance producer or the insured if the surplus lines insurance producer deems it sufficient. ~~After the placing of any surplus lines insurance, the surplus lines insurance producer must complete and file with the commissioner a surplus lines affidavit confirming such a search has been done no later than March first for the quarter ending the preceding December thirty-first, June first for the quarter ending the preceding March thirty-first, September first for the quarter ending the preceding June thirtieth, and December first for the quarter ending the preceding September thirtieth of each year. The affidavit is not required if the insured is an exempt commercial purchaser as defined in North Dakota Century Code section 26.1-44-02.~~

History: Effective January 1, 1982; amended effective December 1, 2001; July 1, 2012; April 1, 2021; January 1, 2024.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-09. Statement of taxable premiums.

Repealed effective July 1, 2012.

APPENDIX I

Categories of Acceptable Surplus Lines Coverage

The following categories of surplus lines coverage are not the only lines which may be written in North Dakota. Other lines of coverage not on this list may be acceptable because of special underwriting considerations. Any exceptions must be fully explained on the surplus lines report of placement.

If the coverage written is in an approved category, there is a presumption that after diligent search the insurance, indemnity contract, or surety bond desired cannot be procured from a company authorized to do business in this state.

These categories may be changed from time to time at the discretion of the insurance commissioner subject to provisions of North Dakota Century Code chapter 28-32, the Administrative Agencies Practice Act.

1. Fiduciary liability.
2. Commercial cyber insurance (inclusive of first-party and/or third-party commercial cyber insurance coverage).
3. Professional liability (E & O) except for hospitals.
~~3.~~4. Directors and officers.
~~4.~~5. Ocean marine cargo, liability and hull.
~~5.~~6. Hazardous cargo and short-term trip transit.
~~6.~~7. Bridges (large).
~~7.~~8. Heavy woodworking property (unprotected, high-value sawmills).
~~8.~~9. Product liability (hazardous).
~~9.~~10. Ski lifts and tows' liability.
~~10.~~11. Fireworks, ammunition, fuse, cartridges, power, nitroglycerine, explosive gases.
~~11.~~12. Environmental impairment - pollution.
~~12.~~13. Kidnap ransom.
~~13.~~14. Oil and gas liability and marine.
~~14.~~15. Livestock mortality (high values and unusual).
~~15.~~16. Short tail (hole-in-one, 300 bowling score, etc.).
~~16.~~17. Large utilities (generation, transmission).
~~17.~~18. Building demolition and moving.
~~18.~~19. Mono line liquor legal liability.
~~19.~~20. Surcharged fire and allied lines excluding uncontrolled marine.
~~20.~~21. High-value substandard private passenger automobile.

~~21.~~22. Commercial automobile physical damage coverage in excess of rating organizations' filed rates.

~~22.~~23. Any excess liability coverages.

~~23.~~24. Day care liability insurance coverages.

History: Amended effective February 1, 1983; November 1, 1987; December 1, 2001; January 1, 2008; July 1, 2012; January 1, 2024.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

ARTICLE 45-10
PETROLEUM TANK RELEASE COMPENSATION FUND

[Repealed effective January 1, 2024]

~~Chapter~~
~~45-10-01 General Provisions [Superseded]~~
~~45-10-02 General Provisions~~

ARTICLE 45-12
NORTH DAKOTA BOILER RULES

[Repealed effective January 1, 2024]

~~Chapter~~

ARTICLE 45-18
FIRE MARSHAL

CHAPTER 45-18-01
FIRE PREVENTION

45-18-01-01. Fire prevention rules - Intent.

It is the intent of this chapter to prescribe regulations consistent with nationally recognized good practice for the safeguarding of life and property from the hazards of fire and explosions.

History: Effective January 1, 2024.
General Authority: NDCC 18-01-04
Law Implemented: NDCC 18-01-02

45-18-01-02. Fire prevention rules - Scope.

1. This chapter supplements all laws defined within the North Dakota Century Code relating to fire safety and applies to all persons without restrictions, unless specifically exempted.

2. This chapter applies to existing conditions, as well as to conditions arising after the adoption of this chapter, except that conditions legally in existence at the time of adoption of this chapter and, not in strict compliance with this chapter, shall be permitted to continue only if, in the opinion of the state fire marshal, they do not constitute a distinct hazard to life or property.

3. Where there is a conflict between this chapter and those provisions of the North Dakota Century Code, the provisions of the North Dakota Century Code shall prevail.

History: Effective January 1, 2024.
General Authority: NDCC 18-01-04, 18-01-33
Law Implemented: NDCC 18-01-02

45-18-01-03. Definitions.

The following definitions shall be used when referred to in the content of this chapter:

1. "Authority having jurisdiction", "bureau of fire prevention", "chief", "chief of the fire department", "chief of the fire prevention bureau", "fire chief", "fire code official", "fire department", "fire marshal", "fire marshal's office", "fire prevention bureau", "fire prevention engineer", "fire prevention inspector", "fire protection engineer", "inspector", or "office of the fire marshal" refers to the state fire marshal or any representative of the state fire marshal's office.

2. "City" or "jurisdiction" refers to the state of North Dakota.

3. "Fire prevention code", "fire prevention rules", or "state fire code" refers to the rules provided for within this chapter.

4. "Local jurisdiction" refers to any agency of local or state government which has a defined responsibility for any population, group of persons, land area, occupancy type, class of persons, or municipality located within this state which is less than the entire land area, population or geographical makeup of this state.

History: Effective January 1, 2024.
General Authority: NDCC 18-01-04, 18-01-33
Law Implemented: NDCC 18-01-04, 18-01-33

45-18-01-04. Fire prevention rules.

The fire prevention rules for this state include the following:

Fire code. The State Fire Code includes:

1. The provisions of the State Building Code, effective January 1, 2023, providing for fire-safe construction and operation, as provided for in North Dakota Century Code section 54-21.3-03.

2. The provisions of the International Fire Code (IFC), 2021 edition International Code Council (ICC), with the following exceptions and modifications:

a. Chapter 1. Scope and administration.

101.1 Title. The words "[NAME OF JURISDICTION]" are replaced with "North Dakota".

102.4 Application of building code. Insert "as amended by the State of North Dakota" after the words "International Building Code" in both instances.

103.1 Creation of agency. The words "[INSERT NAME OF DEPARTMENT]" is replaced with "North Dakota fire marshals division".

105.1.1 Permits required. The words "obtain the required permit" are replaced with "may be required to obtain a permit".

106.4 Retention of construction documents. Remove the words "One set of approved construction documents shall be returned to the applicant, and said set shall be kept on the site of the building or work at all times during which the work authorized thereby is in progress."

112.4 Violation penalties. Does not apply.

b. Chapter 2. Definitions.

Commercial motor vehicle. Commercial motor vehicle is amended to read as follows: "Refer to North Dakota Century Code section 39-06.2-02 for commercial motor vehicle definition."

Fireworks. Fireworks is amended to read as follows: "Refer to North Dakota Century Code chapter 23-15 for the fireworks definition."

Residential child care building. For the purposes of child care fire safety inspections, a residential child care building is defined as a maximum of 30 children in a building designed for residential purposes (i.e. single family dwelling, single apartment, etc.).

Commercial child care or preschool building. For the purposes of child care fire safety inspections, a commercial child care or preschool building is defined as any building licensed for over 30 children, or any building designed for commercial purpose regardless of the number of occupants.

c. Chapter 3. General requirements.

308.1.4 Open-flame cooking devices. Insert "or decks" after the word "balconies".

Exception 3. The words "2 ½ pounds [nominal 1 pound (0.454 kg)" is replaced with "47.8 pounds [nominal 20 pounds (9 kg)".

308.1.6.3 Sky lanterns. Does not apply.

308.3 Group A occupancies. Exception 1. The following is added: "1.4 Open-flame devices for food warming."

314.4 Vehicles. Insert "Batteries may remain connected if keys are not in ignition system." immediately after subsection 1's "safety features." as a subsection a. Delete "Fuel in fuel tanks does not exceed one-quarter tank or 5 gallons (19 L) (whichever is least)" and renumber accordingly.

d. Chapter 5. Fire service features.

510.1 Emergency responder radio coverage in new buildings. In the first sentence, replace "New" with "Where required by the fire code official, new".

e. Chapter 8. Interior finishes.

806.1.1 Restricted occupancies. Insert the following exception:

"3. For purposes of this provision, churches shall not be deemed public buildings and may utilize natural or resin-bearing cut trees in the alter area of the church. No electric lighting is allowed on the tree."

f. Chapter 9. Fire protection and life safety systems.

903.2.8 Group R. The following exception is added: after "fire area." add "Exception: Sprinklers are not required in single family dwellings or residential buildings that contain no more than two dwelling units and no higher risk occupancy within the same building."

903.3.1.1.1 Exempt locations is amended by adding the following exception:

"7. Elevator machine room and machinery spaces. Where sprinklers are not installed in elevator machine rooms, shunt trip required in accordance with IBC 3005.5 shall not be installed."

903.3.5 Water supplies. After the words "fire code official." add "Underground water supply piping shall be constructed of a material allowed by the North Dakota State Plumbing Code and shall be allowed to extend into the building through the slab or wall not more than 24 inches."

905.1.1 Standpipe hose. Add the following "The installation of the fire hose on standpipes may be omitted when approved by the fire code official. Approved standpipe hose valves and connections shall be provided where required."

907.8.3 Fire alarm system interface. Delete this paragraph in its entirety.

g. Chapter 10. Means of egress.

1009.8.1 System requirements. After the words "monitoring location" delete the words "or 9-1-1".

1103.5.1 Group A-2. After the word "Where" remove the words "alcoholic beverages are consumed" and immediately add the words "a state liquor license is applied for or, renewed or in-place".

h. Chapter 23. Wood.

2301.1 Scope. After the words "in accordance with this chapter and" insert the words "/or". After the words "International Mechanical Code" insert the words "NFPA 30 and NFPA 30A."

i. Chapter 61. Liquefied petroleum gases.

6101.3 Construction documents. After the word "Where" delete "a single LP gas container is more than 2,000 gallons (750 L) in water capacity or".

6108.1 General. After the words "(15,140 L)" insert "at the request of the AHJ".

History: Effective January 1, 2024.
General Authority: NDCC 18-01-04, 18-01-33, 18-09-02, 23-15-03
Law Implemented: NDCC 18-01-02, 18-01-04, 18-01-33, 18-09-02, 23-15-03

45-18-01-05. Availability of standards.

The standards listed in section 45-18-01-04 are available from:

1. National Fire Protection Association
   Batterymarch Park
   Quincy, Massachusetts 02269
   (617) 328-9290

2. International Code Council, Inc.
   4051 West Flossmoor Road
   Country Club Hills, IL 60478-5795
   (800) 214-4321

History: Effective January 1, 2024.
General Authority: NDCC 18-01-04, 18-01-33, 18-09-02, 23-15-03
Law Implemented: NDCC 18-01-02, 18-01-04, 18-01-33, 18-09-02, 23-15-03

TITLE 61

STATE BOARD OF PHARMACY

JANUARY 2024

CHAPTER 61-01-01

61-01-01-01. Organization of board of pharmacy.

1. **History and functions.** The 1890 legislative assembly passed pharmacy practice legislation codified as North Dakota Century Code chapter 43-15. This chapter requires the governor to appoint a state board of pharmacy. The board is responsible for examining and licensing applicants for licensure as pharmacists, for issuing permits to operate pharmacies, and for regulating and controlling the dispensing of prescription drugs and the practice of pharmacy for the protection of the health, welfare, and safety of the citizens of the state. The board is to operate and maintain the state's prescription drug monitoring program.

2. **Board membership.** The board consists of seven members appointed by the governor. Five members of the board must be licensed pharmacists, one member must be a registered pharmacy technician, and one member must represent the public and may not be affiliated with any group or profession that provides or regulates any type of health care. Board members serve five-year terms, with one of the pharmacist's terms expiring each year. The term of the public member and registered pharmacy technician member will expire five years from May eighth in the year of their appointment.

3. **Executive director.** The executive director of the board is appointed by the board and is responsible for administration of the activities of the board.

4. **Inquiries.** Inquiries regarding the board may be addressed to the executive director:

   State Board of Pharmacy
   P.O. Box 13541838 East Interstate Avenue Suite D
   Bismarck, ND 58502-135458503
   Street address - 1906 East Broadway Avenue
   Web address - www.nodakpharmacy.com
   Telephone - 701-328-9535701-877-2404
   Fax - 701-328-9536701-877-2405

History: Amended effective August 1, 1983; November 1, 1985; October 1, 1987; February 1, 1993; April 1, 1994; January 1, 2000; January 1, 2004; April 1, 2010; October 1, 2019; January 1, 2024.
General Authority: NDCC 28-32-02.143-15-10(4)
Law Implemented: NDCC 28-32-02.143-15-10(4)

61-02-01-03. Pharmaceutical compounding standards.

The minimum standards and technical equipment to be considered as adequate shall include:

1. Definitions.

   a. "Active chemical or ingredient" refers to chemicals, substances, or other components of articles intended for use in the diagnostics, cure, mitigation, treatment, or prevention of diseases.

   b. "Aseptic processing" is the method of preparing pharmaceutical and medical products that involves the separate sterilization of the product and of the package, the transfer of the product into the container and closure of the container under ISO class 5 or superior conditions, and using procedures designed to preclude contamination of drugs, packaging, equipment, or supplies by micro-organisms during the process.

   c. "Beyond-use date" refers to the date placed on preparation label that is intended to indicate to the patient or caregiver a time beyond which the contents of the preparation are not recommended to be used. The beyond-use date is determined from the date and time compounding of the preparation is completed.

   d. "Component" is any ingredient used in the compounding of a drug product, including any that are used in its preparation, but may not appear on the labeling of such a product.

   e. "Compounded sterile preparation" (CSP) will include all of the following:

      (1) Preparations prepared according to the manufacturer's labeled instructions and other manipulations when manufacturing sterile products that expose the original contents to potential contamination.

      (2) Preparations containing nonsterile ingredients or employing nonsterile components or devices that must be sterilized before administration.

      (3) Biologics, diagnostics, drugs, nutrients, and radiopharmaceuticals that possess either of the above two characteristics, and which include baths and soaks for live organs and tissues, implants, inhalations, injections, powders for injection, irrigations, metered sprays, and ophthalmic preparations.

   f. "Compounder or compounding personnel" is the pharmacist or other licensed or registered health care professional responsible for preparing the compounded preparations.

   g. "Compounding" is the preparation, mixing, assembling, packaging, and labeling of a drug or device in accordance to a licensed practitioner's prescription or medication order. Compounding does not include tablet splitting, reconstitution of oral or topical products as intended by the manufacturer, or repackaging of nonsterile dosage forms for redistribution, dispensing, or administration. Compounding includes:

      (1) Preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns.

      (2) The addition of one or more ingredients to a commercial product as a result of a licensed practitioner's prescription drug order.

      (3) Preparation of drugs or devices for the purposes of, or as an incident to, research, teaching, or chemical analysis.

(4) Categories of compounding.

(a) Nonsterile simple. Should be conducted according to USP chapter 795.

(b) Sterile compounds. Risk levels of compounded sterile preparations. Risk levels are assigned according to the corresponding probability of contaminating a preparation with microbial organisms, spores, and endotoxins, or chemical and physical contamination such as foreign chemicals and physical matter. Preparations should be compounded according to USP chapter 797 based on the appropriate risk level.

(c) Radiopharmaceuticals. See article 61-05.

(d) Veterinary pharmaceuticals. Standards for veterinary pharmaceuticals are consistent with all parts of section 61-02-01-03.

h. "Compounding supervisor" is a person who supervises and is responsible for the compounding and dispensing of a nonsterile or sterile preparation. This may be the pharmacist on duty or the pharmacist-in-charge.

i. "Critical site" is a location that includes any component or fluid pathway surfaces (such as injection ports) or openings (such as opened ampules or needle hubs) exposed and at risk of direct contact with air, moisture, or touch contamination.

j. "Direct and contiguous compounding area" refers to the specific area where a compound is prepared.

k. "Disinfection" is the process by which the total number of micro-organisms is reduced to a safe level or eliminated by applying an agent to inanimate objects that destroys disease-causing pathogens or other harmful micro-organisms but may not kill bacterial and fungal spores.

l. "Hazardous drug" is one of those which studies in animals or humans indicate that exposures to them have a potential for causing cancer, development, or reproductive toxicity or harm to organs.

m. "ISO class" is a description of an atmospheric environment characterized by the number of particles of 0.5 microns or larger, within a cubic foot of air. "ISO class 5" atmospheric environment contains less than 100 particles, 0.5 microns or larger in diameter, per cubic foot of air.

n. "Media fill test" refers to tests used to validate aseptic techniques of compounding personnel and of processes that ensure the personnel and processes used are able to produce sterile products without microbial contamination. Testing uses a microbiological growth medium to substitute for actual drug product to simulate admixture compounding in determining the quality of a person's technique.

o. "NDC number" is the national drug code given to each drug separately and specifically approved by the food and drug administration for identification and reporting.

p. "Preparation" is a drug dosage form, dietary supplement, or a finished device. It contains one or more substances formulated for use on or for the patient or consumer.

q. "Primary engineering control (PEC)" refers to a device or room that provides an ISO class 5 or superior environment during the compounding process, including laminar airflow workbenches (LAFWs), biological safety cabinets (BSCs), compounding aseptic isolators (CAIs), and compounding aseptic containment isolators (CACIs).

r. "Product" is a commercially manufactured drug or nutrient that has been evaluated for safety and efficacy by the food and drug administration, accompanied by full prescribing information.

s. "Repackaging" is the transfer of an ingredient from one container to another.

t. "Risk levels" of CSPs determine the level assigned that represent the probability that it will be contaminated with microbial organisms, spores, endotoxins, foreign chemicals, or other physical matter.

u. "Seventy percent sterile isopropyl" or IPA is an antimicrobial used to clean surfaces used in sterile preparations.

v. "Stability" means the extent to which a preparation retains, with specified limits, and throughout its period of storage and use, the same properties and characteristics it possessed at the time of compounding.

w. "US pharmacopeia (USP)" is the book of official compendia of standards for the United States.

2. General compounding.

a. Responsibility of the compounder.

(1) Personnel engaging in compounding must be proficient, capable, and qualified to perform assigned duties in the compounding area while expanding the individual's knowledge of compounding through seminars or appropriate literature.

(2) Compounding personnel must be familiar with USP standards and North Dakota regulations, including:

(a) Certifying all prescriptions orders.

(b) Approving or rejecting all components, drug product containers, closures, in-process materials, and labeling ensuring preparations and ingredients are of acceptable strength, quality, and purity, with appropriate packaging.

(c) Preparing and reviewing all compounding records to assure that errors have not occurred in the compounding process and the finished product has expected qualities as well as implementing procedures to prevent cross-contamination.

(d) Assuring the proper maintenance, cleanliness, sanitization, and use of all equipment used in prescription compounding practice, including the direct and contiguous compounding area allowing for the compounding environment to be suitable for its intended purpose.

(e) Assuring that the drug product and components of drug products are not on the list of federally recognized drug products that have been withdrawn or removed from the market for public health reasons.

(3) Policies and procedures must be established concerning washing and donning the appropriate clothing specific to the type of process performed to protect the personnel from chemical exposures and prevent drug contamination.

b. Training. All compounding supervisors and all personnel involved in compounding must be well trained and must participate in current, relevant training programs. All training

activities will be covered by standard operating procedures and must be properly documented. Steps in the training procedure include:

(1) Be familiar with pharmaceutical compounding and nonsterile compounding (USP 795), pharmaceutical compounding and sterile compounding (USP 797), hazardous drug compounding (USP 800), and pharmaceutical calculations in prescription compounding (USP 1160).

(2) Be familiar with all procedures relating to compounding specific to the individual's facility, equipment, personnel, compounding process, evaluation, packaging, storage, and dispensing.

(3) Compounding supervisors must be responsible to follow the instructions below to show that personnel are appropriately trained:

(a) Demonstrate compounding procedures to compounding personnel.

(b) Guide personnel through the compounding process with assistance.

(c) Observe personnel performing a compound without assistance but under supervision.

(d) Review the compound, correct mistakes, and answer questions concerning compounding and associated processes.

(e) Confirm verbal and functional knowledge of the personnel concerning compounding.

(f) Have personnel perform a compounding procedure without supervision, yet checking off the final preparation.

(g) If properly compounded and when satisfied, sign the documentation records confirming appropriate training.

(h) Continually monitor the work of the personnel, including calculations.

(4) The pharmacist on duty and the pharmacist-in-charge are ultimately responsible for the finished product.

c. Procedures and documentation. Procedures must be developed for the facility, equipment, personnel, preparation, packaging, and storage of the compounded preparation to ensure accountability, accuracy, quality, safety, and uniformity in compounding. This allows for a compounder, whenever necessary, to systematically trace, evaluate, and replicate the steps included throughout the preparation process of a compounded preparation.

d. Nonsterile drug compounding must meet the facility, equipment, packaging, storage, and beyond-use date standards set in USP chapter 795. Policies and procedures should be developed to ensure compliance with those standards.

e. Compounding controls for nonsterile preparations.

(1) The compounder must ensure that the written procedures for compounding are available electronically or in hard copy and assure the finished products have the correct identity, strength, quality, and purity.

(2) Procedures must be established that give a description of the following:

(a) Components and their amounts.

(b) Order of component additives.

(c) Compounding process.

(d) Drug product.

(e) Required equipment and utensils, including container and closure systems.

(3) The compounder will accurately weigh, measure, and subdivide all components as appropriate.

(a) The compounder must check and recheck each procedure at each point of the process to ensure that each weight or measure is correct.

(b) If a component is transferred from the original container to another, the new container must be identified with the component, name, weight or measure, the lot or control number, the expiration or beyond-use date, and the transfer date.

(4) The compounder must write procedures that describe the tests or examinations that prove uniformity and integrity of the compounded preparations.

(5) Control procedures must be established to monitor the output and validate the performance of compounding personnel that affect variability of final preparations, such as:

(a) Capsule weight variation.

(b) Adequacy of mixing to assure uniformity and homogeneity.

(c) Clarity, completeness, or pH of solutions.

(6) The compounder must establish an appropriate beyond-use date for each compounded preparation.

(7) Facilities engaging in compounding must have a specifically designated and adequate space for orderly compounding, including the placement and storage of equipment and materials.

f. Labeling of nonsterile preparations.

(1) The compounder's preparation label must contain all information required by North Dakota state law and accepted standards of practice found under chapter 61-04-06, prescription label requirements, plus the beyond-use date and assigned lot number.

(2) The compounder must label any excess compounded products so as to refer to the formula used.

(3) Preparations compounded in anticipation of a prescription prior to receiving a valid prescription should be made in a regularly used amount based on the history of prescriptions filled and they should be labeled with:

(a) Complete list of ingredients or preparation time and reference or established chemical name or generic name.

(b) Dosage form.

(c) Strength.

(d) Preparation date and time.

(e) Inactive ingredients.

(f) Batch or lot number.

(g) Assigned beyond-use date.

(h) Storage conditions.

(4) The compounder must examine the preparation for correct labeling after completion.

g. Records and reports for nonsterile preparations.

(1) Records must be maintained, including a hard copy of the prescription with formulation and compounding records.

(2) Adequate records of controlled substances used in compounds.

(3) All records must be kept for five years according to North Dakota state law and be available for inspection.

(4) Formulation record provides a consistent source document for preparing the preparation to allow another compounder to reproduce the identical prescription at a future date and must list:

(a) Name, strength, and dosage form of the preparation compounded.

(b) All ingredients and their quantities.

(c) Equipment needed to prepare the preparation, when appropriate.

(d) Mixing instructions including order of mixing, mixing temperatures, and other valid instructions, such as duration of mixing.

(e) Assigned beyond-use date.

(f) Container used in dispensing.

(g) Storage requirements.

(h) Any quality control procedures.

(5) Compounding record documents the actual ingredients in the preparation and the person responsible for the compounding activity and includes:

(a) Name and strength of the compounded preparation.

(b) The formulation record reference.

(c) Sources and lot numbers of the ingredients.

(d) Total number of dosage units compounded.

(e) Name of compounding personnel who prepared the preparation.

(f) The date of preparation.

(g) The assigned internal identification number, lot number, and prescription numbers.

(h) Assigned beyond-use date.

(i) Results of all quality control procedures.

(6) Temperature log records the daily monitoring of temperatures in the storage area specifically for the controlled room temperature, refrigerator, freezer, or incubator.

3. Nonsterile compounding. Compounders are to use the following steps to minimize error and maximize the prescriber's intent, specifics can be found in pharmaceutical compounding - nonsterile compounding (USP 795):

a. Judge the suitability of the prescription of the preparation in terms of safety and intended use.

b. Perform necessary calculations to establish the amounts of ingredients needed.

c. Identify equipment and utensils needed.

d. Don the proper attire and properly wash hands and arms.

e. Clean the compounding area and needed equipment.

f. Only one prescription can be compounded at a time in the specified compounding area.

g. Assess weight variation, adequacy of mixing, clarity, odor, color consistency, and pH as appropriate of the completed preparation.

h. Annotate the compounding and formulation records.

i. Label the prescription containers appropriately.

j. Sign and date the prescription or compounding record affirming that all procedures were carried out to ensure uniformity, identity, strength, quantity, and purity.

k. Thoroughly clean all equipment immediately when finished.

4. Compounding process for compounded sterile preparations. Compounders are to follow the USP chapter 797 standards and use the following steps to minimize error and maximize the prescriber's intent:

a. Judge the suitability of the prescription for the compounded sterile preparation in terms of safety and intended use.

b. Perform necessary calculations to establish the amounts of ingredients needed.

c. Identify equipment and utensils needed for the preparation of the compounded sterile preparation.

d. Sterile compounding areas and critical areas must be structurally isolated from other areas designated to avoid unnecessary traffic and airflow disturbances according to USP chapter 797, separate from nonsterile compounding areas, and restricted to qualified compounding personnel.

e. Policies and procedures must be established in accordance with USP chapter 797 for personnel cleaning and garbing for protection and avoidance of containment.

f. Clean and sanitize the compounding area and needed equipment according to USP chapter 797.

5. Facilities for sterile compounding should conform with USP chapter 797.

6. Equipment specific for sterile compounding should conform with USP chapter 797.

7. Poison record book and suitable prescription files.

8. Suitable current reference sources either in book or electronic data form (available in the pharmacy or online) which might include the United States Pharmacopeia and National Formulary, the United States Pharmacopeia Dispensing Information, Facts & Comparisons, Micro Medex, the ASHP Formulary, Clinical Pharmacology, or other suitable references determined by the board which are pertinent to the practice carried on in the licensed pharmacy.

9. Compounding for office use.

   a. It is acceptable to compound human drug products to be used by North Dakota practitioners in their office for administration to patients provided they are prepared by a facility licensed as an outsourcing facility in accordance to North Dakota Century Code section 43-15.3-13 or by a resident North Dakota pharmacy. It is acceptable for a North Dakota licensed pharmacy to obtain a compounded human drug from a licensed outsourcing facility and dispense it to a patient.

   b. It is acceptable for any licensed pharmacy to compound veterinary drug products to be used by veterinarians in their office for administration to client's animals. These compounded office use products may be dispensed to clients for use in a single treatment episode, not to exceed a one hundred twenty-hour supply.

   c. Sales to other pharmacies, veterinarians, clinics, or hospitals are manufacturing and are not allowed. It is the responsibility of the pharmacy and pharmacist involved in the compounding to ensure compliance with this section for the products they compound.

10. Compounding of hazardous drugs.

   a. Hazardous drugs shall be prepared under conditions that protect the health care worker and other personnel in the preparation and storage areas according to USP chapter 800. Appropriate personnel protective equipment shall be worn when compounding hazardous drugs according to USP chapter 800.

   b. Hazardous drugs shall be stored and prepared separately from other nonhazardous drugs in a manner to prevent contamination and personnel exposure according to USP chapter 800.

   c. Hazardous drugs shall be handled by the pharmacy according to USP chapter 800.

   d. All personnel who compound hazardous drugs shall be fully trained in the storage, handling, and disposal of these drugs according to USP chapter 800.

History: Amended effective August 1, 1983; April 1, 1988; October 1, 1999; December 1, 2003; April 1, 2012; April 1, 2017; December 1, 2019; January 1, 2024.
General Authority: NDCC ~~28-32-02, 43-15-10(9), 43-15-10(12), 43-15-10(14)~~43-15-10(9)(12)(14), 43-15-35(2), ~~43-15-35(3),~~ 43-15-36
Law Implemented: NDCC ~~28-32-03, 43-15-10(9), 43-15-10(12), 43-15-10(14)~~43-15-10(9)(12)(14), 43-15-35(2), ~~43-15-35(3),~~ 43-15-36

CHAPTER 61-02-07.1

61-02-07.1-02. Definitions.

1. "Pharmacy technician" means a person registered by the board of pharmacy who is employed by a pharmacy under the responsibility of the pharmacist-in-charge or a staff pharmacist so designated by the pharmacist-in-charge, to assist in the technical services of preparing pharmaceuticals for final dispensing by a licensed pharmacist in compliance with subsection 4 of North Dakota Century Code section 43-15-01 and subsection 16 of North Dakota Century Code section 43-15-01.

2. "Pharmacy technician in training" is a person who is enrolled in an academic experiential rotation program ~~of North Dakota state college of science or in an on-the-job self-instructioned pharmacy technician study program under the supervision of a licensed pharmacist~~accredited by the american society of health systems pharmacists (ASHP)/accreditation council for pharmacy education (ACPE). A pharmacy technician in training, as they progress through their training program, may perform any of the duties of a registered pharmacy technician at the discretion of the pharmacist in charge and the pharmacist supervising their training program unless otherwise specified in the rules.

3. "Supportive personnel" means a person other than a licensed pharmacist, pharmacy intern, or pharmacy technician who may be performing duties assigned by the pharmacist under direct supervision.

History: Effective October 1, 1993; amended effective July 1, 1996; January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10(12)(14)(19)
Law Implemented: NDCC ~~28-32-03~~43-15-10(12)(14)(19)

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, or copy thereof, must be ~~displayed and visible to the public~~available or on file 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 or make the necessary update on the board's website. 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. Evidence of current certification by a national certification body approved by the board of pharmacy meets this requirement.

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; January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10(12)(14)(19)
Law Implemented: NDCC ~~28-32-03~~43-15-10(12)(14)(19), 43-51-11, 43-51-11.1

61-02-07.1-12. Technicians checking technicians.

Activities allowed by law to be performed within a licensed pharmacy by a registered pharmacy technician in the preparation of a prescription or order for dispensing or administration may be performed by one registered pharmacy technician, who may be a technician in training and verified by another registered pharmacy technician who may not be a technician in training, working in the same licensed pharmacy, under the following conditions:

1. The licensed pharmacy where the work is being conducted has policies and procedures specifically describing the scope of the activities to be verified through this practice, included in the policy and procedure manual required under section 61-02-01-18.

    a. Training for the specific activity is reflected in a written policy.

    b. A record of the individuals trained is maintained in the pharmacy for two years.

2. The pharmacy has a continuous quality improvement system in place to periodically verify the accuracy of the final product, including:

   a. Recording any quality related events leading up to the final dispensing or administration of the drug prepared.

   b. Recording any errors which actually reach the patient as a result of these activities.

   c. Specific limits of acceptable quality related event levels before reassessment is required.

   d. Consideration must be made for high-risk medications on the institute for safe medication practices (ISMP) list and specific monitoring, review, and quality assurance parameters must be instituted if any of these products are included in the pharmacy's technicians-checking-technicians program.

3. Any error must trigger pharmacist review of the process. This review and subsequent recommendations must be documented.

4. The pharmacy has a system in place to review all quality related events and errors recorded and takes corrective action based on the information to reduce quality related events and eliminate errors reaching the patient.

5. As always, the pharmacist-in-charge and the permitholder are jointly responsible for the final product dispensed or released for administration from the pharmacy.

History: Effective January 1, 2009; amended effective October 1, 2014; January 1, 2024.
General Authority: NDCC ~~28-32-02~~43-15-10(12)(14)(19)
Law Implemented: NDCC ~~28-32-03~~43-15-10(12)(14)(19)

61-02-07.1-13. Pharmacy technician reinstatement.

If a registered pharmacy technician fails to pay the fee for a renewal registration within the time required, the executive director of the board shall cancel the registration for nonpayment. Upon application, the delinquent registrant may procure a renewed registration once the payment of all back registration fees, late fees, up to a maximum of five years and proof of ten hours of continuing pharmaceutical education obtained within the past year are submitted, evidence of current certification by a national certification body approved by the board of pharmacy meets this requirement, provided there have been no disciplinary actions involved with the registration and the board is satisfied that the applicant is a proper person to receive the same.

History: Effective January 1, 2011; amended effective January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10(12)(14)(19)
Law Implemented: NDCC ~~28-32-03,~~ 43-15-10(12)(14)(19)

CHAPTER 61-03-01

61-03-01-01. Applications.

All applicants for licensure by examination as pharmacists must appear in person before the board of pharmacy at a meeting scheduled for examination of applicants for licensure. ~~Applications must be in the hands of the secretary of the board three days before the examination.~~ All applications must be accompanied by affidavits ~~from former employers~~of graduation and hours of internship, showing that the applicant has ~~had the experience required under a licensed pharmacist, as required by~~met the requirements of North Dakota Century Code section 43-15-15.

History: Amended effective January 1, 2024.
General Authority: NDCC 43-15-19
Law Implemented: NDCC 43-15-19

61-03-01-02. Approved schools.

~~**The board of pharmacy designates as approved schools all**~~

1. All colleges of pharmacy which ~~are members of the American association of colleges of pharmacy or maintain standards equivalent to those required for membership in that association, and~~ have been accredited by the accreditation council for pharmacy education (ACPE).

2. All schools of pharmacy accredited by the Canadian council for accreditation of pharmacy programs (CCAPP).

History: Amended effective October 1, 2007; January 1, 2024.
General Authority: NDCC 43-15-15
Law Implemented: NDCC 43-15-15

61-03-01-03. Score required.

An applicant for licensure as a pharmacist in North Dakota by examination or ~~reciprocity~~license transfer must obtain a passing score ~~of seventy-five~~ in any written, oral, or practical laboratory examination required by the board.

History: Amended effective August 1, 1983; June 1, 1986; January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10(3)(12)(14), 43-15-19
Law Implemented: NDCC ~~28-32-03,~~ 43-15-10(3)(12)(14), 43-15-19

61-03-01-04. Licensure transfer.

1. An applicant seeking licensure by licensure transfer ~~or reciprocity~~ must secure and file an electronic license transfer 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.

3. An applicant who holds a pharmacy license in Canada that is in good standing and meets all of the following:

a. The applicant has passed the NAPLEX or both part I and part II of the pharmacy examining board of Canada (PEBC) pharmacists qualifying examination.

b. The applicant completed educational requirements for a pharmacist license from a school of pharmacy accredited by ACPE or accredited by the canadian council for accreditation of pharmacy programs (CCAPP).

c. The applicant held a pharmacist license for one year in Canada and they have acquired a minimum of one thousand five hundred hours of pharmacy practice either through an approved internship or hours engaged in the practice as a pharmacist.

d. The applicant must pass the North Dakota law examination and pay the appropriate fees to obtain licensure.

History: Amended effective April 1, 2016; April 1, 2020; January 1, 2022; January 1, 2024.
General Authority: NDCC ~~28-32-02~~43-15-10(3), 43-15-22
Law Implemented: NDCC 43-15-22, 43-51-11, 43-51-11.1

61-03-01-07. Posting of certificate.

Each ~~pharmacist shall post the~~ pharmacist's certificate or renewal thereof ~~in a conspicuous place~~must be available or on file in the pharmacy in which the pharmacist is practicing the pharmacist's profession.

History: Amended effective January 1, 2024.
General Authority: NDCC 43-15-10(9)
Law Implemented: NDCC 43-15-10(9), 43-15-25

61-03-01-09. Inactive status.

Any pharmacist holding a certificate of licensure as a pharmacist in North Dakota may go on inactive status, and continue to hold a certificate of licensure in North Dakota, provided that the pharmacist on inactive status may not practice pharmacy within North Dakota. A pharmacist on inactive status may not be required to meet the requirements of continuing pharmaceutical education as required by North Dakota Century Code section 43-15-25.1 or rules of the boards under chapter 61-03-04. In order for a pharmacist to change an inactive status certificate of licensure to an active status of licensure, the pharmacist will have to complete ~~internship hours and~~ continuing education hours as determined by the board, based on the length of time of inactive status, and then must comply with continuing pharmaceutical education requirements of the board and state of North Dakota thereafter.

History: Effective April 1, 1988; amended effective January 1, 2005; January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10(2)(12)(14), 43-15-15, 43-15-25.1
Law Implemented: NDCC ~~28-32-02,~~ 43-15-10(2)(12)(14), 43-15-15, 43-15-25.1

61-03-01-10. Reinstatement procedures.

~~If a licensed pharmacist in this state fails to pay the fee for a renewal of a license within the time required, the director of the board shall mail the pharmacist a notice, addressed to the pharmacist's last-known place of residence, notifying the pharmacist of failure to obtain a renewal license. The delinquent licenseholder, within sixty days after the notice is mailed, may procure a renewal license upon the payment of a renewal fee to be set by the board not to exceed two hundred dollars. If the licenseholder fails to have a license renewed within sixty days after the notice is mailed, the original or renewal license, as the case may be, becomes void and the registry thereof must be canceled. The board, on application of the delinquent licenseholder and upon the payment of all unpaid fees, may authorize the issuance of a new license without examination, if it is satisfied that the applicant is a proper person to receive the same. The board may require reexamination or completion of internship and continuing education hours as determined by the board.~~If a licensed pharmacist fails to pay the fee for a renewal of a license within the time required, the executive director of the board shall cancel the license for nonpayment. Upon application, the delinquent licensee may procure a renewed license once the payment of all back licensure fees and proof of fifteen hours of continuing pharmaceutical education obtained within the past year are submitted, provided there have been no disciplinary actions involved with the licensee and the board is satisfied that the applicant is a proper person to receive the same.

History: Effective January 1, 2005; amended effective January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10(2)(12)(14), 43-15-15, 43-15-25.1
Law Implemented: NDCC 43-15-26

ARTICLE 61-04
PROFESSIONAL PRACTICE

CHAPTER 61-04-10
CLIA WAIVED LABORATORY TESTS

61-04-10-01. Definitions.

For purposes of this chapter:

1. "CLIA" means the federal Clinical Laboratory Improvement Act of 1988, as amended.

2. "OSHA" means the federal occupational safety and health administration.

~~3. "Portfolio review" means a review by the board of a pharmacist's records of training logs, control testing logs, and records of patient tests performed to determine that a pharmacist is continuously and consistently providing a service in a quality and competent manner.~~

History: Effective December 1, 1999; amended effective April 1, 2016; January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10
Law Implemented: NDCC 43-15-10(12)(14), 43-15-25.3

61-04-10-02. Education requirements for pharmacists or pharmacy technicians to perform CLIA waived laboratory tests.

A pharmacist and each pharmacy technician delegated must meet the following requirements in order to perform CLIA waived laboratory tests authorized by North Dakota Century Code section 43-15-25.3 or added to the list as allowed by section 61-04-10-06:

1. Successfully complete training and education that incorporates, at a minimum:

   a. Infection control;

   b. OSHA requirements;

   c. Proper technique to collect laboratory specimens;

   d. Recognized screening and monitoring values;

   e. Quality control; and

   f. The manufacturers' instructions for the waived tests being performed.

~~2. Obtain and recertify the CLIA waived certificate every two years.~~

History: Effective December 1, 1999; amended effective April 1, 2016; January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10
Law Implemented: NDCC 43-15-10(12)(14)(19), 43-15-25.3

61-04-10-04. Proper CLIA registration.

The pharmacist-in-charge of a licensed pharmacy performing tests or any pharmacist operating in a facility not licensed by the board is responsible for ensuring that the ~~pharmacy performing the CLIA waved test~~location has a ~~proper~~current CLIA waived certificate.

History: Effective December 1, 1999; amended effective April 1, 2016; January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10
Law Implemented: NDCC 43-15-10(12)(14), 43-15-25.3

61-04-10-05. Notification of the board of pharmacy.

Repealed effective January 1, 2024.

~~The pharmacist-in-charge of a licensed pharmacy that has obtained a CLIA certificate or any pharmacist operating in a facility not licensed by the board of pharmacy must notify the board prior to the initial performance of any CLIA waived tests.~~

~~**History:** Effective December 1, 1999; amended effective April 1, 2016.~~
~~**General Authority:** NDCC 28-32-02, 43-15-10~~
~~**Law Implemented:** NDCC 43-15-25.3~~

61-04-10-06. Exempt tests and methods.

An individual licensed or registered by the board, performing the following food and drug administration-waived tests and using the following methods, is exempt from the provisions of North Dakota Century Code chapter 43-48:

1. Total cholesterol, HDL cholesterol, LDL cholesterol, and triglycerides test by any accepted method.

2. Any of the following tests by nonautomated or automated urinalysis by dipstick:

   a. Bilirubin.

   b. Blood.

   c. Glucose.

d. Ketone.

e. Leukocyte.

f. Nitrate.

g. Potential of hydrogen (pH).

h. Protein.

i. Specific gravity.

j. Urobilinogen.

3. Fecal occult blood by any accepted method.

4. Ovulation test by visual color comparison.

5. Qualitative urine pregnancy test by visual color comparison.

6. Erythrocyte sedimentation rate by any accepted nonautomated method.

7. Whole blood glucose by any accepted single analyte method.

8. Spun microhematocrit by any accepted method.

9. Hemoglobin by single analyte instrument or manual copper sulfate method.

10. Any of the following tests by immunoassay using a rapid test device that detects antibodies or antigens:

a. Helicobacter pylori.

b. Influenza.

c. Mononucleosis.

d. Streptococcus group A.

e. Hepatitis C virus.

f. Respiratory syncytial virus.

11. Prothrombin time international normalized ratio by mechanical endpoint.

12. Antibodies to human immunodeficiency virus types 1 and 2.

13. Nicotine or cotinine test by urine.

14. Thyroid stimulating hormone test by blood.

15. Bone mass and bone mineral density test by any accepted method.

16. Drug screening tests by urine.

History: Effective April 1, 2016; amended effective January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10
Law Implemented: NDCC 43-15-10(12)(14), 43-15-25.3

61-04-10-07. Delegation to registered pharmacy technicians.

Under the responsibility of the pharmacist-in-charge or pharmacist, a registered pharmacy technician may assist in performing CLIA waived laboratory tests. The registered pharmacy technician must have met the education requirements in section 61-04-10-02. The responsible pharmacist may not delegate the interpretation of the result of a CLIA waived test or clinical education of the patient to the registered pharmacy technician.

History: Effective January 1, 2024.
General Authority: NDCC 43-15-10
Law Implemented: NDCC 43-15-10(12)(14)(19), 43-15-25.3

CHAPTER 61-04-12
LIMITED PRESCRIPTIVE AUTHORITY FOR ~~NALOXONE~~OPIOID ANTAGONISTS

61-04-12-02. Pharmacists furnishing ~~naloxone~~opioid antagonists.

1. Protocol.

   a. Pharmacists are authorized to furnish ~~naloxone~~opioid antagonist drug therapy solely in accordance with the written protocol for ~~naloxone~~opioid antagonist drug therapy approved by the board.

   b. Any pharmacist exercising prescriptive authority for ~~naloxone~~opioid antagonist drug therapy shall maintain a current copy of the written protocol for ~~naloxone~~opioid antagonist drug therapy approved by the board.

2. Procedure. When a patient requests ~~naloxone~~an opioid antagonist, or when a pharmacist in his or her professional judgment decides to advise of the availability and appropriateness of ~~naloxone~~an opioid antagonist, the pharmacist shall complete the following steps:

   a. Screen for the following conditions:

      (1) Whether the potential recipient currently uses or has a history of using illicit or prescription opioids (if yes, skip to subdivision b and continue with procedure);

      (2) Whether the potential recipient is in contact with anyone who uses or has a history of using illicit or prescription opioids (if yes, continue with procedure); and

      (3) Whether the person to whom the ~~naloxone~~opioid antagonist would be administered has a known hypersensitivity to ~~naloxone~~opioid antagonist (if yes, do not furnish).

   b. Provide training in opioid overdose prevention, recognition, response, and administration of the antidote ~~naloxone~~opioid antagonist.

   c. When ~~naloxone~~an opioid antagonist is furnished:

      (1) The pharmacist shall provide the patient with appropriate patient information and counseling on the product furnished, including dosing, effectiveness, adverse effects, storage conditions, shelf-life, and safety. A pharmacist furnishing ~~naloxone~~an opioid antagonist drug therapy may not permit the patient to whom the drug is furnished to waive the patient information required by the board.

      (2) The pharmacist shall provide the patient with any resources and referrals to appropriate resources if the patient indicates interest in addiction treatment, recovery services, or medication disposal resources at this time.

      (3) The pharmacist shall answer all questions the recipient may have regarding ~~naloxone~~an opioid antagonist.

3. Authorized drugs.

   a. Prescriptive authority is limited to ~~naloxone~~all opioid antagonists and includes any device approved for the administration of ~~naloxone~~an opioid antagonist.

b. Those administering ~~naloxone~~an opioid antagonist should choose the route of administration based on the formulation available, how well they can administer it, the setting, and local context.

4. Education and training. Prior to furnishing ~~naloxone~~an opioid antagonist, pharmacists who participate in this protocol shall successfully complete a minimum of one hour of an approved continuing education program specific to the use of ~~naloxone~~an opioid antagonist, or an equivalent curriculum-based training program completed in a board-recognized school of pharmacy.

5. Records. The prescribing pharmacist must generate a written or electronic prescription for any ~~naloxone~~opioid antagonist dispensed and the pharmacist shall record themselves as the prescriber or the protocol practitioner if appropriate. Documentation shall be made in a medication record for the patient. The prescription shall be kept on file and maintained for five years as required in North Dakota Century Code section 43-15-31.

6. Notification. If the patient is the potential individual to whom the ~~naloxone~~opioid antagonist will be administered, the pharmacist shall notify the patient's primary care provider of any drugs and devices furnished, or enter the appropriate information in a record system shared with the primary care provider.

   If the patient does not have a primary care provider, the pharmacist shall provide a written record of the drugs and devices furnished and advise the patient to consult an appropriate health care provider of the patient's choice.

History: Effective April 1, 2016; amended effective January 1, 2024.
General Authority: NDCC ~~28-32-02,~~ 43-15-10
Law Implemented: NDCC 23-01-42, 43-15-10(23)

TITLE 67

PUBLIC INSTRUCTION, SUPERINTENDENT OF

JANUARY 2024

ARTICLE 67-04
MILITARY INSTALLATIONS

CHAPTER 67-04-02
APPOINTMENT OF SCHOOL BOARD MEMBERS

67-04-02-01. Appointment of school board members on military installation school district.

1. The superintendent of public instruction shall invite the following persons to submit applications for appointment of school board members prior to March first of each year:

   a. Active members of the military installation;

   b. Spouses of active members of the military installation;

   c. Retired members of the military installation whose permanent residence is located within the state and is no greater than twenty miles from the military installation; or

   d. Spouses of retired members of the military installation whose permanent residence is located within the state and is no greater than twenty miles from the military installation.

2. The superintendent of public instruction shall ask applicants to provide information about their qualifications for and interest in an appointment to the school board, and such other information as the state board of public school education may require, in or attached to a letter of application. The information may be used by the superintendent of public instruction and the state board of public school education in their deliberations for appointment of school board members.

3. The superintendent of public instruction shall forward copies of the letters of application and any attachments to representatives of parent groups on the military installation and to the commander of the military installation for their review.

4. The representatives of parent groups shall submit recommendations regarding applicants for school board membership to the superintendent of public instruction and the commander of the military installation prior to April first.

5. After consulting with the commander of the military installation which has formed the school district about the appointments to be made that year, the superintendent of public instruction shall submit a list of recommended applicants, along with a list of all the applicants, and information obtained from the applicants and the commander of the military installation, to the state board of public school education.

6. The state board of public school education shall meet prior to May first of each year to consider approval of applicants for appointment of school board members from school districts formed on military installations.

7. Within fifteen days of the approval of applicants by the state board of public school education, the superintendent of public instruction shall announce the appointment of school board members for that year and the terms of the appointment for each member. The announcement of appointments must be made prior to May first of each year.

8. In making the initial appointment of school board members from newly formed school districts formed on military installations, if complying with the procedures in accordance with the date limitations of this section is an impossibility, the superintendent of public instruction and the state board of public school education shall comply with all of the procedures provided by this section in a reasonable manner, in spite of the date limitations.

9. An individual who serves on the board of a school district where they reside may not simultaneously be appointed to the board of a military installation.

History: Effective October 1, 2023.
General Authority: NDCC 15.1-08-02, 28-32-02
Law Implemented: NDCC 15.1-08-02

TITLE 67.1

EDUCATION STANDARDS AND PRACTICES BOARD

JANUARY 2024

CHAPTER 67.1-02-01

67.1-02-01-01. Student teachers.

A student teacher is one who teaches in a regular classroom situation as part of the requirements in professional preparation.

1. All college students in education must have classroom-related preprofessional experience prior to student teaching. A criminal background investigation including the bureau of criminal investigation and federal bureau of investigation must be completed prior to any student teaching experience.

2. The student teacher should be assigned by a college or university to a cooperating school on a full-time block. A full-time block is construed as a full day for ten consecutive weeks with exceptions documented through program approval. The student teacher must be placed in a classroom where the cooperating teacher is regularly assigned. Additional student teaching experiences shall be determined by the training institution. ~~Participation in one continuous semester of classroom teaching as authorized by section 67.1-02-01-06 shall be considered a qualifying student teaching experience.~~

3. In the event of an emergency, the student teacher may be placed as a substitute in the student teacher's regularly assigned classroom for a period of time not to exceed two consecutive days, one time~~, except as otherwise authorized by section 67.1-02-01-06~~.

4. Student teachers may be placed only in accredited schools.

5. Teaching experience cannot be used for a waiver of student teaching, except as specified in section 67.1-02-01-06 or subdivision d of subsection 1 of section 67.1-02-02-02.

6. Student teachers may receive a stipend from the school where they have student taught.

7. A student teacher will be eligible for a forty-day provisional license upon completion of all requirements for the student teacher's bachelor's degree minus the awarding of the degree and the official transcript as documented by the institution of higher education registrar. Once the degree has been awarded and the official transcript has been received, the student teacher must complete the initial application process.

History: Effective July 1, 1995; amended effective October 1, 1998; March 1, 2000; April 1, 2006; July 1, 2008; October 1, 2020; August 9, 2023; January 1, 2024.
General Authority: NDCC 15.1-13-08, 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-08, 15.1-13-10

67.1-02-01-02. Cooperating teachers.

A cooperating teacher is the teacher in the cooperating school who works with, helps, and advises the student teacher.

~~1.~~ Every cooperating teacher must have acquired a minimum of two semester hours or three quarter hours in supervision of a student teaching course or an inservice requirement that meets the necessary essentials in preparing cooperating teachers to supervise student teachers. ~~Those cooperating teachers who have served prior to July 1, 1976, may have this requirement waived at the discretion of the host college and cooperating school.~~

~~2.~~1. The cooperating teacher must have at least three years of teaching experience. The cooperating teacher must have at least one year of teaching experience in the school system in which the student teacher is being supervised.

~~3.~~2. Before being accepted and approved as a cooperating teacher, the teacher must be recommended by the administration of the school in which student teaching is performed.

~~4.~~3. A cooperating teacher who cannot recommend a student teacher for teaching or licensure shall have a conference with the college supervisor and the student teacher prior to the student teaching evaluation and recommendation.

History: Effective July 1, 1995; amended effective October 1, 1998; March 1, 2000; August 1, 2002; October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-08, 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-08, 15.1-13-10

CHAPTER 67.1-02-02
EDUCATOR'S PROFESSIONAL LICENSE

Section

67.1-02-02-02. Initial licenses.

1. Initial teacher licensure for in-state graduates or graduates of out-of-state programs requires a minimum of a four-year bachelor's degree from a board-approved teacher education program. The approved program must include North Dakota standards for teacher education program approval:

   a. General studies component includes liberal arts preparation in the areas of the humanities, fine arts, mathematics, natural sciences, behavioral sciences, and symbolic systems as prerequisite to entrance into the professional education program.

   b. North Dakota recognized program area majors are printed on the application form and include content-specific majors at the secondary level, content-specific kindergarten through grade twelve majors as listed below, majors in middle level education, or majors in elementary education. Majors that are transcripted by state-approved teacher education programs using terminology not appearing on the application form must be compared to the North Dakota standards for teacher education program approval to determine whether they meet the same criteria as the listed recognized majors. Majors must include a minimum of thirty-two semester hours of coursework specific to the major beyond the introductory level.

      (1) The secondary content-specific major must include a minimum of four semester hours in special methods of teaching at the secondary level and special methods of teaching in the specific content area. Effective July 1, 2008, all initial secondary licensure applicants grades five through twelve in the core and non-core academic areas will need to meet or exceed the cut scores for the content test as set by the education standards and practices board. Effective July 1, 2010, all initial secondary licensure applicants grades five through twelve in the core and non-core academic areas will need to meet or exceed the cut scores for the pedagogical test as set by the education standards and practices board. For purposes of this section, English, reading and language arts, mathematics, science, foreign languages, music, visual arts, history, civics and government, geography, and economics are considered core academic areas. All other areas are considered non-core academic areas.

      (2) The middle level major must include study of middle level foundations, adolescent development, reading in the content areas at the middle level, and twenty-four semester hours of content coursework in one of the content areas of English and

language arts, social studies, science, or mathematics meeting the teacher education program approval standards, and special methods of teaching at the middle level. Study of these areas must total a minimum of thirty-two semester hours, which includes at least two semester hours of special methods of teaching at the middle level and middle level classroom field experience. Effective July 1, 2008, all initial middle level licensure applicants grades five through eight in the core and non-core academic areas will need to meet or exceed the cut scores for the content test as set by the education standards and practices board. Effective July 1, 2012, all initial middle level licensure applicants grades five through eight in the core and non-core academic areas will need to meet or exceed the cut scores for the pedagogical test as set by the education standards and practices board.

(3) The elementary major must include special methods of teaching elementary content areas with a minimum of twelve semester hours specific to teaching elementary school mathematics, science, social studies, reading, and language arts. Effective July 1, 2006, all initial elementary licensure applicants for grades one through eight restricted licenses will need to meet or exceed the cut scores as set by the education standards and practices board for the elementary test and the pedagogical test. For the school year 2005-06 and beyond, all elementary teachers new to the profession, but previously licensed, will need to complete the elementary test and pedagogical test during the school year. Classroom teaching experience will be accepted from all other states toward the requirements of this paragraph.

(4) Prekindergarten through grade twelve preparation programs in special education, foreign language, art, music, physical education, business education, technology education, and computer education must include a minimum of four semester hours of special methods of teaching inclusive of kindergarten through grade twelve, special methods of teaching in the specific content area, and student teaching in elementary and secondary schools, grades prekindergarten through grade twelve. Effective July 1, 2006, all applicants in foreign language, art, and music will need to meet or exceed the cut scores for the content tests and the pedagogical ~~tests grades seven through twelve~~test as set by the education standards and practices board. Effective July 1, 2012, all initial prekindergarten through grade twelve licensure applicants grades seven through twelve in the core and non-core academic areas will need to meet or exceed the cut scores for the content test and the pedagogical test grades seven through twelve as set by the board.

(5) The early childhood major must include study of child development, birth through age eight, and include special methods of teaching at the early childhood level. Effective July 1, 2012, all initial early childhood licensure applicants birth through grade three will need to meet or exceed the cut scores for the state-identified principles of teaching and learning test and the state-identified early childhood education content specific cut score as set by the board.

(6) Effective July 1, 2008, all applicants in special education majors or endorsements must meet or exceed the state-approved test cut scores as set by the board.

c. The professional education component includes a minimum of twenty-two semester hours of pedagogical study of teaching and learning in addition to the program-specific major. This coursework must be from the areas of educational foundations, educational psychology, child development, teaching and learning theory, educational diagnosis and assessment, inclusive education, educational technology, classroom and behavioral management, and human relations specific to teaching. The professional education component must also include classroom professional experience prior to student teaching and a minimum of ten weeks of full-time successful participation in student

teaching at appropriate grade levels. The professional education component, including student teaching, must be completed under the supervision of a teacher training institution approved by the education standards and practices board in North Dakota or the appropriate state, provincial, or similar jurisdictional authority for out-of-state institutions.

d. Student teaching exception - Internship. An applicant who graduated from a state-approved teacher education program, in-state or out-of-state, prior to January 1, 1988, which did not include a minimum of ten weeks of full-time student teaching may qualify under one of the two options under this subdivision. These options are available only if the applicant has met all other requirements for licensure of the board and North Dakota Century Code sections 15.1-18-02 and 15.1-18-03, except the requirement of ten weeks of student teaching.

(1) The applicant must document a minimum of eight full weeks of student teaching at the appropriate level in the major field of study under the supervision of a state-approved teacher education program and document five years of successful teaching within the last ten years; or

(2) An applicant who can document a minimum of eight weeks of successful student teaching but cannot document a minimum of five years of successful teaching experience must either complete the additional student teaching hours or may choose to complete an internship under the supervision of a state-approved college of teacher education to fulfill the additional hours.

(a) The internship contact hours in the classroom must consist of classroom time blocks not less than one-half day and when added to the applicant's existing student teaching hours total a minimum of ten weeks of full-time equivalent student teaching and supervised internship experience.

(b) The internship must occur in a regular kindergarten through grade twelve classroom setting and allow the intern to experience the full range of curriculum and classroom operations.

(c) The internship must be approved by the board and transcripted through a state-approved teacher education institution.

e. Teaching minors. A teaching minor may only be earned or added to a teaching major. ~~An individual may not be licensed or change grade levels of licensure with only a teaching minor.~~

~~A teaching minor is defined as a minimum of sixteen semester or twenty-four quarter credit hours in a single designated academic area and the methods of teaching the content area. These sixteen semester or twenty-four quarter credit hours must be in courses for which the institution gives credit toward graduation in the major and be included in the teacher education program approval process.~~

2. Grade point average.

a. An applicant must have a minimum overall grade point average (GPA) of 2.50. The board will use the college-figured grade point average if all previous college coursework is on the transcript.

b. An applicant must have a minimum GPA of 2.50 for all coursework required for the applicant's degree. Coursework not needed for a degree in teacher education need not be included in GPA calculations. Coursework used in any way for licensure or endorsements must be included in GPA calculations.

3. Acceptable translations for preparations received in foreign institutions will be requested at the applicant's expense.

4. Application form.

   a. An application fee of thirty dollars must accompany an initial application form.

   b. The completed application form, including the original signature of the applicant and recommendation by the state-approved teacher education program will be considered for licensure by the education standards and practices board.

   c. A fee of ~~seventy-five~~eighty-five dollars must accompany the application for initial licensure for in-state and out-of-state graduates. An additional fee of one hundred seventy-five dollars for transcript review from out-of-state graduates must also accompany the licensure application.

   d. The application will be kept on file at the education standards and practices board office for six months. Upon expiration of the six-month period, applicable fees will be refunded to the applicant if the license has not been issued.

5. All initial licenses are valid for at least two consecutive years and will expire on the applicant's birthday.

6. Fingerprinting. In addition to completing the licensure application process outlined in this section, an applicant applying for licensure in North Dakota for the first time after August 1, 1997, must submit to a fingerprint screening for criminal records in accordance with North Dakota Century Code section 15.1-13-14.

   a. An applicant graduating from a North Dakota teacher preparation program may obtain the fingerprinting materials from college officials. Previous graduates and out-of-state graduates must contact the education standards and practices board directly for the fingerprinting materials. Fingerprint screening reports from other agencies are not available to the board. Applicants must complete the process with cards and release forms designating the board as the agency to receive the report.

   b. The applicant must have the fingerprinting done by an authorized law enforcement agency such as a sheriff's office, police department, campus police, or private fingerprinting company. Both cards are to be completed with a ten-finger check. The criminal record inquiry authorization form must also be completed, including an original signature. The fingerprint cards and authorization form must be returned directly to the education standards and practices board office.

   c. Unofficial, incomplete, altered, or damaged cards and forms will not be accepted.

   d. The applicant is responsible for all local, state, and federal law enforcement agency fees related to the fingerprint background check.

   e. The applicant is advised to allow a minimum of eight weeks for the fingerprint screening process. An applicant must hold a valid North Dakota license to be employed or permitted to teach in North Dakota. Individuals who have completed all requirements for the professional educator's license except final completion of the fingerprint background check may obtain a provisional license under section 67.1-02-04-04.

   f. Fingerprint screening reports must be recent and may only be used for licensure for eighteen months from the date the report is received by the board.

7. Re-education for initial licensure. Applicants who hold nonteaching degrees in content areas taught in public schools may receive initial licensure by completing the professional education requirements at a state-approved program authorized through program approval to recommend applicants for licensure in the approved program area. This re-education may be completed at the undergraduate or graduate level. The institution with the approved program must document that the applicant's specialty area degree is equivalent to its approved program's specialty area requirements in subdivisions b and c of subsection 1, and recommend the applicant for licensure. Applicants applying under this section must file a completed application form as other initial applicants, comply with the fingerprint background check in subsection 9, complete all tests, and pay all applicable fees.

8. Preprofessional skills test. All applicants for initial licensure will need to submit either their test scores in reading, writing, and mathematics which meet or exceed the state cut score or composite score or their ACT aspire scores that meet or exceed a composite score of twenty-two, mathematics score of twenty-one, and English language arts score of twenty-one. Documentation of the scores must be submitted with the application form. Applicants also may submit their SAT scores that meet or exceed reading scores of five hundred forty-three, mathematics scores of five hundred thirty-two, and writing scores of five.

9. The board may issue an initial license to an individual with a documented disability, as determined by the board, which allows the individual to teach in areas where documented shortages of regularly licensed teachers exist, as determined by the board, if due to the documented disability, the individual is unable to meet all the requirements of the Praxis I, Praxis II PLT, or Praxis II content-specific test in the content area to be assigned but who is otherwise qualified to teach as determined by the board.

10. The board may issue a second alternative access license to an individual who is on an initial alternative access license and has attempted the content-specific test three times during the initial alternative access license period. If the applicant has attempted the Praxis II content-specific test an additional two times during the second alternative access license and provides documentation, during the third year following the applicant's receipt of the initial alternative access license the applicant will be issued an initial license when the following requirements are met and approved by the board:

    a. A letter from the superintendent requesting an initial license for the applicant;

    b. A letter from the applicant acknowledging financial responsibility for observation by a content expert;

    c. Documentation of a positive observation;

    d. Evidence of passing the pedagogy test; and

    e. If required, a criminal history background check as required by North Dakota Century Code section 15.1-13-14.

History: Effective July 1, 1995; amended effective October 1, 1998; October 16, 1998; April 14, 1999; June 1, 1999; March 1, 2000; August 1, 2002; July 1, 2004; April 1, 2006; July 1, 2008; July 1, 2010; April 1, 2012; July 1, 2012; October 1, 2014; January 1, 2015; April 1, 2018; January 1, 2020; October 1, 2020; October 1, 2021; January 1, 2024.
General Authority: NDCC 15.1-13-08, 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-08, 15.1-13-10, 15.1-13-11, 15.1-13-12, 15.1-13-14

67.1-02-02-04. Two-year and five-year renewals.

1. **Two-year renewal license.**

a. A two-year renewal license will be issued to applicants with less than eighteen months of successful contracted teaching in North Dakota who have completed all of the requirements on the application form and pay the required fee of ~~fifty-five~~sixty-five dollars. Applications for renewal may only be submitted six months prior to the expiration of the current license and will expire after a minimum of two years after the applicant's birth date.

b. A two-year re-entry license will be issued to an applicant re-entering the profession after an absence of five years who has completed all of the requirements on the application form. Prior to applying for the re-entry license, the applicant must submit to a fingerprint screening for criminal records in accordance with North Dakota Century Code section 15.1-13-14. An applicant re-entering the profession must complete eight semester hours of re-education credit during the applicant's first two years of contracted employment as stated in this section and in section 67.1-02-02-09. The fee for the re-entry license is ~~seventy-five~~eighty-five dollars. Applications for renewal may only be submitted six months prior to the expiration of the current license and will expire after a minimum of two years on the applicant's birth date.

c. A two-year re-entry license will be issued to an applicant from out of state who has had an absence from the profession of more than five years, or to an applicant who cannot submit six semester hours of credit taken during each of the past two five-year periods if employed in education out of state. Such an applicant must meet the requirements of North Dakota initial licensure as stated in section 67.1-02-02-02 and must also complete the requirements for re-entry education as stated in this section and in section 67.1-02-02-09. The fee for the re-entry license is ~~seventy-five~~eighty-five dollars. Applications for renewal may only be submitted six months prior to the expiration of the current license and will expire after a minimum of two years on the applicant's birth date.

d. A two-year renewal license will be issued for substitute teaching to those applicants who have completed all of the requirements on the application form. A substitute teacher must maintain a valid teaching license using the two-year renewal cycle, but is not required to submit re-education hours unless the person signs a contract. The fee for this two-year renewal is ~~fifty-five~~sixty-five dollars. Applications for renewal may only be submitted six months prior to the expiration of the current license and will expire after a minimum of two years on the applicant's birth date.

e. In extraordinary circumstances, the board may waive or extend the time for completion of the re-education credits.

f. For the school year 2005-06 and beyond, all elementary teachers new to the profession, but previously licensed, will need to complete the elementary test and pedagogical test during the school year meeting North Dakota cut scores. Contracted classroom teaching experience will be accepted from all other states toward the requirements of this subdivision. A new to the profession teacher is defined as one who has never been contracted as a kindergarten through grade 12 teacher.

2. **Five-year renewal license.**

a. The first five-year renewal will be issued to those applicants who have successfully been contracted for eighteen months within the past five years in the state on a valid North Dakota license and who have completed all of the requirements on the application form. Applications for renewal may only be submitted six months prior to the expiration of the current license and will expire after a minimum of five years on the applicant's birth date.

(1) All five-year license applications must be accompanied by a fee of ~~one hundred twenty-five~~one hundred thirty-five dollars.

(2) Succeeding five-year renewals require evidence of thirty teaching days of contracted service and completion of a minimum of four semester hours of re-education credit to avoid reverting to entry status. As licenses are renewed, after July 1, 2011, six semester hours of re-education credit will be required for the new five-year period. All re-education credit must be documented by college or state-approved alternative program transcripts.

(3) For the school year 2005-06 and beyond, all elementary teachers new to the profession, but previously licensed, will need to complete the elementary test and pedagogical test during the school year meeting North Dakota cut scores. Contracted classroom teaching experience will be accepted from all other states toward the requirements of this paragraph. A new to the profession teacher is defined as one who has never been contracted as a kindergarten through grade 12 teacher.

b. A renewal applicant who has completed the six semester hours of credit but has not been contracted for at least thirty days under the five-year license will revert to the two-year renewal cycle.

c. Probationary license. An applicant who has failed to complete the six semester hours of re-education credit, whether the application has been contracted or not, will either not be renewed, or may agree to be placed on a two-year probationary license. Eight semester hours of re-education semester credit must be supplied as a condition of the two-year probationary license. A second probationary license will not be issued.

d. In extraordinary circumstances, the board may waive or extend the time for completion of the re-education credits.

e. Once the requirements have been met for the probationary license, a two-year renewal license will be issued.

History: Effective July 1, 1995; amended effective October 1, 1998; October 16, 1998; April 14, 1999; June 1, 1999; March 1, 2000; August 1, 2002; July 1, 2004; April 1, 2006; July 1, 2008; July 1, 2010; April 1, 2012; July 1, 2012; October 1, 2014; April 1, 2018; October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-09, 15.1-13-10, 15.1-13-11

67.1-02-02-09. Re-entry.

1. Prior to applying for the re-entry license, the applicant must submit to a fingerprint screening for a statewide and nationwide criminal history record check in accordance with North Dakota Century Code sections 15.1-13-14 and 20-60-24.

2. An applicant who has been out of teaching for a period of more than five years must earn a total of eight semester hours or twelve quarter hours of college or university credit, as documented by college or state-approved alternative program transcripts, in the area in which the teacher wishes to renew licensure during the first two years of re-entry contracted service.

3. Substitute teachers are exempt from the eight semester hour requirement until the individual accepts a contracted position.

4. The fee for the two-year re-entry license is ~~seventy~~eighty dollars.

5. Re-entry applicants should also refer to information in subsection 1 of section 67.1-02-02-04, regarding two-year and five-year renewals.

History: Effective July 1, 1995; amended effective October 1, 1998; June 1, 1999; March 1, 2000; August 1, 2002; July 1, 2004; April 1, 2006; July 1, 2008; October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-09, 15.1-13-10, 15.1-13-11

67.1-02-02-13. Special education authorization.

1. The request for a special education authorization must be initiated by a school. The school board or administration must make the request in writing to the board for consideration of a special education authorization, indicating intent to offer a contract if licensure can be arranged. The request must document that a diligent effort has been made to employ a regularly licensed teacher to fill the position. Documentation of a diligent effort to employ qualified personnel should include information on how long the position was advertised, whether schools of education have been contacted in search of applicants, how many qualified applicants applied, how many applicants were interviewed, whether increases in salary or other incentives were offered in an attempt to attract qualified applicants, and whether these incentives are comparable to those offered by other schools of similar size and means.

2. An applicant must have a minimum overall grade point average (GPA) of 2.50. The board will use the college-figured grade point average if all previous college coursework is on the transcript. An applicant must have a minimum GPA of 2.50 for all coursework required for the applicant's degree. Coursework not needed for a degree in teacher education need not be included in GPA calculations. Coursework used in any way for licensure or endorsements must be included in GPA calculations.

3. Complete official college or state-approved alternative program transcripts must be sent to the board.

4. Passed the required state tests, including the test in the content area.

5. Initial applicants for the special education authorization must also submit to the fingerprint background check as stated in subsection 6 of section 67.1-02-02-02.

6. Once the criminal background investigation has been successfully completed and all official transcripts or other original, signed, or certified documents received, the education standards and practices board may issue the authorization for which the individual is qualified with its respective fees and conditions.

7. Upon completion of all the requirements for regular licensure stated in section 67.1-02-02-02, an individual holding a special education authorization may apply for a regular two-year initial license and begin accruing the eighteen months of successful teaching time required to move into the five-year cycle according to sections 67.1-02-02-02 and 67.1-02-02-04.

8. Fee for the special education authorization is one hundred and fifty-five dollars and is issued for a one-year time period.

History: Effective January 1, 2024.
General Authority: NDCC 15.1-18-10
Law Implemented: NDCC 15.1-18-10

67.1-02-02-14. Special education authorization - Application of laws and rules - Discipline.

Individuals receiving a special education authorization from the board pursuant to North Dakota Century Code section 15.1-18-10 shall comply with the following sections of the Century Code and administrative rules:

1. North Dakota Century Code sections 15.1-13-25 and 15.1-13-26;

2. Section 67.1-01-01-03;

3. Section 67.1-01-01-04;

4. Section 67.1-02-02-06;

5. Chapter 67.1-02-05;

6. Chapter 67.1-03-01; and

7. Chapter 67.1-04-04.

History: Effective January 1, 2024.
General Authority: NDCC 15.1-18-10
Law Implemented: NDCC 15.1-18-10

CHAPTER 67.1-02-03

67.1-02-03-01. Elementary endorsement.

Re-education of a licensed teacher for elementary schoolteaching may be accomplished by:

1. Completing a state-approved elementary teacher education program of thirty-two semester hours, including a regular classroom student teaching experience of six quarter hours or a minimum of five consecutive weeks between kindergarten through grade eight; or

2. The clinical practice option described in section 67.1-02-04-07. The coursework must include special methods of teaching elementary content areas with a minimum of twelve semester hours specific to teaching elementary school reading, language arts, mathematics, science, and social studies along with additional appropriate elementary education coursework.

All elementary endorsement applicants grades one through eight will need to meet or exceed the cut scores for the elementary test and the principles of learning and teaching test as set by the education standards and practices board.

A verified successful college-supervised internship with credit may be substituted for student teaching under this section. The internship option within the elementary endorsement is available only:

1. To an individual who has graduated from a state-approved teacher education program that has as part of its approved preparation a year of college-supervised internship at the elementary level; or

2. To an individual licensed by the North Dakota education standards and practices board to teach kindergarten through grade twelve in accordance with North Dakota Century Code sections 15.1-18-03 and 15.1-18-02 who has already successfully completed a minimum of five weeks of full-time student teaching at the elementary level in the individual's specialty area. The total internship contact hours in the classroom must be equivalent to a minimum of five weeks of full-time student teaching and consist of classroom time blocks not less than one-half of one day.

3. The internship must occur in a regular kindergarten through grade eight classroom setting and allow the intern to experience the full range of curriculum and classroom operations. Individuals performing elementary endorsement internships work under the supervision of licensed teachers and must not be assigned in lieu of regularly employed teachers.

   State-approved test endorsement - elementary. Re-education of a licensed teacher for elementary schoolteaching may also be accomplished by holding a North Dakota regular educator's professional license and the successful completion of the pedagogical test grades one through six, and elementary content test meeting or exceeding the minimum scores determined by the board in the content area to be taught. Re-education for the elementary endorsement must be completed prior to assignment to teach in the elementary content area.

4. Specialty area endorsement in art, foreign language, or music for elementary teachers grades one through eight. Elementary teachers with a major or major equivalency defined in section 67.1-02-03-01 in elementary education will be considered qualified to teach art, foreign language, or music grades one through eight. Elementary teachers with a major, minor, or minor equivalency endorsement in art, foreign language, or music will be considered qualified in art, foreign language, or music grades one through eight.

5. The applicant shall apply online at www.nd.gov/espb using the online application ND Teach, submit official transcripts, and pay the review fee of ~~seventy-five~~eighty-five dollars.

History: Effective July 1, 1995; amended effective June 1, 1999; March 1, 2000; August 1, 2002; July 1, 2004; April 1, 2006; July 1, 2012; October 1, 2014; April 1, 2018; October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-18-02

67.1-02-03-02. Kindergarten endorsement.

1. Reeducation of elementary teachers for kindergarten schoolteaching may be accomplished by presenting a minimum of twelve semester hours of kindergarten coursework in foundations of early childhood, kindergarten methods and materials, early language and literacy, observation, and assessment for the kindergarten child. The applicant must have a minimum of one year full-time equivalent successful teaching experience in prekindergarten, kindergarten, or grade one or student teaching of four semester hours or six quarter hours or a minimum of five consecutive weeks applicable to the endorsed area. Re-education for the kindergarten endorsement must be completed prior to or within two years of assignment to teach at the kindergarten level; or

2. State-approved test endorsement - kindergarten. Re-education of a licensed teacher for kindergarten schoolteaching may also be accomplished by holding a North Dakota regular educator's professional license and successful completion of the pedagogical test birth through grade three and early childhood content test meeting or exceeding the minimum scores determined by the education standards and practices board in the content area to be taught. Re-education for the kindergarten endorsement must be completed prior to assignment to teach in the kindergarten content area.

3. A kindergarten endorsement shall be issued to those applicants for a North Dakota other state educator license who:

   a. Hold a regular teaching license in early childhood, elementary, middle, or secondary education from another state;

   b. Have a kindergarten endorsement from another state; or

   c. Provide verification of two years of successful teaching of kindergarten students.

The applicant must apply online at www.nd.gov/espb using the online application ND Teach, submit official transcripts, and the review fee of ~~seventy-five~~eighty-five dollars.

History: Effective July 1, 1995; amended effective June 1, 1999; March 1, 2000; July 1, 2004; April 1, 2006; October 1, 2014; April 1, 2018; October 1, 2022; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-18-02

67.1-02-03-03. Secondary endorsement.

Re-education for secondary schoolteaching may be accomplished in one of the following ways:

1. By completing the minimum requirements for a degree in secondary education, including student teaching in grades five through twelve or the clinical practice option as described in section 67.1-02-04-07, and a North Dakota-recognized content area major.

2. An individual who already has a North Dakota-recognized major meeting the state-approved teacher education standards may complete the secondary minor equivalency.

3. An individual who has a bachelor's degree in elementary education with a transcripted recognized content minor may complete the coursework necessary for the major in the core

academic areas, secondary methods coursework, and a minimum of five weeks of student teaching in grades five through twelve or the interim licensure clinical practice option under section 67.1-02-04-07.

4. An individual who has a bachelor's degree in elementary education with a transcripted recognized content minor is licensed to teach in the minor area in grades five through twelve.

5. State-approved test endorsement - secondary. Re-education of a licensed teacher for secondary schoolteaching may be accomplished by holding a North Dakota regular educator's professional license and the successful completion of the secondary or specialty content test meeting or exceeding the minimum scores determined by the board in the content area to be taught. Re-education for the secondary endorsement must be completed prior to assignment to teach in the secondary content area. An official transcript and test scores documenting the major must be attached to the endorsement form.

The applicant must apply online at www.nd.gov/espb using the online application ND Teach, submit official transcripts, and the review fee of ~~eighty~~ninety dollars.

History: Effective July 1, 1995; amended effective October 1, 1998; June 1, 1999; March 1, 2000; August 1, 2002; July 1, 2004; April 1, 2006; July 1, 2008; October 1, 2014; April 1, 2018; October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-18-03

67.1-02-03-04. Middle school pedagogical endorsement for grades five through eight.

The middle school pedagogical endorsement (50517) is optional for teachers licensed for grades five through twelve to qualify for work with grades five through eight in the subject fields of their licensure. Elementary teachers licensed to teach grades one through eight must complete the middle school pedagogical endorsement (50017) to teach in grades seven and eight. A review of past coursework will be conducted and a program of study needed for completion will be established. The middle school pedagogical endorsement requires a minimum of ten semester hours, including all of the following:

1. Development of young adolescents.

2. Philosophy and curriculum (foundations) of middle school education.

3. Teaching reading and other study or learning skills in the content areas.

4. Methods or strategies of teaching in the middle grades, two semester hours minimum.

5. Re-education for the middle level endorsement must include a twenty clock-hour field experience in grades five through eight in a school setting where middle level philosophy has been implemented, or successful teaching in grades five through eight in a school setting where middle level philosophy has been implemented.

Re-education for the middle school endorsement must be completed within two years of application of the endorsement.

State-approved test endorsement - middle level. Re-education of a licensed teacher for middle level schoolteaching may also be accomplished by holding a North Dakota regular educator's professional license and successful completion of the pedagogical test grades five through eight and middle level content test meeting or exceeding the minimum scores determined by the education standards and practices board in the content area to be taught. Re-education for the middle endorsement must be completed prior to assignment to teach in the middle content area.

The applicant must apply online at www.nd.gov/espb using the online application ND Teach, submit official transcripts, and the review fee of ~~seventy-five~~eighty-five dollars.

History: Effective July 1, 1995; amended effective June 1, 1999; March 1, 2000; August 1, 2002; July 1, 2004; April 1, 2006; July 1, 2008; July 1, 2012; October 1, 2014; April 1, 2018; October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-18-02

67.1-02-03-05. Bilingual education or English language development endorsement.

English language development endorsement (24000). Re-education for "English language development" endorsement for any licensed teacher may be accomplished by presenting at least sixteen semester hours or twenty-four quarter hours of college coursework in all of the areas following in subsections 1 through 5.

Bilingual education endorsement (24500). Re-education for a bilingual education endorsement for any licensed teacher may be accomplished by completing all the requirements for the English language development endorsement in subsections 1 through 5 and meeting the additional requirements related to bilingual education in subsections 6 and 7.

1. Foundations. Four semester hours or six quarter hours of college coursework, including the following:

   a. Multicultural education.

   b. Foundations of second language instruction.

2. Linguistics. Six semester or nine quarter hours of college coursework, including the following areas:

   a. Linguistics.

   b. Psycholinguistics.

   c. Sociolinguistics.

3. Methods. Two semester or three quarter hours of college coursework, including methods of teaching English as a second language to students.

4. Assessment. Two semester hours or three quarter hours of college coursework from assessment and testing of culturally diverse students.

5. Field experience. Two semester or three quarter hours of college coursework in field teaching experience with limited English proficient students in a bilingual or English as a second language setting.

6. Methods of teaching bilingual education.

7. A minimum of sixteen semester hours or twenty-four quarter hours in a language other than English or documented proficiency in a language other than English.

Re-education for the bilingual education or English language development endorsement must be completed within two years of assignment to teach bilingual education or English as a second language. The applicant shall file a plan with the board upon becoming employed as a bilingual or English language development teacher, outlining how the endorsement will be completed within the two-year period. The bilingual or English language development endorsement enables the applicant to teach bilingual or English as a second language grades prekindergarten through twelve. Applicants

teaching other content material must hold licensure appropriate to the teaching of that content at the assigned grade levels in compliance with North Dakota Century Code sections 15.1-18-03 and 15.1-18-02 and this article.

The applicant must complete the endorsement ~~form~~application and ~~return~~submit to the board office with the official transcripts and the ~~review~~ fee of ~~seventy-five~~eighty dollars.

History: Effective July 1, 1995; amended effective October 1, 1998; June 1, 1999; March 1, 2000; August 1, 2002; July 1, 2004; July 1, 2008; July 1, 2012; October 1, 2020; October 1, 2022; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10

67.1-02-03-06. Minor equivalency endorsement.

1. Nothing in this section may be interpreted to affect the validity of minor equivalencies issued by the department of public instruction prior to September 1, 1998.

2. The applicant wishing to apply under the minor equivalency endorsement option must be licensed to teach under North Dakota Century Code section 15.1-18-02 or 15.1-18-03. The minor equivalency endorsement will be issued for the same grade levels as the individual's primary licensure, the same as for minors transcripted by colleges of teacher education. Those whose primary licensure is secondary may use the endorsement to teach the new content area in grades five through twelve. Those whose primary licensure is elementary grades one through eight or middle school (grades five through eight) may use the endorsement for additional content expertise at those levels but may not use it to teach at the high school level without a complete secondary endorsement.

3. The applicant must apply for the minor equivalency online using the NDTeach system, and submit transcripts and the review fee of ~~seventy-five~~eighty dollars.

4. Three levels of content area endorsements are available to be added to the existing North Dakota professional educator's license.

   a. The ME16 requires a minimum of sixteen semester hours of content-specific coursework, including the areas of study approved and required by the education standards and practices board. The ME16 will be reviewed when the applicant applies for renewal licensure. The coursework for the ME24 must be completed within five years of the application date for the ME16. If the ME24 coursework is not completed within five years, the ME16 will be removed from the license.

   b. The ME24 requires a minimum of twenty-four semester hours of content-specific coursework, including the areas of study approved and required by the education standards and practices board. The ME24 also must include the special methods of teaching in the content area. The ME24 is considered equivalent to a full teaching minor.

5. All coursework for the minor equivalency endorsement must be beyond the introductory level general studies courses as defined in section 67.1-02-02-02 and be transcripted by a state-approved college of teacher education program.

6. The minor equivalency endorsement must be completed prior to contracted teaching in the content area.

7. The following coursework and requirements must be completed for the specific minor equivalency:

a. Agriculture (01005) - A total of sixteen semester hours, including three semester hours each in agriculture economics, agriculture management, animal science, plant science, and elective; six semester hours in agriculture leadership, community development, or philosophy of career and technical education; and special methods of teaching agriculture education.

b. Art (02005) - A total of sixteen semester hours, including art history, design, drawing, painting, ceramics, and special methods of teaching art.

c. Biology (13010) - A total of sixteen semester hours, including biology I and II, botany, zoology, genetics, general chemistry I and II, and special methods of teaching biology or science.

d. Business (03020) - A total of sixteen semester hours, including three semester hours in keyboarding, six semester hours in accounting, three semester hours in computer technology, general business, business communication, and special methods of teaching business.

e. Chemistry (13020) - A total of sixteen semester hours, including general chemistry I and II with labs, organic chemistry I and II with labs, analytic chemistry, and special methods of teaching chemistry or science.

f. Composite science (13047) - A total of twenty-four semester hours with eight semester hours with labs in biology, chemistry, physics, and earth science, and special methods of teaching science.

g. Computer science (23000) - A total of sixteen semester hours, including six semester hours a year-long sequence of structured language, two semester hours in advanced assembler language, eight semester hours in computer-related coursework, microcomputing, data structures and algorithms, operating systems, and special methods of teaching computer science.

h. CTE health careers (07000) - Criteria to meet this endorsement is available through the department of career and technical education.

i. CTE trade, industry, and technical (17000) - Criteria to meet this endorsement is available through the department of career and technical education.

~~j. CTE diversified occupations (25000) - Coordinating techniques. Criteria to meet this endorsement is available through the department of career and technical education.~~

~~k.~~j. CTE resource educator (26000) - Philosophy and practices of career and technical education, vocational assessment, career development, competency-based career and technical education, cooperative education, special needs teaching methods, introduction to exceptional children, mental retardation, learning disabilities, or emotional disturbance, working with at-risk students, behavior problems, classroom strategies, and other courses or workshops as approved by the career and technical education supervisor.

~~l.~~k. CTE information technology (27000) - Criteria to meet this endorsement is available through the department of career and technical education.

~~m.~~l. CTE basic skills educator (28000) - Philosophy and practices of career and technical education, vocational assessment, career development, competency-based career and technical education, cooperative education, special needs teaching methods, introduction to exceptional children, mental retardation, learning disabilities, or emotional disturbance, working with at-risk students, behavior problems, remedial mathematics, remedial

reading, and other courses or workshops as approved by the career and technical education supervisor.

~~n.~~m. CTE teacher student mentor (29000) - Criteria to meet this endorsement is available through the department of career and technical education.

~~o.~~n. CTE career clusters (37000) - Criteria to meet this endorsement is available through the department of career and technical education.

~~p.~~o. Drama or theater (05015) - Sixteen semester hours of drama or theater coursework.

~~q.~~p. Driver education (21005) - Valid operator's license not suspended or revoked. Provide by January first of each year a complete abstract of the applicant's driving record for the past thirty-six months from a state driver's licensing office evidencing a satisfactory driving record free from any conviction that would constitute the basis for suspension or revocation on the instructor's operator's license, and not more than three moving traffic violations. Ten semester hours consisting of at least one course each in classroom driver and traffic education, in-car instruction, beginning driver problems, and organization and administration of safety education. Fourteen semester hours with no more than three semester hours in any one area: first aid; substance abuse education; equipment training, which may include simulator use and educational technology; classroom management; developmental psychology covering adolescent psychology; stress management; curriculum, planning, and assessment; teaching diverse learners; and educational psychology. Field experience required for elementary or middle school teachers provided by a driver's education mentor with a minimum of three years' experience in driver's education must include three clock-hours of in-car observation and three clock-hours of in-car instruction. This field experience must be documented with a letter from the school principal and driver education mentor. The renewal of the driver's education endorsement requires two semester hours every five years of driver and traffic safety coursework. It is the responsibility of the instructor to notify the education standards and practices board of any driving offense, suspension, revocation, or cancellation of the driving license. Applicants holding a lifetime teaching license with ten years of driver's education instruction in North Dakota shall complete two semester hours of re-education every six years.

~~r.~~q. Earth science (13035) - A total of sixteen semester hours, including general chemistry I and II with labs, physical geology, historical geology, astronomy, meteorology, and special methods of teaching science.

~~s.~~r. Economics (15010) - A total of sixteen semester hours, including principles of macroeconomics I and II, money and banking, computer applications in economics, and methods of teaching economics or social science.

~~t.~~s. English (05020) - A total of sixteen semester hours, including three semester hours of grammar and usage, six semester hours of composition, three semester hours of speech, three semester hours of developmental reading, literary analysis and criticism, nine semester hours of American and English literature, media, and special methods of teaching English.

~~u.~~t. Family and consumer science (09040) - A total of sixteen semester hours, including child development and family science, consumer education and resource management, food and nutrition, health and wellness, apparel and textiles, housing issues and interior design, and the special methods of teaching family and consumer science.

~~v.~~u. Foreign languages (French 06010, German 06015, Greek 06020, Latin 06025, Spanish 06035, Chinese 06260) - Sixteen semester hours specific to the foreign language,

including composition and conversational structure of the language, culture, customs, and civilization relative to the language, introduction to literature in the language, and the special methods of teaching foreign language.

~~w.~~v. Geography (15015) - A total of sixteen semester hours, including physical geography, cultural geography, world geography, North American geography, and the special methods of teaching geography or social science.

~~x.~~w. Government and political science (15007) - A total of sixteen semester hours, including American government, political thought, international or global politics, and the special methods of teaching social science.

~~y.~~x. Health (18015) - Twenty-four semester hours in first aid, and safety, nutrition, exercise physiology or fitness, personal and community health, current issues in health education, and the special methods and curriculum in school health education.

~~z.~~y. History (15020) - A total of sixteen semester hours, including United States history I and II, western civilization I and II or world history I and II, and the special methods of teaching.

~~aa.~~z. Library science (50065) - Twenty-four semester hours in introduction to the role of the librarian in the school library, reference, selection of materials and collection development, classification and cataloging of library materials, library administration, conducting research following state and national library standards, current issues in school librarianship, a study of children's literature, young adult literature, and reading methods.

~~bb.~~aa. Marketing (04006) - A total of sixteen semester hours, including marketing, economics, promotion and advertising, management, student organizations, methods of teaching marketing or business education, philosophy of career and technical education, and nine credits in any of the following: accounting, advertising, business, business technology, economics, finance, promotion, and selling.

~~cc.~~bb. Mathematics (11010) - A total of sixteen semester hours, including calculus, abstract algebra, geometry (axiomatic), calculus I and II, linear algebra, abstract algebra, probability and statistics, and methods of teaching mathematics.

~~dd.~~cc. Music composite (12010) - Twenty-four semester hours in music theory (six semester hours), music history or literature, ear training or sight singing, conducting, keyboard proficiency, and methods of elementary and secondary music teaching.

~~ee.~~dd. Instrumental music (12005) - A total of sixteen semester hours, including music theory, ear training or sight singing, conducting, and eight semester hours of coursework in instrumental music, keyboard proficiency, and methods of elementary and secondary music teaching.

~~ff.~~ee. Choral or vocal music (12015) - A total of sixteen semester hours, including music theory, ear training or sight singing, conducting, and eight semester hours of coursework in vocal music, keyboard proficiency, and methods of elementary and secondary music teaching.

~~gg.~~ff. Physics (13050) - A total of sixteen semester hours, including general physics I and II, modern physics, electronics, mechanics, and methods of teaching science.

~~hh.~~gg. Physical education (08025) - A total of sixteen semester hours, including organization and administration of physical education and health, first aid and cardiopulmonary resuscitation, prevention and care of athletic injuries, health issues, physiology of exercise, foundations or curriculum of physical education, human physiology or anatomy,

physical education for exceptional children, band, and methods of teaching sports activities, games, and dance.

~~ii.~~hh. Physical science (13045) - A total of sixteen semester hours, including eight semester hours each in general chemistry I and II with labs, general physics I and II, and methods of teaching science.

~~jj.~~ii. Psychology (15030) - A total of sixteen semester hours, including introduction to psychology, development psychology, abnormal psychology, personality theory, social psychology, and methods of teaching psychology or social science.

~~kk.~~jj. Reading (58904) - Sixteen semester hours of content specific coursework beyond the introductory level.

~~ll.~~kk. Social studies composite (15035) - Twenty-four semester hours in United States history, world civilization, world history, American government, world geography, physical geography, introduction to sociology, economics, psychology, and methods of teaching social science.

~~mm.~~ll. Sociology (15040) - A total of sixteen semester hours, including introduction to sociology, introduction to anthropology, social psychology, and methods of teaching social science.

mm. Special education (19015) - A total of sixteen semester hours of special education coursework required for the ME 16. For ME 24, twenty-four semester hours of coursework must include special education law, special education assessment, special education methods/strategies, and a special education practicum.

nn. Speech (05045) - Sixteen semester hours of speech or communication coursework.

oo. Technology education (10007) - Coursework must include sixteen semester hours from the following list: principles or foundations of technology, technology and society, impacts of technology, history of technology, engineering design, design process, troubleshooting, invention and innovation, research and development, technology systems, modeling, i.e., three-dimensional modeling and prototyping, technology resources, and intelligent machines or robotics or automated systems. Coursework must include six semester hours from the following list: medical technology, agriculture and related biotechnologies, energy and power technologies, information and communication technologies, transportation technology, manufacturing technology, and construction technology. A minimum of three semester hours in study of methods of teaching technology education that must include curriculum and methods in standards-based instruction.

pp. Native language endorsement (15046) - Coursework must include thirty semester hours in classroom management; theories of second language acquisition; methods of second language acquisition; introduction to the specific native language linguistic analysis I and II; native American studies I; the specific native language I, II, III, and IV; and native language history and culture.

qq. STEM education (10300) - Coursework must include twelve semester hours in STEM (transdisciplinary coursework in science, technology, engineering, and mathematics) philosophy, STEM curriculum, STEM methods, STEM strategies, and a two-day field experience in a STEM business or industry or school-based setting.

rr. Theology (50040) - Requirements needed for the theology endorsement include a letter from the nonpublic school administration and the documentation on official transcripts of the baccalaureate degree.

History: Effective March 1, 2000; amended effective August 1, 2002; July 1, 2004; April 1, 2006; July 1, 2008; July 1, 2010; July 1, 2012; October 1, 2014; April 1, 2018; October 1, 2020; October 1, 2021; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-08, 15.1-13-10, 15.1-13-11, 15.1-18-03

67.1-02-03-08. Career and technical educator endorsements.

The applicant wishing to apply for the career and technical educator endorsements must be licensed by the board to teach under North Dakota Century Code section 15.1-18-02 or 15.1-18-03. Prior to applying for the career and technical educator endorsement, the applicant must be approved by the career and technical educator state supervisor of special needs and trade, technical, and health, or the state supervisor of information technology, ~~or the state supervisor of diversified occupations~~ through the review of work experience or college transcripts, development of a program of study, and completion of the career and technical educator endorsement form. The form, transcripts, and ~~review~~ fee of ~~seventy-five~~eighty-five dollars should be forwarded to the board office. Applicants may apply for the career and technical educator endorsements in career and technical resource educator endorsement, career and technical basic skills educator endorsement, career and technical teacher-student mentor endorsement, diversified occupations endorsements, trade, technical, and health endorsement, or the information technology endorsement.

Individuals with a career and technical educator license, who have a four-year degree, and have completed the transition to teaching program may take the state-approved test to qualify for a non-career and technical educator content area.

History: Effective July 1, 2004; amended effective July 1, 2012; October 1, 2020; October 1, 2022; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-13-11, 15.1-13-14

67.1-02-03-09. Early childhood education endorsement (50037).

The birth to grade three early childhood education endorsement may be completed by an applicant with a nonteaching degree in a related field or holding a valid North Dakota educator's professional license. The applicant must complete all requirements for initial licensure in section 67.1-02-02-02, submit a program of study from a state-approved teacher education program including thirty-two semester hours in early childhood education, twenty-two semester hours of professional education, and field experience or student teaching of ten weeks in grades prekindergarten through grade three. If the applicant has completed a previous student teaching experience of ten weeks, the re-education early childhood student teaching experience may be five weeks.

The early childhood education coursework must include six semester hours in child development and learning; three semester hours in building family and community relations; three semester hours in observation and assessment; eighteen semester hours in methods of mathematics, science, social studies, reading, language arts, early language literacy, and play; three semester hours in administration and leadership; twenty-two semester hours in education foundations, educational psychology, teaching and learning theory, educational diagnosis and assessment, inclusive education, educational technology, classroom and behavioral management, and multicultural or native American studies specific to teaching; and field experience must include three supervised field experiences and two student teaching experiences for a minimum of ten weeks (five weeks student teaching for applicants with an existing teaching license). One student teaching experience must be in an accredited prekindergarten or kindergarten setting and the other in grade one, two, or three, and include the opportunity to work with children with special needs.

Effective July 1, 2006, all early childhood endorsement applicants will need to meet or exceed the cut scores as determined by the board for the early childhood education test and the pedagogical assessment.

Re-education of a licensed teacher for early childhood schoolteaching may also be accomplished by holding a North Dakota professional educator's regular license and completion of the pedagogical test birth through grade three, and early childhood content test meeting or exceeding the minimum scores determined by the education standards and practices board in the content area to be taught.

The applicant must apply online at www.nd.gov/espb using the online application ND Teach, submit transcripts, and the review fee of ~~seventy-five~~eighty dollars.

History: Effective April 1, 2006; amended effective July 1, 2008; July 1, 2012; October 1, 2014; April 1, 2018; October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-13-11, 15.1-13-14

CHAPTER 67.1-02-04

67.1-02-04-01. Alternative access licenses for teacher shortages.

Alternative access licenses will be issued under the following conditions:

1. Consideration for alternative access licenses will not be granted until after July first in any year.

2. Alternative access licenses may be issued only in areas where documented shortages of regularly licensed teachers exist as determined by the board. Shortage areas must be determined by the board based upon the ratio of regularly licensed teachers in the state who are qualified for the position to the number of schools with open positions requesting alternative access licensure. In cases where near shortages exist, the board must give additional consideration to whether the hiring school has made a diligent effort to attract and hire regularly licensed teachers.

3. The request for an alternative access license must be initiated by a school. The school board or administration must make the request in writing to the board for consideration of an alternative access license, indicating intent to offer a contract if licensure can be arranged. The request must document that a diligent effort has been made to employ a regularly licensed teacher to fill the position. Documentation of a diligent effort to employ qualified personnel should include information on how and how long the position was advertised, whether schools of education have been contacted in search of applicants, how many qualified applicants applied, how many applicants were interviewed, whether increases in salary or other incentives were offered in an attempt to attract qualified applicants, and whether these incentives are comparable to those offered by other schools of similar size and means.

4. The applicant must write a letter indicating willingness to accept the position if offered and complete all of the application requirements and fees prior to receiving the alternative access license.

5. Complete official college or state-approved alternative program transcripts must be sent to the board.

6. The applicant must have proficiency and hold minimum qualifications or equivalent of a bachelor's degree in the content area to be assigned or have held a valid license from another state for a minimum of two years in the content area to be assigned and have completed the required North Dakota state tests, including the test in the content area to be assigned. The applicant may apply for the forty-day provisional license before submitting the required North Dakota state test scores.

7. Renewal of alternative access licenses will be reviewed each year and will depend upon the supply of and demand for teachers as evidenced by documented efforts to obtain a licensed person for the position. The alternate access license will be issued only once to complete all testing requirements for regular licensure.

8. Renewal of the alternative access license, if permitted, is contingent upon presentation of at least one-third completion of the requirements for regular licensure as stated in section 67.1-02-02-02 and the North Dakota standards for teacher education program.

9. The fee for the alternative access license is ~~one hundred five~~one hundred fifteen dollars for each year the license is issued.

10. Alternative access licensure is to address documented shortage areas only. Alternative access licensure may not be issued to applicants who have failed to meet the deadlines or conditions of their regular licensure renewal.

11. Initial applicants for alternative access licensure must also submit to the fingerprint background check as stated in subsection 9 of section 67.1-02-02-02.

12. Upon completion of all of the requirements for regular licensure stated in section 67.1-02-02-02, an individual holding an alternative access license may apply for a regular two-year initial license and begin accruing the eighteen months of successful teaching time required to move into the five-year cycle according to sections 67.1-02-02-02 and 67.1-02-02-04.

History: Effective July 1, 1995; amended effective October 1, 1998; October 16, 1998-April 14, 1999; June 1, 1999; March 1, 2000; July 1, 2004; April 1, 2006; July 1, 2008; July 1, 2010; April 1, 2013; October 1, 2020; October 1, 2021; October 1, 2022; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-13-11, 15.1-13-14

67.1-02-04-02. Interim licenses for substitute teachers.

Interim licensure may be granted for substitute teachers who hold a minimum of two years of postsecondary education (forty-eight semester hours) when a shortage of regularly licensed substitutes exists. If the applicant for the interim substitute license does not hold a bachelor's degree, the applicant may not spend more than thirty consecutive days in the same classroom as the substitute teacher. The applicant must complete all of the application requirements, fees, and submit to the fingerprint background check as stated in subsection 9 of section 67.1-02-02-02 prior to receiving the interim substitute license. The interim license fee for substitute teachers is ~~eighty~~ninety dollars for two years. The interim license is valid for a minimum of two years and will expire on the applicant's birthday.

Interim licensure may be granted for substitute teachers who hold a high school diploma or equivalent when a shortage of regularly licensed substitutes exists. If the applicant for the interim substitute license does not hold a bachelor's degree, the applicant may not spend more than thirty consecutive days in the same classroom as the substitute teacher. The applicant must submit evidence of completion of the state-approved substitute training program. The applicant must complete all of the application requirements, fees, and submit to the fingerprint background check as stated in subsection 9 of section 67.1-02-02-02 before receiving the interim substitute license. The interim license fee for substitute teachers is ~~eighty~~ninety dollars for two years. The interim license is valid for a minimum of two years and will expire on the applicant's birthday.

History: Effective October 16, 1998-April 14, 1999; amended effective June 1, 1999; March 1, 2000; July 1, 2004; April 1, 2006; July 1, 2010; July 1, 2012; April 1, 2018; October 1, 2021; October 1, 2022; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-13-11

67.1-02-04-04. Forty-day provisional licenses.

Provisional licenses will be issued for a period of forty days under the following conditions:

1. Provisional licenses can only be issued to those individuals who have met all of the other requirements for a license except:

   a. For the final clearance of the bureau of criminal investigation and the federal bureau of investigation;

   b. Pending the receipt of official transcripts or other original, signed, or certified documents;

c. The awarding of the degree and the official transcripts as documented by the institution of higher education registrar; or

d. Pending the receipt of the official test scores for the Praxis I or the Praxis II.

2. The school wishing to hire the individual has submitted to the board a letter of need and intent to hire.

3. The individual has submitted the completed application packet and a letter to the education standards and practices board indicating no criminal background and the intent to accept the position.

4. The provisional license is issued for forty days but may be renewed at the discretion of the education standards and practices board and continued request of the school.

5. There is a one-time fee for the provisional license of ~~fifty-five~~sixty-five dollars.

6. Once the criminal background investigation has been completed and all official transcripts or other original, signed, or certified documents received, the education standards and practices board may issue the license for which the individual is qualified with its respective fees and conditions.

History: Effective March 1, 2000; amended effective July 1, 2004; April 1, 2006; July 1, 2008; July 1, 2010; July 1, 2012; October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-13-11, 15.1-13-13, 15.1-13-14

67.1-02-04-06. Trade, industry, technical, and health occupations interim license.

Applicants entering the profession of teaching in the areas of trade, industry, technical, and health occupations in compliance with the standards prescribed by the state board for career and technical education under North Dakota Century Code section 15-20.1-03 are issued restricted trade, industry, technical, and health occupations interim licensure by the education standards and practices board under North Dakota Century Code section 15.1-13-10. Applicants for the initial trade, industry, technical, and health occupations interim license pay the thirty dollar initial application fee and ~~a seventy~~an eighty dollar fee for the first two-year license, and must also submit to a fingerprint screening for criminal records in accordance with North Dakota Century Code section 15.1-13-14.

The trade, industry, technical, and health occupations interim license is renewable upon satisfactory completion of re-education requirements prescribed and verified by the state board for career and technical education, submission of a completed application for renewal, positive recommendations, and payment of the license fee. Subsequent two-year or five-year renewal licenses will be issued in accordance with the renewal requirements in section 67.1-02-02-04. An applicant issued a restricted trade, industry, technical, and health occupations license may teach or substitute teach only in that licensed area and may move into a regular teaching license by completing the requirements for regular licensure under section 67.1-02-02-02.

The trade, industry, technical, and health occupations endorsement is required for those educators teaching occupational intent programs grades nine through twelve that meet the career and technical education standards or industry standards, or both. A review of past coursework and experience will be conducted and a program of studies needed for completion will be established. Re-education for the trade, industry, technical, and health occupations endorsement must be completed prior to or within two years of assignment.

The applicant must request the endorsement form from the department of career and technical education, complete it, and ~~return~~submit it with the official documentation, and ~~review~~ fee of ~~seventy-five~~eighty dollars.

History: Effective August 1, 2002; amended effective July 1, 2004; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-13-11, 15.1-13-14

CHAPTER 67.1-02-05
LICENSURE POLICIES

Section
67.1-02-05-01 Reciprocity of Suspensions and Revocations
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67.1-02-05-04 Endorsements, Added Degrees, and Restrictions
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67.1-02-05-06 Levels of Licensure

67.1-02-05-04. Endorsements, added degrees, and restrictions.

The North Dakota educator's professional license is issued as described in section 67.1-02-02-02. This license qualifies the holder for regular classroom teaching or for functioning in areas with the proper endorsements and restrictions as assigned. Degrees and endorsements in content areas of elementary, middle level, or secondary schools, educational pedagogy, or educational leadership must be obtained through regional or state-approved teacher education programs and meet North Dakota program approval standards for the content area.

1. **Endorsements.** An individual holding a valid North Dakota teaching license may request endorsements in early childhood, kindergarten, elementary, middle school, bilingual, secondary, or content area minor equivalency endorsements or any other endorsement issued by the board. Specific requirements appear in chapter 67.1-02-03, regarding re-education. A one-time, nonrefundable review fee of ~~seventy-five~~eighty dollars must accompany the request to add an endorsement.

2. **New degrees.** A newly acquired major, minor, or new degree may be added between renewal periods by submitting official transcripts, a complete application form, including part six, completed by the college or university, and paying the regular renewal fee for those renewing two-year licenses or five-year licenses. An additional two-year or five-year extension, respectively, is added to the license expiration date at the time of the addition of the new major, minor, or degree.

3. **Added qualifications on life certificates.** An individual who holds a life certificate under section 67.1-02-02-01 may add degrees or endorsements to the board licensure records by submitting official transcripts and paying the review fee pursuant to subsection 2. An official duplicate of the life certificate showing the added degree will be issued to the life certificate holder at the time of the addition. Official duplicate copies of lost life certificates or renewable licenses will be provided at a cost to the holder of twenty dollars.

4. **Restricted licenses.** Programs that include a specialized rather than a regular professional education core are issued initial two-year licenses that restrict the holder to teaching in that specialty area. Applicants must submit the completed application form, original transcripts, fees, and fingerprint cards to the education standards and practices board prior to licensure. National certification may be used for re-education credits for as long as the certification is current.

   a. Restricted licenses are issued to applicants with specialist or master's degrees in:

      (1) School psychology. The prekindergarten through grade twelve school psychology restricted license will be issued to those applicants who have:

         (a) Obtained a specialist degree in school psychology from a national association of school psychology-accredited institution;

(b) Achieved the national certification of school psychologist certification. To qualify for the national certification of school psychologist license, the candidate must have successfully met the standards for training and field placement programs in school psychology, standards for the credentialing of school psychologist, standards for the provision of school psychological services, and principles of professional ethics; or

(c) Obtained a specialist degree in school psychology with the expectation of obtaining national certification within two years.

The board of psychologist examiners must be given, each year, a list of names of individuals with a school psychologist credential.

(2) School psychologist intern. A school psychologist who does not have the school psychologist requirements in subparagraph a, b, or c of paragraph 1 may qualify for an intern license. The school psychologist intern license will be issued for one year, or on an annual basis until the specialist degree has been completed, for applicants who have:

(a) Obtained a master's degree in school psychology (minimum 30 credits) from a national association of school psychology-accredited institution;

(b) A recommendation of the advisor of an accredited school psychology training instruction stating the applicant is eligible for enrollment in the internship program; and

(c) An outline of remaining coursework with specified dates for completion, including completion of a thesis or equivalent.

(3) Speech-language pathology. The prekindergarten through grade twelve speech-language pathology restricted license will be issued to those applicants who have a master's degree in speech-language pathology or communication disorders, one hundred hours of school-based practicum, and have graduated from a program accredited by the council on academic accreditation of the American speech and hearing association. Applications for renewal of the bachelor level speech-language pathology license will be denied after July 1, 2010.

(4) School counseling. The prekindergarten through grade twelve professional school counseling restricted license will be issued to those applicants who have professional education coursework in educational psychology; instructional planning, methods, and assessment; classroom management; and school-based field experience or practicum and completed one of the following master's programs from a state-approved counselor education program:

(a) Master's degree in school counseling;

(b) Master's degree in counseling with emphasis in school counseling;

(c) Master's degree and graduate coursework equivalent to a master's degree in school counseling; or

(d) Master's degree in counseling and a program of study from an approved school counselor education program to complete the coursework requirements for the equivalent of a master's degree in school counseling, educational coursework in educational psychology, instructional planning, methods, and assessment, classroom management, and the school-based field experience

or practicum within four years. Two 2-year licenses will be issued to those applicants while the requirements are being completed.

b. Restricted licenses are issued to applicants with baccalaureate degrees in the following areas who do not also meet qualifications for regular early childhood, elementary, middle level, secondary, or kindergarten through grade twelve licenses as stated in section 67.1-02-02-02 that have completed the application form and submitted fees and transcripts, background investigation, and praxis II tests:

(1) Intellectual disabilities education (19006). The intellectual disabilities prekindergarten through grade twelve restricted license will be issued to those people qualifying for a valid North Dakota teaching license in special education who hold a bachelor of science degree major in intellectual disabilities. The applicant will only provide consultative services.

(2) Hearing-impaired education (19920). The hearing-impaired prekindergarten through grade twelve restricted license will be issued to those applicants who have a bachelor of science degree major in education of the deaf with thirty-two hours of hearing-impaired qualifying coursework. The applicant will only provide consultative services.

(3) Visually impaired education (19945). The visually impaired prekindergarten through grade twelve restricted license will be issued to those applicants who have a bachelor of science degree with a major in visually impaired and twenty-one through twenty-three semester hours in qualifying visually impaired coursework. The applicant will only provide consultative services.

(4) Early childhood special education (19937). The early childhood special education restricted license birth through grade three will be issued to those applicants who have a baccalaureate degree in early childhood special education. The applicant will only provide consultative services.

(5) All other special education categories require regular early childhood, elementary, middle, or secondary qualifications.

(6) Career and technical education. The trade, industry, technical, and health occupations restricted license will be issued to applicants holding a baccalaureate level degree in career and technical education if that degree does not include the general education or regular professional education core as required for regular licensure under section 67.1-02-02-02, and is restricted to teaching in grades seven through grade twelve.

(7) Reserve officers training corps. The reserve officers training corps license will be issued pursuant to section 67.1-02-05-03.

(8) Native American language instruction.

(a) The native American language restricted kindergarten through grade twelve license will be issued to those applicants holding a baccalaureate level degree in native American language if that degree does not include the general education or regular professional education core as required for regular licensure under section 67.1-02-02-02 and has completed a three semester hour course in classroom instruction at a tribal college or other institution of higher education.

(b) The native American language restricted kindergarten through grade twelve licensed will be issued to those applicants holding a baccalaureate level

degree and a native American language endorsement, including three semester hours in classroom instruction.

(9) Theological studies instruction (50040). The theological studies kindergarten through grade twelve license will be issued to those applicants holding a baccalaureate degree and is recommended for approval as an instructor of theological studies by the governing board or administration of a nonpublic school offering a theological studies course.

c. Restricted licenses are issued to those nondegreed applicants in:

(1) Career and technical education. Restricted licenses are issued for trade, industry, technical, and health occupations in accordance with section 67.1-02-04-06 and are restricted to teaching in grades nine through twelve.

(2) North Dakota American Indian language as pursuant to North Dakota Century Code section 15.1-13-22 to those applicants who display competence in North Dakota American Indian languages and culture and are recommended for licensure to teach North Dakota native languages kindergarten through grade twelve by an indigenous language board created by a tribal government in this state and have completed a three semester hour course in classroom instruction at a tribal college or other institution of higher education.

d. Teachers with restricted licenses may teach only in the restricted specified area.

History: Effective July 1, 1995; amended effective October 1, 1998; June 1, 1999; March 1, 2000; August 1, 2002; July 1, 2004; April 1, 2006; July 1, 2008; July 1, 2010; July 1, 2012; October 1, 2020; October 1, 2021; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-08, 15.1-13-10, 15.1-13-11, 15.1-13-12.1, 15.1-13-22, 15.1-18-02, 15.1-18-03; S.L. 2001, ch. 173, § 16

67.1-02-05-04.1. Scope of practice - School psychologist.

1. School psychologists are licensed practitioners of the healing arts which is defined as the application of psychological principles, methods, and procedures from educational psychology, developmental psychology, clinical psychology, community psychology, and behavior analysis to meet the learning, mental and behavioral health needs of children ages birth through twenty-one.

2. The "practice of licensed school psychology" may only be practiced in a public or nonpublic school and is defined as:

a. The diagnostic assessment, including psychoeducational, developmental and vocational assessment, evaluation and interpretation of intelligence, cognitive processes, aptitudes, vocational, academic achievement, behavioral, and affective adjustment, personality factors and motivations, or any other attributes, to individual students or groups of students that relate to developmental status, attention and executive functioning skills, learning, education, and social, emotional, and behavioral functioning;

b. The development and implementation of educationally related mental and behavioral health approaches to increase adjustment and academic success including the provision of psychotherapeutic, counseling and interpretive services to reduce education-related problems, including verbal interaction, interviewing, behavior techniques, developmental and vocational intervention, environmental management and group processes with students, parents of students, teachers, school administrators and school staff;

c. Consultation with representatives of schools, agencies and organizations, families or individuals, including psychoeducational, developmental and vocational assistance and direct educational services in the form of in-service or continuing professional development services related to learning problems and adjustment to those problems to the benefit of an individual student or group of students including the screening of social, affective, and behavioral functioning of the students;

d. The development of programming, including participating in or conducting research, designing, implementing and/or evaluating educationally and psychologically sound learning environments and the facilitation of psychoeducational development of individuals, families or groups; and

e. The provision of supervision of school psychology services, inclusive of those preprofessionals completing an internship as part of the students' accredited university requirement.

History: Effective January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-08, 15.1-13-10

CHAPTER 67.1-02-06

67.1-02-06-01. Out-of-state reciprocal licensure.

North Dakota has conditional reciprocity with other states. To receive out-of-state reciprocal licensure, an applicant must hold at least a bachelor's degree in education, which includes student teaching from an accredited university from another state, province, or similar jurisdiction, or have completed a state-approved teacher education program and submit a completed application.

1. **Out-of-state reciprocal entrance requirements.** Those who apply to the board, meet the minimum reciprocity requirements, and submit a satisfactory plan for competing the remaining North Dakota requirements will be issued a two-year out-of-state reciprocal license which has a fee of ~~seventy~~eighty dollars. The minimum reciprocity qualifications are:

   a. A four-year bachelor's degree that includes a major that meets the issuing jurisdiction's requirements in elementary education, middle level education, or a content area taught in public high school;

   b. Completion of a professional education sequence from a state-approved teacher education program, including supervised student teaching;

   c. Fingerprint background check as required of all initial applicants; and

   d. Submission and education standards and practices board approval of a plan to complete all remaining requirements for full North Dakota licensure as stated in section 67.1-02-02-02. That plan will include the successful completion of the state-approved test content test in the transcripted major area of early childhood, elementary, middle level, or the core academic areas. The state-approved test must be completed within the first two-year license period.

2. **Remaining North Dakota requirements.** An applicant will be notified of remaining requirements for full North Dakota licensure by the board. All out-of-state applicants shall submit transcripts for review by the same criteria as North Dakota applicants. The applicant must provide official copies of transcripts from all the institutions of higher education the applicant has attended. The nonrefundable fee for the transcript review process is one hundred seventy-five dollars.

3. **Renewals.** The out-of-state reciprocal license is valid for two years and is renewable twice for ~~up to five~~three additional years, provided adequate progress toward completing the remaining requirements is documented and approved by the education standards and practices board. The interim reciprocal license will expire on the applicant's birthdate.

History: Effective July 1, 2012; amended effective April 1, 2018; October 1, 2020; October 1, 2021; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-10, 15.1-13-11, 15.1-13-14, 15.1-13-20, 15.1-13-21

CHAPTER 67.1-04-03

67.1-04-03-01. National board certification.

1. **Definitions.**

   a. "Board" means the education standards and practices board.

   b. "Certification" means national board certification as provided by the national board.

   c. "National board" means the national board for professional teaching standards.

2. **Board duties.** Based upon receiving state dollars, the board shall:

   a. Inform teachers of the national board certification program and the scholarships and services the national board provides to teachers seeking certification.

   b. Collect and review in the order received scholarship applications from individuals who are licensed to teach by the board or approved to teach by the board.

   c. Approve ~~no more than seventeen state-funded applications per year~~first-time applicants based on funding availability.

   d. During each year of the biennium, reserve three of the available scholarships until October first for individuals teaching at low-performing schools. At that time, the three slots, if not filled, become available to other applicants.

   e. Require the recipient to serve during the school year as a full-time classroom teacher in a public or nonpublic school.

   f. Require the recipient to participate in mentoring developed and implemented in the employing school or district.

   g. Ensure that all scholarship recipients receive adequate information regarding level of commitment required to acquire certification.

   h. If any individual who receives a scholarship under this section does not complete the certification process within the time allotted by the board, the individual must reimburse the state an amount equal to one-half of the amount awarded to the individual as a scholarship.

3. **Recertification process.**

   a. Collect and review in the order received scholarship applications for national board recertification from individuals who are licensed to teach by the board or approved to teach by the board;

   b. Approve ~~no more than three scholarship applications per year under this subsection~~recertification applications, based upon availability of state funds, applications will be accepted and funded on a first-come, first-served basis;

   c. Require each recipient for a scholarship under this subsection serve during the school year as a full-time classroom teacher in a public or nonpublic school in this state; and

   d. If available, require each recipient of a scholarship under this subsection to participate in mentoring programs developed and implemented in the employing school or school district.

4. **Stipends.**

   a. The board shall pay to any individual who received national board certification before July 1, 2007, one thousand dollars for each year the individual has maintained and continues to maintain national board certification, provided the individual continues to be employed by a school district in this state. An individual may not receive more than four thousand dollars under this subsection.

   b. At the conclusion of each school year after the individual received national board certification, the board shall pay to an individual an additional one thousand state dollars for the life of the national board certificate, if:

      (1) The individual was employed during the school year as a full-time classroom teacher by a school district in this state.

      (2) If available, require the participant for a scholarship under this section to participate in any efforts of the employing school district to develop and implement teacher mentoring programs.

   c. The payment provided for in this subsection is available beginning with the 2007-08 school year.

   d. As a prerequisite, the applicant must:

      (1) Have acquired a baccalaureate degree from a state-approved or accredited teacher education program;

      (2) Hold a valid North Dakota educator's professional license;

      (3) Have successfully completed three years of teaching at one or more elementary, middle, or secondary schools in North Dakota; and

      (4) Currently be North Dakota kindergarten through grade twelve public or nonpublic classroom instructors.

   e. The applicant may apply for the guide to national board certification, which includes the application process by contacting the education standards and practices board, and for one-half of the application fee by submitting the completed application to the education standards and practices board by December first. Based upon availability of state funds, applications will be accepted and funded on a first-come, first-served basis. ~~One-half of the application fees will be matched with federal dollars.~~

5. **Successful completion.** Upon documented successful completion, the national board for professional teaching standards certification may be added between renewal periods for a fee as pursuant to the five-year renewal fee in section 67.1-02-02-04, and additional years equivalent to the number of years left of national certification is also added to the license expiration date at the time of the addition of national board for professional teaching standards certification.

6. **Renewal.** The board recognizes the national board certification as fulfilling the requirement for license renewal until expiration of the national board certificate.

History: Effective July 1, 2012; amended effective October 1, 2020; January 1, 2024.
General Authority: NDCC 15.1-13-09, 15.1-13-10
Law Implemented: NDCC 15.1-13-08, 15.1-13-10, 15.1-13-11, 15.1-13-12.1, 15.1-13-22, 15.1-18-02, 15.1-18-03

TITLE 75

DEPARTMENT OF HUMAN SERVICES

JANUARY 2024

CHAPTER 75-02-02
MEDICAL SERVICES

75-02-02-24 Contractual Rights to Receive Money Payments [Repealed]
75-02-02-25 Disqualifying Transfers [Repealed]
75-02-02-26 Eligibility Under 1972 State Plan [Repealed]
75-02-02-27 Scope of Drug Benefits - Prior Authorization
75-02-02-28 Drug Use Review Board and Appeals
75-02-02-29 Primary Care Provider [Repealed]

75-02-02-03. State organization.

1. **Single state agency.** The department of health and human services is the single state agency with authority to supervise the administration of the Medicaid and children's health insurance program state plan and program.

2. **Statewide operation.**

   a. The state plan will be in operation, through a system of local offices on a statewide basis, in accordance with equitable standards for assistance and administration that are mandatory throughout the state.

   b. The state plan will be administered by the political subdivisions of the state and will be mandatory on such political subdivisions.

   c. The department of health and human services, hereinafter referred to as the ~~state agency~~department, will assure that the plan is continuously in operation in all local offices or local agencies through:

      (1) Methods for informing staff of state policies, standards, procedures, and instructions.

      (2) Regular planned examination and evaluation of operations in local offices by regularly assigned state staff, including regular visits by such staff; and through reports, controls, or other necessary methods.

History: Effective October 1, 1979; amended effective May 1, 1986; April 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-06-05.1, 50-24.1-04; 42 CFR 431.10; 42 CFR 431.20

75-02-02-03.2. Definitions.

For purposes of this chapter:

1. ~~"Behavioral health service" means an evaluation, therapy, or testing service rendered by one of the following practitioners within their scope of practice: physician, licensed clinical social worker, psychologist, licensed addiction counselor, licensed clinical addiction counselor, master addiction counselor, licensed associate professional counselor, licensed professional counselor, licensed professional clinical counselor, clinical nurse specialist, physician assistant, nurse practitioner, licensed baccalaureate social worker, licensed marriage and family therapist, or licensed master social worker.~~

~~2.~~ "Certification of need" means a regulatory review process that requires specific health care providers to obtain prior authorization for provision of services for Medicaid applicants or eligible recipients under age twenty-one. Certification of need is a determination of the medical necessity of the proposed services as required for all applicants or recipients under the age of twenty-one prior to admission to a psychiatric hospital, an inpatient psychiatric program in a hospital, or a psychiatric facility, including a psychiatric residential treatment facility. The certification of need evaluates the individual's capacity to benefit from proposed services, the

efficacy of proposed services, and consideration of the availability of less restrictive services to meet the individual's needs.

~~3.~~2. "Department" means the North Dakota department of health and human services.

~~4.~~3. "Drug use review board" means the board established pursuant to North Dakota Century Code chapter 50-24.6.

4. "Enrolled in-state provider" means the enrolled medical provider who has assumed responsibility for the advice and care of the recipient.

5. "Exercise program" includes regimens to achieve various improvements in physical fitness and health.

6. "Home health agency" means a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act, or is determined currently to meet the requirements for participation.

7. "Indian health ~~services~~service or tribal health facility or clinic" means either a health ~~services~~service facility or clinic operated by the United States department of health and human services Indian health ~~services~~service division or a federally recognized tribal nation that has opted to contract with Indian health ~~services~~service to plan, conduct, and administer one or more individual programs, functions, services, or activities, resulting in tribal health facilities or clinics operated by tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act [Pub. L. 93-638].

8. "Licensed practitioner" means an individual other than a physician who is licensed or otherwise authorized by the state to provide health care services within the practitioner's scope of practice.

9. "Medical emergency" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the ~~person's~~individual's health, or with respect to a pregnant ~~woman~~individual, the health of the ~~woman~~individual or ~~her~~their unborn child, in serious jeopardy.

10. "Medically necessary" includes only medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the recipient's diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the recipient or provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective.

11. "Provider" means an individual, entity, or facility furnishing medical or remedial services or supplies pursuant to a provider agreement with the department.

12. "Psychiatric residential treatment facility" is as defined in subsection 13 of section 75-03-17-01.

13. "Recipient" means an individual approved as eligible for Medicaid or children's health insurance program.

14. "Rehabilitative services" means any medical or remedial items or services prescribed for a recipient by the recipient's physician or other licensed practitioner of the healing arts, within

the scope of the physician's or practitioner's practice as defined by state law, for the purpose of maximum reduction of physical or mental disability and restoration of the recipient to the recipient's best possible functional level.

15. "Remedial services" includes those services, including rehabilitative services, which produce the maximum reduction in physical or mental disability and restoration of a recipient to the recipient's best possible functional level.

16. "Weight loss program" includes programs designed for reduction in weight, but does not include weight loss surgery.

History: Effective May 1, 2000; amended effective August 29, 2000; November 1, 2001; September 1, 2003; October 1, 2012; April 1, 2016; January 1, 2017; April 1, 2018; April 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

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~~an individual who is terminally ill ~~individual~~and 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~~individual'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~~individual'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~~recommended by a physician or other licensed practitioner of the healing arts, within the scope of ~~the physician's or practitioner's~~authorized practice as defined by state law, to prevent illness, disease, disability, and other health ~~deviations~~conditions 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~~individuals 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~~recipients 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~~individual who is pregnant 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; January 1, 2024.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 USC 1396n(b)(1); 42 CFR 431.53; 42 CFR 431.110; 42 CFR 435.1009; 42 CFR Part 440; 42 CFR Part 441, subparts A, B, D

75-02-02-09. Nursing facility level of care.

1. "Nursing facility level of care" means, for purposes of Medicaid and children's health insurance program, services provided by a facility that meets the standards for nursing facility licensing established by the ~~state~~ department ~~of health~~, and in addition, meets all requirements for nursing facilities imposed under federal law and regulations governing the Medicaid program and the children's health insurance program.

2. Except as provided in subsection 3 or 4, an individual who applies for care in a nursing facility, or who resides in a nursing facility, may demonstrate that a nursing facility level of care is medically necessary only if any one of the criteria in this subsection is met.

   a. The individual's nursing facility stay is, or is anticipated to be, temporary for receipt of Medicare part A benefits. A nursing facility stay may be based on this criterion for no more than fourteen days after termination of Medicare part A benefits.

   b. The individual is in a comatose state.

   c. The individual requires the use of a ventilator at least six hours per day, seven days a week.

   d. The individual has respiratory problems that require regular treatment, observation, or monitoring that may only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse, and is incapable of self-care.

   e. The individual requires constant help sixty percent or more of the time with at least two of the activities of daily living of toileting, eating, transferring, and locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

   f. The individual requires aspiration for maintenance of a clear airway.

   g. The individual has dementia, physician-diagnosed or supported with corroborative evidence, for at least six months, and as a direct result of that dementia, the individual's condition has deteriorated to the point when a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.

3. If no criteria of subsection 2 is met, an individual who applies for care in a nursing facility or who resides in a nursing facility may demonstrate that a nursing facility level of care is medically necessary if any two of the criteria in this subsection are met.

   a. The individual requires administration of prescribed:

      (1) Injectable medication;

      (2) Intravenous medication or solutions on a daily basis; or

      (3) Routine oral medications, eye drops, or ointments on a daily basis.

   b. The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse.

   c. The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments, such as gait training or bowel and bladder training, which are provided at least five days per week.

   d. The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.

   e. The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.

f. The individual requires constant help sixty percent or more of the time with any one of the activities of daily living of toileting, eating, transferring, or locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

4. If no criteria of subsection 2 or 3 is met, an individual who applies to or resides in a nursing facility designated as a facility for nongeriatric individuals with physical disabilities may demonstrate that a nursing facility level of care is medically necessary if the individual is determined to have restorative potential.

5. If no criteria of subsection 2, 3, or 4 is met, an individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if:

   a. The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; and

   b. As a result of the brain injury, the individual requires direct supervision at least four hours a day, five days a week.

6. a. Payment, by the department ~~of human services~~, for care furnished in a nursing facility to individuals who were applicants for or recipients of Medicaid or children's health insurance program benefits prior to admission to the nursing facility may be made only for periods after a nursing facility level of care determination is made. If a nursing facility admits an individual who has applied for or is receiving Medicaid or children's health insurance program benefits before a nursing facility level of care determination is made, the nursing facility may not solicit or receive payment, from any source, for services furnished before the level of care determination is made.

   b. Payment, by the department ~~of human services~~, for care furnished in a nursing facility to individuals who become applicants for or recipients of Medicaid or children's health insurance program benefits after admission to the nursing facility may be made only after a nursing facility level of care determination is made.

   c. Payment, by the department ~~of human services~~, for care furnished in a nursing facility to individuals who are eligible for Medicare benefits related to that care, and who are also eligible for Medicaid or children's health insurance program, may be made only after a nursing facility level of care determination is made.

7. A nursing facility shall ensure that appropriate medical, social, and psychological services are provided to each resident of the facility who is dependent in whole or in part on the Medicaid program or children's health insurance program. The appropriateness of such services must be based on the need of each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and must consider, among other factors, age.

History: Amended effective September 1, 1979; July 1, 1993; November 1, 2001; October 1, 2012; April 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 442

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~~individuals 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~~recipient and the provider.

8. Payment for the tasks of laundry, shopping, meal preparation, money management, and communication may be made to a provider if the activity benefits the ~~client~~recipient. The department may pay a provider for housekeeping activities involving the ~~client's~~recipient's personal private space and if the ~~client~~recipient is living with an adult, the ~~client's~~recipient'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 be provided to a recipient who has natural supports. For purposes of this subsection, "natural supports" means an informal, unpaid caregiver that provides care to an applicant or ~~client~~recipient.

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~~recipient presents an immediate threat to the health or safety of the ~~client~~recipient, 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~~recipient, the provider of services, or others.

17. Decisions regarding personal care services for an incapacitated ~~client~~recipient 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~~recipient 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; January 1, 2024.
General Authority: NDCC 50-24.1-18
Law Implemented: NDCC 50-24.1-18; 42 CFR Part 440.167

75-02-02-11. Coordinated services.

1. For purposes of this section:

   a. "Coordinated services" means the process used to limit a recipient's medical care and treatment to a single physician or other provider to prevent the continued misutilization of services.

   b. "Coordinated services provider" means a physician, nurse practitioner, physician assistant, or Indian health ~~services~~service or tribal health facility or clinic selected by the coordinated services recipient to provide care and treatment to the recipient. The selected coordinated services provider is subject to approval by the department.

   c. "Misutilization" means the incorrect, improper, or excessive utilization of medical services which may increase the possibility of adverse effects to a recipient's health or may result in a decrease in the overall quality of care.

2. Coordinated services may be required by the department of a past, current, or future recipient who has misutilized services, including:

   a. Securing excessive services from more than one provider when there is little or no evidence of a medical need for those services;

b. Drug acquisition in excess of medical need resulting from securing prescriptions or drugs from more than one provider;

c. Excessive utilization of emergency services when no medical emergency is present; or

d. Causing services to be misutilized due to fraud, deception, or direct action, without regard to payer source.

3. The determination to require coordinated services of a recipient is made by the department upon recommendation of medical professionals who have reviewed and identified the services the recipient appears to be misutilizing.

4. The following factors must be considered in determining if coordinated services is to be required:

a. The seriousness of the misutilization;

b. The historical utilization of the recipient; and

c. The availability of a coordinated services physician or provider.

5. If a coordinated services recipient does not select a coordinated services provider within thirty days after qualifying for the program, the department will limit the recipient to only medically necessary medical and pharmacy services. If a coordinated services recipient selects a coordinated services provider after the initial thirty days, the selection will be reviewed by the department to determine if the selected provider is appropriate and to ensure the provider accepts the assignment. A coordinated services recipient may have a coordinated services provider in more than one specialty, such as medical, dental, or pharmacy.

6. Upon a determination to require coordinated services:

a. The department shall provide the recipient with written notice of:

(1) The decision to require coordinated services;

(2) The recipient's right to choose a coordinated services provider, subject to approval by the department and acceptance by the provider;

(3) The recipient's responsibility to pay for medical care or services rendered by any provider other than the coordinated services provider; and

(4) The recipient's right to appeal the requirement of enrollment into the coordinated services program.

b. The appropriate human service zone shall:

(1) Obtain the recipient's selection of a coordinated services provider; and

(2) Document that selection in the case record.

7. Coordinated services may be required of an individual recipient and may not be imposed on an entire Medicaid or children's health insurance program case. If more than one recipient within a case is misutilizing medical care, each individual recipient must be treated separately.

8. Coordinated services may be required without regard to breaks in eligibility until the department determines coordinated services is discontinued.

9. No Medicaid or children's health insurance program payment may be made for misutilized medical care or services furnished to the coordinated services recipient by any provider other than the recipient's coordinated services physician or provider, except for:

   a. Medical care rendered in a medical emergency; or

   b. Medical care rendered by a provider upon referral by the coordinated services physician or provider and approved by the department.

10. A recipient may appeal the decision to require coordinated services in the manner provided by chapter 75-01-03.

History: Effective May 1, 1981; amended effective May 1, 2000; July 1, 2006; October 1, 2012; April 1, 2016; April 1, 2018; April 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.1-02
Law Implemented: NDCC 50-24.1-01; 42 CFR Part 455

75-02-02-12. Limitations on emergency room services.

1. For purposes of this section, "screening" means the initial evaluation of an individual, intended to determine suitability for a particular medical treatment modality.

2. The provider of emergency services shall assure that a recipient is referred to the appropriate health delivery setting, including the recipient's ~~primary care~~enrolled in-state provider, when emergency room services are not judged to be appropriate.

3. Payment for emergency room services.

   a. Claims for payment, and documentation in support of those claims, must be submitted on forms prescribed by the department. The claim must contain sufficient documentation to indicate that a medical emergency required emergency room diagnostic services and treatment.

   b. Except as provided in subsection 4, providers must be paid for any medically necessary services.

   c. Except as provided in subsection 4, providers must be paid for screening or examination services rendered.

   d. Providers must be paid for services rendered to recipients who reside outside of the provider's regular service area and who do not normally utilize the provider's services.

4. If the emergency room service claim does not demonstrate the existence of a medical emergency, payment must be denied (except for screening services) unless the services are shown to be medically necessary by a redetermination. The provider, upon receipt of notice of denial, may, in writing, make a redetermination request to the department. A redetermination must include a statement refuting the stated basis for the payment denial and affirmatively demonstrating a medical emergency.

History: Effective February 1, 1982; amended effective May 1, 2000; October 1, 2012; April 1, 2016; April 1, 2018; January 1, 2024.
General Authority: NDCC 50-24.1-02
Law Implemented: NDCC 50-24.1-01; 42 CFR Part 455

75-02-02-13. Limitations on out-of-state care.

1. For purposes of this section:

a. "Out-of-state care" means care or services furnished by any individual, entity, or facility, pursuant to a provider agreement with the department, at a site located more than fifty statute miles [80.45 kilometers] from the nearest North Dakota border.

b. "Out-of-state provider" means a provider of care or services that is located more than fifty statute miles [80.45 kilometers] outside of North Dakota. An out-of-state provider may be an individual or a facility but may not be located outside of the United States.

c. ~~"Primary care provider" means the enrolled medical provider who has assumed responsibility for the advice and care of the recipient.~~

~~d.~~ "Specialist" means a physician board certified in the required medical specialty who regularly practices within North Dakota or at a site within fifty statute miles [80.45 kilometers] from the nearest North Dakota border.

2. Except as provided in subsection 3, no payment for out-of-state care, including related travel expenses, will be made unless:

a. The recipient was first seen by that recipient's ~~primary care~~enrolled in-state provider~~, unless the recipient is not required to have a primary care provider~~;

b. The ~~primary care~~enrolled in-state provider determines~~, unless the recipient is not required to have a primary care provider,~~ that it is advisable to refer the recipient for care or services which the ~~primary care~~enrolled in-state provider is unable to render and a referral is made to an in-state, board-certified physician specialist, if available;

c. Recipient is evaluated by a board-certified physician specialist;

d. The physician specialist concludes that the recipient should be referred to an appropriate out-of-state provider because necessary care or services are unavailable in the state;

e. The ~~primary care~~enrolled in-state provider or in-state, board-certified physician specialist submits, to the department, a written request that includes medical and other pertinent information, including the report of the specialist that documents the specialist's conclusion that the out-of-state referral is medically necessary;

f. The department determines that the medically necessary care and services are unavailable in the state and approves the referral on that basis; and

g. The claim for payment is otherwise allowable and verifies that the department approved the referral for out-of-state care.

3. a. A referral for emergency care, including related travel expenses, to an out-of-state provider can be made by the enrolled in-state ~~primary care~~ provider. A determination that the emergency requires out-of-state care may be made at the ~~primary care~~enrolled in-state provider's discretion, but is subject to review by the department. Claims for payment for such emergency services must identify the referring ~~primary care~~enrolled in-state provider and document the emergency.

b. Claims for payment for care for a medical emergency or surgical emergency, as those terms are defined in section 75-02-02-12, which occurs when the affected recipient is traveling outside of North Dakota, will be paid unless payment is denied pursuant to limitations contained in section 75-02-02-12.

c. Claims for payment for any covered service rendered to a recipient who is a resident of North Dakota for Medicaid and children's health insurance program purposes, but whose current place of abode is outside of North Dakota, will not be governed by this section.

d. Claims for payment for any covered service rendered to a recipient during a verified retroactive eligibility period will not be governed by this section.

e. If a recipient is referred for out-of-state care without first securing approval under subsection 2, and the care is not otherwise allowable under this subsection, the department may approve payment upon receipt of a written request, from the ~~primary care~~enrolled in-state provider or specialist, that:

(1) Demonstrates good cause for not first securing approval under subsection 2;

(2) Clearly establishes that the care and services were unavailable in the state; and

(3) Documents that the care and services were medically necessary.

4. An out-of-state provider who does not maintain a physical, in-state location or a location within fifty statute miles [80.45 kilometers] of North Dakota will not be enrolled as a Medicaid provider unless the department determines the provider's enrollment is necessary to ensure access to covered services.

History: Effective November 1, 1983; amended effective October 1, 1995; October 1, 2012; April 1, 2018; April 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02-13.1. Travel expenses for medical purposes - Limitations.

1. For purposes of this section~~:~~

~~a. "Family member" means spouse, sibling, parent, stepparent, child, stepchild, grandparent, stepgrandparent, grandchild, stepgrandchild, aunt, uncle, niece, or nephew, whether by half or whole blood, and whether by birth, marriage, or adoption; and~~

~~b. "Travel~~, "travel expenses" means fares, mileage, meals, lodging, and driver and attendant care.

2. General requirements.

a. A transportation service provider shall be enrolled as a provider in the Medicaid program and children's health insurance program and may be an individual, a taxi, a bus, a food service provider, a lodging provider, an airline service provider, a travel agency, or another commercial form of transportation.

b. The department or human service zone may determine and authorize the most efficient, economical, and appropriate means of travel to meet the medical needs of the recipient.

c. The cost of travel provided by a parent, spouse, or any other member of the recipient's Medicaid unit, as defined in section 75-02-02.1-08, may be allowed as an expense of necessary medical or remedial care for recipient liability purposes, unless the parent, spouse, or any other member of the recipient's Medicaid unit is enrolled as a transportation provider. ~~No~~A parent, spouse, friend, household member, or family member of the recipient may be paid as an enrolled provider for transportation for that recipient. An individual who provides foster care, kinship, or guardianship may enroll as a transportation provider and is eligible for reimbursement to transport a Medicaid-eligible child to and from Medicaid-eligible medical appointments in situations in which the Medicaid-eligible child's medical needs exceed ordinary, typical, and routine levels. A guardian of a vulnerable adult may enroll as a transportation provider and is eligible for reimbursement to transport a Medicaid-eligible adult, for whom the guardian has been

court-ordered to provide guardianship services, to and from Medicaid-covered medical appointments.

d. Emergency transport by ambulance is a covered service when provided in response to a medical emergency.

e. Nonemergency transportation by ambulance is a covered service only when medically necessary and ordered by the attending licensed provider.

f. A recipient may choose to obtain medical services outside the recipient's community. If similar medical services are available within the community and the recipient chooses to seek medical services elsewhere, travel expenses are not covered services and are the responsibility of the recipient.

g. If a provider refers a recipient to a facility or provider that is not located at the closest medical center, travel expenses ~~are~~may not be covered services and are the responsibility of the recipient, unless special circumstances apply and prior authorization is secured.

3. Out-of-state travel expenses. Travel expenses for nonemergency out-of-state medical services, including follow-up visits, may be authorized if the out-of-state medical services are first approved by the department under section 75-02-02-13 or if prior approval is not required under that section.

4. Limitations.

a. Private or noncommercial vehicle mileage compensation is limited to the amount on the department fee schedule. This limit applies even if more than one recipient is transported at the same time. Mileage is determined by map miles from the residence or community of the recipient to the medical facility. When necessary to ensure volunteer drivers continue to provide transportation services to a recipient, the ~~human service zone~~department may ~~request authorization from the department to make~~authorize payment for additional mileage. Transportation services may be billed to the Medicaid program or children's health insurance program only upon completion of the service. ~~Transportation services may be allowed if the recipient or a household member does not have a vehicle that is in operable condition or if the health of the recipient or household member does not permit safe operation of the vehicle. If free or low-cost transportation services are available, including transportation that could be provided by a friend, family member, or household member, the department will not pay transportation costs.~~

b. Meals compensation is allowed only when medical services or travel arrangements require a recipient to stay overnight. Compensation is limited to the amount on the department fee schedule. The entity providing meals must be an enrolled Medicaid provider and must submit the proper requests for payment.

c. Lodging expense is allowed only when medical services or travel arrangements require a recipient to stay overnight. Lodging compensation is limited to the amount on the department fee schedule. Lodging providers must be enrolled in Medicaid and shall submit the proper requests for payment.

d. Travel expenses may not be authorized for both a driver and an attendant unless the referring licensed practitioner determines that one individual cannot function both as driver and attendant. Travel expenses may not be allowed for a noncommercial driver or an attendant while the recipient is a patient in a medical facility unless it is more economical for the driver or attendant to remain in the service area, as determined by the department.

e. Travel expenses may be authorized for one parent to travel with a child who is under eighteen years of age. No additional travel expenses may be authorized for another driver, attendant, or parent unless the referring licensed practitioner determines that ~~person's~~individual's presence is necessary for the physical, psychological, or medical needs of the child.

f. Compensation for attendant services, provided by an attendant who is not a family member, may be allowed at a rate determined by the department if the department determines attendant services are medically necessary. Attendant services must be approved by the department or human service zone.

History: Effective July 1, 1996; amended effective May 1, 2000; September 1, 2003; October 1, 2012; July 1, 2014; April 1, 2016; April 1, 2018; April 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

75-02-02-13.2. Travel expenses for medical purposes - ~~Institutionalized individuals~~Individuals in an institution - Limitations.

1. For purposes of this section:

   a. "Long-term care facility" means a nursing facility, intermediate care facility for individuals with intellectual disabilities, or swing-bed facility; and

   b. "Medical center city" means Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, and Williston, and includes any city that shares a common boundary with any of those cities.

2. A long-term care facility may not charge a resident for the cost of travel provided by the facility. Except as provided in subsection 4, a long-term care facility shall provide transportation to and from any provider of necessary medical services located within, or at no greater distance than the distance to, the nearest medical center city. Distance must be calculated by road miles.

3. If the resident has to travel farther than the nearest medical center city, the costs of travel may be reimbursed by Medicaid according to the appropriate fee schedule. Distance must be calculated by map miles.

4. A long-term care facility is not required to pay for transportation by ambulance for emergency or nonemergency situations for residents.

5. A service provider that is paid a rate, determined by the department on a cost basis that includes transportation service expenses, however denominated, may not be compensated as a transportation service provider for transportation services provided to an individual residing in the provider's facility. The following service providers may not be so compensated:

   a. Basic care facilities;

   b. Residential habilitation services for individuals with intellectual or developmental disabilities;

   c. Intermediate care facilities for individuals with intellectual disabilities;

   d. Independent habilitation services for individuals with intellectual or developmental disabilities;

   e. Nursing facilities;

   f. Psychiatric residential treatment facilities;

g. Qualified residential treatment programs; and

h. Swing-bed facilities.

6. If, under the circumstances, a long-term care facility is not required to transport a resident, and the facility does not actually transport the resident, the availability of transportation services and payment of travel expenses is governed by section 75-02-02-13.1.

History: Effective July 1, 1996; amended effective July 1, 2012; October 1, 2012; April 1, 2016; April 1, 2018; April 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

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~~shall 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~~shall 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~~eighteen 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~~child and adolescent 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~~shall 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; January 1, 2024.
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.

Repealed effective January 1, 2024.

~~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, 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 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

CHAPTER 75-02-02.1
ELIGIBILITY FOR MEDICAID

75-02-02.1-01. Definitions.

For the purposes of this chapter:

1. "Agency" means the North Dakota department of health and human services.

2. "Applicant" means an individual seeking health care coverage benefits.

3. "Asset" means any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights.

4. "Blind" has the same meaning as the term has when used by the social security administration in determining blindness for title II or XVI of the Act.

5. "Child" means an individual, under twenty-one, or, if blind or disabled, under age eighteen, who is not living independently.

6. "Children's health insurance program" means the North Dakota children's health insurance program implemented pursuant to North Dakota Century Code chapter 50-29 and 42 U.S.C. 1397aa et seq. to furnish health assistance to low-income children funded through title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.].

7. "Contiguous" means real property which is not separated by other real property owned by others. Roads and other public rights of way which run through the property, even if owned by others, do not affect the property's contiguity.

8. "County agency" means the human service zone.

9. "Creditable health insurance coverage" means a health benefit plan which includes coverage for hospital, medical, or major medical. The following are not considered creditable health insurance coverage:

   a. Coverage only for accident or disability income insurance;

b. Coverage issued as a supplement to automobile liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workforce safety and insurance or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for onsite medical clinics;

h. Other similar insurance coverage specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance;

i. Coverage for dental or vision;

j. Coverage for long-term care, nursing home care, home health care, or community-based care;

k. Coverage only for specified disease or illness;

l. Hospital indemnity or other fixed indemnity insurance; and

m. Coverage provided through Indian health ~~services~~service.

10. "Department" means the North Dakota department of health and human services.

11. "Deprived child" means a child who is deprived of parental support or care because one or both parents are deceased, incapacitated, disabled, aged, or maintains and resides in a separate verified residence for reasons other than employment, education, training, medical care, or uniformed service.

12. "Disabled" has the same meaning as the term has when used by the social security administration in determining disability for title II or XVI of the Act.

13. "Disabled adult child" means a disabled or blind individual over the age of twenty-one who became blind or disabled before age twenty-two.

14. "Full calendar month" means the period which begins at midnight on the last day of the previous month and ends at midnight on the last day of the month under consideration.

15. "Good-faith effort to sell" means an honest effort to sell in a manner which is reasonably calculated to induce a willing buyer to believe that the property offered for sale is actually for sale at a fair price. A good-faith effort to sell includes, at a minimum, making the offer at a price based on an appraisal, a market analysis by a realtor, or another method which produces an accurate reflection of fair market value or, with respect to a determination of qualified disabled and working individual benefits under section 75-02-02.1-23, sixty-six and two-thirds percent of fair market value, in the following manner:

a. To any coowner, joint owner, possessor, or occupier of the property, and, if no buyer is thereby secured;

b. To the regular market for such property, if any regular market exists, or, if no regular market exists;

c. By public advertisement for sale in a newspaper of general circulation, the circulation area of which includes the location of any property resource offered for sale, which advertisement was published successively for two weeks if the newspaper is a weekly

publication and for one week if the newspaper is a daily publication, and which includes a plain and accurate description of the property, the selling price, and the name, address, and telephone number of a person who will answer inquiries and receive offers.

16. "Home" includes, when used in the phrase "the home occupied by the Medicaid unit", the land on which the home is located, provided that the acreage [hectarage] does not exceed one hundred sixty contiguous acres [64.75 hectares] if rural or two acres [.81 hectares] if located within the established boundaries of a city.

17. "Home and community-based services" means services, provided under a waiver secured from the United States department of health and human services, which are:

    a. Not otherwise available under Medicaid; and

    b. Furnished only to individuals who, but for the provision of such services, would require the level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.

18. "Institutionalized individual" means an individual who is an inpatient in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, the state hospital, a psychiatric residential treatment facility, an institution for mental disease, or who receives swing-bed care in a hospital.

19. "Living independently" means, in reference to an individual under the age of twenty-one, a status which arises in any of the following circumstances:

    a. The individual has served a tour of active duty with the armed services of the United States and lives separately and apart from the parent.

    b. The individual has married, even though that marriage may have ended through divorce or separation. A marriage ended by legal annulment is treated as if the marriage never occurred.

    c. The individual has lived separately and apart from both parents for at least three consecutive full calendar months after the date the individual left a parental home, continues to live separately and apart from both parents, and has received no support or assistance from either parent while living separately and apart. For purposes of this subsection:

        (1) Periods when the individual is attending an educational or training facility, receiving care in a specialized facility, or is an institutionalized individual are deemed to be periods when the individual is living with a parent unless the individual first established that the individual was living independently; and

        (2) Health insurance coverage and court-ordered child support payments are not "assistance or support".

    d. The individual is a former foster care recipient who has established a living arrangement separate and apart from either parent and received no support or assistance from either parent.

    e. The individual lives separately and apart from both parents due to incest and receives no support or assistance from either parent.

20. "Long-term care" means the services received by an individual when the individual is screened or certified as requiring long-term care services.

21. "MAGI-based methodology" means the method of determining eligibility for Medicaid that generally follows modified adjusted gross income rules.

22. "Medicaid" means a program implemented pursuant to North Dakota Century Code chapter 50-24.1 and title XIX of the Act [42 U.S.C. 1396 et seq.].

23. "Medicare cost sharing" means the following costs:

    a. (1) Medicare part A premiums; and

       (2) Medicare part B premiums;

    b. Medicare coinsurance;

    c. Medicare deductibles; and

    d. Twenty percent of the allowed cost for Medicare covered services where Medicare covers only eighty percent of the allowed costs.

24. "Nursing care services" means nursing care provided in a medical institution, a nursing facility, a swing-bed, the state hospital, or a home and community-based services setting.

25. "Occupied" means, when used in the phrase "the home occupied by the Medicaid unit", the home the Medicaid unit is living in or, if temporarily absent from, possessed with an intention to return and the capability of returning within a reasonable length of time. Property is not occupied if the right to occupy has been given up through a rental or lease agreement, whether or not that rental or lease agreement is written. Property is not occupied by an individual in long-term care or the state hospital, with no spouse, disabled adult child, or child under age twenty-one at home, unless a physician has certified that the individual is likely to return home within six months.

26. "Poverty level" means the income official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2).

27. "Property that is essential to earning a livelihood" means property that a member of a Medicaid unit owns, and which the Medicaid unit is actively engaged in using to earn income, and where the total benefit of such income is derived for the Medicaid unit's needs. A member of a Medicaid unit is actively engaged in using the property if a member of the unit contributes significant current personal labor in using the property for income-producing purposes. The payment of social security taxes on the income from such current personal labor is an indicator of the active use of the property.

28. "Property that is not saleable without working an undue hardship" means property which the owner has made a good-faith effort to sell which has produced no buyer willing to pay an amount equaling or exceeding seventy-five percent of the property's fair market value, or sixty-six and two-thirds percent of the property's fair market value with respect to determination of qualified disabled and working individual benefits under section 75-02-02.1-23, and which is continuously for sale. Property may not be included within this definition at any time earlier than the first day of the first month in which a good-faith effort to sell is begun or if a bona fide offer is received by the third month after the month in which the good-faith effort to sell is begun.

29. "Recipient" means an individual approved as eligible for health care coverage.

30. "Regulation", as used in 42 CFR 431.210, 431.244, and 435.912, includes any written statement of federal or state law or policy, including, but not limited to, federal and state

constitutions, statutes, regulations, rules, policy manuals or directives, policy letters or instructions, and relevant controlling decisions of federal or state courts.

31. "Remedial services" means those services, provided in specialized facilities, which produce the maximum reduction of physical or mental disability and restoration of the facilities' residents to the residents' best possible level of functioning.

32. "Residing in the home" refers to individuals who are physically present, individuals who are temporarily absent, or individuals attending educational facilities.

33. "Specialized facility" means a residential facility, including a basic care facility, a licensed family foster care home for children or adults, a licensed group foster care home for children or adults, a transitional living facility, a facility established to provide quarters to clients of a sheltered workshop, and any other facility determined by the department to be a provider of remedial services, but does not mean an acute care facility or a nursing facility.

34. ~~"State agency" means the North Dakota department of human services.~~

~~35.~~ "Student" means an individual who regularly attends and makes satisfactory progress in elementary or secondary school, general educational development classes, college, university, vocational training, including summer vacation periods if the individual intends to return to school in the fall, or a home school program recognized or supervised by the student's state or local school district. A full-time student is an individual who attends school on a schedule equal to a full curriculum.

~~36.~~35. "Supplemental security income" means a program administered under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

~~37.~~36. "Temporary assistance for needy families" means a program administered under North Dakota Century Code chapter 50-09 and title IV-A of the Act [42 U.S.C. 601 et seq.].

~~38.~~37. "The Act" means the Social Security Act [42 U.S.C. 301 et seq.].

~~39.~~38. "Title II" means title II of the Social Security Act [42 U.S.C. 401 et seq.].

~~40.~~39. "Title IV-E" means title IV-E of the Social Security Act [42 U.S.C. 670 et seq.].

~~41.~~40. "Title XIX" means title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

~~42.~~41. "Title XXI" means title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.].

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; October 1, 1993; July 1, 2003; August 1, 2005; April 1, 2008; January 1, 2011; April 1, 2012; July 1, 2012; January 1, 2014; January 1, 2020; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-05. Coverage groups.

Within the limits of legislative appropriation, the department may provide benefits to coverage groups described in the approved Medicaid state plan in effect at the time those benefits are sought. These coverage groups do not define eligibility for benefits. Any individual who is within a coverage group must also demonstrate that all other eligibility criteria are met.

1. The categorically needy coverage group includes:

   a. Children for whom adoption assistance maintenance payments are made under title IV-E;

b. Children for whom foster care maintenance payments are made under title IV-E;

c. Children who are living in North Dakota and are receiving title IV-E adoption assistance payments from another state;

d. Children in a foster care placement in North Dakota and receiving a title IV-E foster care payment from another state;

e. Caretakers of deprived children who meet the parent and caretaker relative eligibility criteria;

f. Families who were eligible under the family coverage group in at least three of the six months immediately preceding the month in which the family became ineligible because of the caretaker relative's earned income or because a member of the unit has a reduction in the time-limited earned income disregard;

g. Families who were eligible under the family coverage group in at least three of the six months immediately preceding the month in which they became ineligible as a result, wholly or partly, of the collection or increased collection of child or spousal support continue eligible for Medicaid for four calendar months;

h. Pregnant women who meet the nonfinancial requirements with modified adjusted gross income at or below the modified adjusted gross income level for pregnant women;

i. Eligible pregnant women who applied for and were eligible for Medicaid as categorically needy during pregnancy continue to be eligible for twelve months beginning on the last day of the pregnancy, and through the end of the month in which the twelve-month period ends;

j. Children born to the categorically needy eligible pregnant women who applied for and were 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 through the end of the month in which the twelve-month period ends;

k. Children up to age nineteen who meet the nonfinancial Medicaid requirements with modified adjusted gross income at or below the modified adjusted gross income level for that child's age;

l. Adults between the ages of nineteen and sixty-four, inclusive, who meet the nonfinancial Medicaid requirements:

   (1) Who are not eligible under subdivisions e through k above; or

   (2) Who are not eligible for supplemental security income, unless they fail the medically needy asset test; or

   (3) Whose modified adjusted gross income is at or below the established modified adjusted gross income level for this group;

m. Former foster care children through the month they turn twenty-six years of age, who were enrolled in Medicaid and were in foster care when they turned eighteen years old, provided they are not eligible under any of the categorically eligible groups other than the group identified in subdivision l.

n. Aged, blind, or disabled individuals who are receiving supplemental security income payments or who appear on the state data exchange as zero payment as a result of supplemental security income's recovery of an overpayment or who are suspended

because the individuals do not have a protective payee, provided that the more restrictive Medicaid criteria is met; and

o. Individuals who meet the more restrictive requirements of the Medicaid program and qualify for supplemental security income benefits under section 1619(a) or 1619(b) of the Act [42 U.S.C. 1382h(a) or 1382h(b)].

2. The optional categorically needy coverage group includes:

a. Individuals under age twenty-one who are residing in adoptive homes and who have been determined under the state-subsidized adoption program to be eligible as provided in state law and in accordance with the requirements of the department;

b. Uninsured individuals under age sixty-five, who are not otherwise eligible for Medicaid, who have been screened for breast or cervical cancer under the centers for disease control and prevention breast and cervical cancer early detection program, and who need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix;

c. Gainfully employed individuals with disabilities age eighteen to sixty-five who meet medically needy nonfinancial criteria, have countable assets within the medically needy asset levels, have income below two hundred twenty-five percent of the poverty level, and are not eligible for Medicaid under any other provision except as a qualified Medicare beneficiary or a special low-income Medicare beneficiary. Coverage under this group ends on the last day of the month before the month in which the individual attains the age of sixty-five; and

d. Individuals under age nineteen who are disabled, who meet medically needy nonfinancial criteria, who have income at or below two hundred fifty percent of the poverty level, and who are not eligible for Medicaid under any other provision. Coverage under this group ends on the last day of the month in which the individual reaches age nineteen.

3. The medically needy coverage group includes:

a. Individuals under the age of twenty-one who qualify for and require medical services on the basis of insufficient income, but who do not qualify under categorically needy or optional categorically needy groups, including foster care children who do not qualify as categorically needy or optional categorically needy;

b. Pregnant women whose pregnancy has been medically verified and who qualify on the basis of financial eligibility;

c. Eligible pregnant women who applied for Medicaid during pregnancy, and for whom recipient liability for the month was met no later than on the date each pregnancy ends, continue to be eligible for twelve months beginning on the last day of pregnancy and through the end of the month in which the twelve-month period ends;

d. Children born to eligible pregnant women who have applied for and been found eligible for Medicaid on or before the day of the child's birth, for twelve months beginning on the day of the child's birth, and through the end of the month in which the twelve-month period ends;

e. Aged, blind, or disabled individuals who are not in receipt of supplemental security income; and

f. Individuals under age twenty-one who have been certified as needing the service, or age sixty-five and over in the state hospital who qualify on the basis of financial eligibility.

4. The poverty level coverage group includes:

   a. Qualified Medicare beneficiaries who are entitled to Medicare part A benefits, who meet the medically needy nonfinancial criteria, whose assets do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) [42 U.S.C. 1395w-114(a)(3)], and have income at or below one hundred percent of the poverty level;

   b. Qualified disabled and working individuals who are individuals entitled to enroll in Medicare part A under section 1818a of the Social Security Act [42 U.S.C. 1395i-2(a)], who have income no greater than two hundred percent of the federal poverty level and assets no greater than twice the supplemental security income resource standard, and who are not eligible for Medicaid under any other provision;

   c. Special low-income Medicare beneficiaries who are entitled to Medicare part A benefits, who meet the medically needy nonfinancial criteria, whose assets do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) [42 U.S.C. 1395w-114(a)(3)], and have income above one hundred percent of the poverty level, but not in excess of one hundred twenty percent of the poverty level; ~~and~~

   d. Qualifying individuals who are entitled to Medicare part A benefits, who meet the medically needy nonfinancial criteria, whose assets do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) [42 U.S.C. 1395w-114(a)(3)], have income above one hundred twenty percent of the poverty level, but not in excess of one hundred thirty-five percent of the poverty level, and are not eligible for Medicaid under any other provision; and

   e. Individuals eligible for the Medicare part B immunosuppressive drug benefit are entitled to coverage for the Medicare part B immunosuppressive drug benefit only, and who are not eligible for Medicaid under any other provision.

5. Children's health insurance program includes individuals under age nineteen, and who have income at or below ~~one~~two hundred ~~seventy~~ten percent of the poverty level. Coverage under this group ends on the last day of the month in which the individual reaches age nineteen.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; January 1, 1994; January 1, 1997; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2010; April 1, 2012; January 1, 2014; April 1, 2018; January 1, 2020; January 1, 2023; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-31, 50-24.1-37; 42 USC 1396a(e)

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~~entering the state~~, in which case the earliest date of eligibility~~ is eligible for Medicaid as of the date the individual entered the state; or

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 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; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-16. State of residence.

A resident of the state is an individual who is living in the state voluntarily and not for a temporary purpose. Temporary absences from the state with subsequent returns to the state, or intent to return when the purpose of the absence has been accomplished, do not interrupt continuity of residence. Residence is retained until abandoned or established in another state.

1. For individuals entering the state, the earliest date of eligibility is the date of entry. Residence may not be established for individuals who claim residence in another state.

2. Individuals under age twenty-one.

   a. For any individual under age twenty-one who is living independently from the individual's parents or who is married and capable of indicating intent, the state of residence is the state where the individual is living with the intention to remain there.

   b. For any individual who is receiving foster care or adoption assistance payments, under title IV-E, from another state and is living in North Dakota, North Dakota is the state of residence for Medicaid purposes.

   c. For any individual under age twenty-one not residing in an institution, whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living.

   d. For any other noninstitutionalized individual under age twenty-one, the state of residence is the state in which the child is living with the child's parent or caretaker relative on other than a temporary basis. A child who comes to North Dakota to receive an education, special training, or services in a facility such as the Anne Carlsen facility, a maternity home, or a vocational training center is normally regarded as living temporarily in the

state if the intent is to return to the child's home state upon completion of the education or service. A child placed by an out-of-state placement authority, including a court, into the home of relatives or foster parents in North Dakota on other than a permanent basis or for an indefinite period is living in the state for a temporary purpose and remains a legal resident of the state of origin unless the interstate compact on the placement of children is silent regarding Medicaid coverage. If the interstate compact on the placement of children is silent, the child must be considered a resident of North Dakota for Medicaid purposes. A resident of North Dakota who leaves the state temporarily to pursue educational goals (including any child participating in job corps) or other specialized services (including a child placed by a North Dakota placement authority, including a court, into the home of out-of-state relatives or foster parents) does not lose residence in the state.

e. For any institutionalized individual, under age twenty-one, who is neither married nor living independently, residence is that of the parents or legal guardian at the time of placement or the state of residence of the parent or legal guardian at the time of Medicaid application if the child is institutionalized in the same state. Only if the parental rights have been terminated, and a guardian or custodian appointed, may the residence of the guardian or custodian be used. If the individual has been abandoned by the individual's parents and does not have a guardian, the individual is a resident of the state in which the individual is institutionalized.

3. Individuals age twenty-one and over:

a. For any individual not residing in an institution, the state of residence is the state where the individual is living with the intention to remain there or is entering the state with a job commitment or seeking employment. The state of residence, for Medicaid purposes, of a migrant or seasonal farm worker is the state in which the individual is employed or seeking employment.

b. Except as provided in subdivision c, the state of residence of an institutionalized individual is the state where the individual is living with the intention to remain there.

c. For an institutionalized individual who became incapable of indicating intent before age twenty-one, the state of residence is that of the parent or guardian making application, at the time of placement or, if the individual is institutionalized in that state, at the time of application. If the individual has no guardian, the application is not made by either parent, and the placement was not made by another state, the state of residence is the state in which the individual is physically present.

4. For purposes of this subsection:

a. "Individual incapable of indicating intent" means one who:

(1) Has an intelligence quotient of forty-nine or less, or a mental age of seven or less, based upon tests acceptable to the behavioral health division ~~of mental health~~ of the department ~~of human services~~;

(2) Has been found by a court of competent jurisdiction to be an incapacitated person as defined in subsection 2 of North Dakota Century Code section 30.1-26-01;

(3) Has been found by a court of competent jurisdiction to be legally incompetent; or

(4) Is found incapable of indicating intent based on medical documentation obtained from a physician or surgeon, clinical psychologist, or other person licensed by the state in the field of mental retardation; and

b. "Institution" means an establishment that furnishes, in single or multiple facilities, food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

5. Notwithstanding any other provision of this section except subsections 6 through 9, individuals placed in out-of-state institutions by a state retain residence in that state regardless of the individual's indicated intent or ability to indicate intent. The application of this subsection ends when a person capable of indicating intent leaves an institution in which the person was placed by this state. Providing information about another state's Medicaid program or about the availability of health care services and facilities in another state, or assisting an individual in locating an institution in another state, does not constitute a state placement.

6. For any individual receiving a state supplemental payment, the state of residence is the state making the payment.

7. For any individual on whose behalf payments for regular foster care or state adoption assistance are made, the state of residence is the state making the payment.

8. If an interstate reciprocal residency agreement has been entered into between this state and another state pursuant to 42 CFR 435.403(k), the state of residence of an affected individual is the state determined under that agreement.

9. When two or more states cannot agree which state is the individual's state of residence, the state of residence is the state in which the individual is physically present.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2010; January 1, 2014; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 CFR Part 435

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. Individuals from the compact of free associated states, including the Federated States of Micronesia, the Republic of Marshall Islands, and the Republic of Palau, 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.

10. Pregnant women who are lawfully present in the United States and are otherwise eligible for Medicaid are not subject to the five-year, forty-quarter ban through the twelve months postpartum coverage.

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; January 1, 2024.
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 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. Individuals eligible for the Medicare part B immunosuppressive drug benefit are entitled to coverage for the Medicare part B immunosuppressive drug benefit only. To be eligible, the individual is required to have Medicare coverage under Medicare end stage renal disease and this benefit ends thirty-six months after a successful transplant.

5. All medically needy technical eligibility factors apply to the Medicare savings programs except as identified in this section.

~~5.~~6. No ~~person~~individual 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.~~7. 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.~~8. 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; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-33.1. Disqualifying transfers made before February 8, 2006.

Repealed effective January 1, 2024.

~~1. a. Except as provided in subsections 2 and 10, an individual is ineligible for nursing care services, swing-bed services, or home and community-based services if the individual or the spouse of the individual disposes of assets or income for less than fair market value on or after the look-back date specified in subdivision b.~~

~~b. The look-back date specified in this subdivision is a date that is the number of months specified in paragraph 1 or 2 before the first date on which the individual is both receiving nursing care services and has applied for benefits under this chapter, without regard to the action taken on the application.~~

~~(1) Except as provided in paragraph 2, the number of months is thirty-six months.~~

~~(2) The number of months is sixty months:~~

~~(a) In the case of payments from a revocable trust that are treated as income or assets disposed of by an individual pursuant to subdivision c of subsection 4 of section 75-02-02.1-31 or paragraph 3 of subdivision a of subsection 3 of section 75-02-02.1-31.1;~~

~~(b) In the case of payments from an irrevocable trust that are treated as income or assets disposed of by an individual pursuant to subparagraph b of paragraph 1 of subdivision b of subsection 3 of section 75-02-02.1-31.1; and~~

~~(c) In the case of payments to an irrevocable trust that are treated as income or assets disposed of by an individual pursuant to paragraph 2 of subdivision b of subsection 3 of section 75-02-02.1-31.1.~~

~~c. The period of ineligibility begins the first day of the month in which income or assets have been transferred for less than fair market value, or if that day is within any other period of ineligibility under this section, the first day thereafter that is not in such a period of ineligibility.~~

~~d. The number of months and days of ineligibility for an individual shall be equal to the total cumulative uncompensated value of all income and assets transferred by the individual, or individual's spouse, on or after the look-back date specified in subdivision b, divided by the average monthly cost, or average daily cost as appropriate, of nursing facility care in North Dakota at the time of the individual's first application.~~

~~e. Any portion of the transferred asset or income returned prior to the imposition of the period of ineligibility reduces the total amount of the disqualifying transfer.~~

2. An individual may not be ineligible for Medicaid by reason of subsection 1 to the extent that:

a. The assets transferred were a home, and title to the home was transferred to:

(1) The individual's spouse;

(2) The individual's son or daughter who is under age twenty-one, blind, or disabled;

(3) The individual's brother or sister who has an equity interest in the individual's home and who was residing in the individual's home for a period of at least one year immediately before the date the individual became an institutionalized individual; or

(4) The individual's son or daughter, other than a child described in paragraph 2, who was residing in the individual's home for a period of at least two years immediately before the date the individual began receiving nursing care services, and who provided care to the individual which permitted the individual to avoid receiving nursing care services;

b. The income or assets:

(1) Were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

(2) Were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

(3) Were transferred to, or to a trust established solely for the benefit of, the individual's child who is blind or disabled; or

(4) Were transferred to a trust established solely for the benefit of an individual under sixty-five years of age who is disabled;

c. The individual makes a satisfactory showing that:

(1) The individual intended to dispose of the income or assets, either at fair market value or other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;

(2) The income or assets were transferred exclusively for a purpose other than to qualify for Medicaid; or

(3) For periods after the return, all income or assets transferred for less than fair market value have been returned to the individual; or

d. The asset transferred was an asset excluded for Medicaid purposes other than:

(1) The home or residence of the individual or the individual's spouse;

(2) Property which is not saleable without working an undue hardship;

(3) Excluded home replacement funds;

(4) Excluded payments, excluded interest on those payments, and excluded in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets;

(5) Life estate interests;

(6) Mineral interests;

(7) An asset received from a decedent's estate during any period it is considered to be unavailable under subsection 5 of section 75-02-02.1-25;

(8) An annuity; or

(9) A motor vehicle.

3. An individual shall not be ineligible for Medicaid by reason of subsection 1 to the extent the individual makes a satisfactory showing that an undue hardship exists.

a. An undue hardship exists only if the total cumulative uncompensated value of all income and assets transferred for less than fair market value by the individual or the individual's spouse is less than the total of all unpaid nursing care bills for services:

(1) Provided after the last such transfer was made which are not subject to payment by any third party; and

(2) Incurred when the individual and the individual's spouse had no assets in excess of the appropriate asset levels.

b. If the individual shows that an undue hardship exists, the individual shall be subject to an alternative period of ineligibility that begins on the first day of the month in which the individual and the individual's spouse had no excess assets and continues for the number of months determined by dividing the total cumulative uncompensated value of all such transfers by the average monthly unpaid charges incurred by the individual for nursing care services provided after the beginning of the alternative period of ineligibility.

4. There is a presumption that a transfer for less than fair market value was made for purposes that include the purpose of qualifying for Medicaid:

a. In any case in which the individual's assets (and the assets of the individual's spouse) remaining after the transfer produce income which, when added to other income available to the individual (and to the individual's spouse) totals an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred by the individual (and by the individual's spouse) in the month of transfer and in the thirty-five months (or fifty-nine months in the case of a transfer from a revocable or irrevocable trust that is treated as assets or income disposed of by the individual (or the individual's spouse) or in the case of payments to an irrevocable trust that are treated as assets or income disposed of by the individual (or the individual's spouse)) following the month of transfer;

b. In any case in which an inquiry about Medicaid benefits was made, by or on behalf of the individual to any person, before the date of the transfer;

c. In any case in which the individual or the individual's spouse was an applicant for or recipient of Medicaid before the date of transfer;

d. In any case in which a transfer is made by or on behalf of the individual or the individual's spouse, if the value of the transferred income or asset, when added to the value of the individual's other countable assets, would exceed the asset limits at section 75-02-02.1-26; or

e. In any case in which the transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the individual's relative, or to the guardian, conservator, or attorney-in-fact or to any parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew, whether by birth,

adoption, and whether by whole or half-blood, of the guardian, conservator, or attorney-in-fact or the spouse or former spouse of the guardian, conservator, or attorney-in-fact.

5. An applicant or recipient who claims that income or assets were transferred exclusively for a purpose other than to qualify for Medicaid must show that a desire to receive Medicaid benefits played no part in the decision to make the transfer and must rebut any presumption arising under subsection 4. The fact, if it is a fact, that the individual would be eligible for the Medicaid coverage for nursing care services, had the individual or the individual's spouse not transferred income or assets for less than fair market value, is not evidence that the income or assets were transferred exclusively for a purpose other than to qualify for Medicaid.

6. If a transfer results in a period of ineligibility under this section for an individual receiving nursing care services, and the transfer was made on or after the look-back date of the individual's spouse, and if the individual's spouse is otherwise eligible for Medicaid and requires nursing care services, the remaining period of ineligibility shall be apportioned equally between the spouses. If one such spouse dies or stops receiving nursing care services, any months remaining in that spouse's apportioned period of ineligibility must be assigned or reassigned to the spouse who continues to receive nursing care services.

7. No income or asset transferred to a parent, stepparent, child, stepchild, grandparent, grandchild, brother, sister, stepsister, stepbrother, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew of the individual or the individual's spouse, purportedly for services or assistance furnished by the transferee to the individual or the individual's spouse, may be treated as consideration for the services or assistance furnished unless:

a. The transfer is made pursuant to a valid written contract entered into prior to rendering the services or assistance or in absence of a valid written contract, evidence is provided the services were required and provided;

b. The contract was executed by the individual or the individual's fiduciary who is not a provider of services or assistance under the contract;

c. Compensation is consistent with rates paid in the open market for the services or assistance actually provided; and

d. The parties' course of dealing included paying compensation upon rendering services or assistance, or within thirty days thereafter.

8. A transfer is complete when the individual or the individual's spouse making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

9. For purposes of this section:

a. "Annuity" means a policy, certificate, contract, or other arrangement between two or more parties whereby one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future, but does not mean an employee benefit that qualifies for favorable tax treatment under the Internal Revenue Code or a plan described in the Internal Revenue Code as a retirement plan under which contributions must end and withdrawals must begin by age seventy and one-half.

b. "Average monthly cost of nursing facility care" means the cost determined by the department under section 1917(c)(1)(E)(i)(II) of the Act [42 U.S.C. 1396p(c)(1)(E)(i)(II)].

c. "Fair market value" means:

(1) In the case of a liquid asset that is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and fungible commodities, one hundred percent of apparent fair market value;

(2) In the case of real or personal property that is subject to reasonable dispute concerning its value seventy-five percent of the estimated fair market value; and

(3) In the case of income, one hundred percent of apparent fair market value.

d. "Major medical policy" includes any policy, certificate, or subscriber contract issued on a group or individual basis by any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization, which provides a plan of health insurance or health benefit coverage including medical, hospital, and surgical care, approved for issuance by the insurance regulatory body in the state of issuance, but does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance or automobile medical payment insurance, or a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance.

e. "Medicare" means the Health Insurance for the Aged and Disabled Act, title XVIII of the Social Security Act of 1965, as amended [42 U.S.C. 1395, et seq.; Pub. L. 92-603; 86 Stat. 1370].

f. "Medicare supplement policy offering plan F benefits" means a policy, group, or individual accident and health insurance policy or a subscriber contract of a health service corporation or a health care plan of a health maintenance organization or preferred provider organization, other than a policy issued pursuant to a contract under section 1876 or 1833 of the Social Security Act [42 U.S.C. 1395, et seq.] or an issued policy under a demonstration project authorized pursuant to amendments to the Social Security Act that:

(1) Is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare;

(2) Is not a policy or contract of one or more employers or labor organizations, or the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organization;

(3) Is approved for issuance by the insurance regulatory body in the state of issuance; and

(4) Includes:

(a) Hospitalization benefits consisting of Medicare part A coinsurance plus coverage for three hundred sixty-five additional days after Medicare benefits end;

(b) Medical expense benefits consisting of Medicare part B coinsurance;

(c) Blood provision consisting of the first three pints of blood each year;

(d) Skilled nursing coinsurance;

(e) Medicare part A deductible coverage;

(f) Medicare part B deductible coverage;

(g) Medicare part B excess benefits at one hundred percent coverage; and

(h) Foreign travel emergency coverage.

g. "Relative" means a parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, nephew, great-great-grandparent, great-great-grandchild, great-aunt, great-uncle, first cousin, grandniece, or grandnephew, whether by birth or adoption, and whether by whole or half-blood, of the individual or the individual's current or former spouse.

h. "Uncompensated value" means the difference between fair market value and the value of any consideration received.

10. The provisions of this section do not apply in determining eligibility for Medicare savings programs.

11. An individual disposes of assets or income when the individual, or anyone on behalf of the individual or at the request of the individual, acts or fails to act in a manner that effects a transfer, conveyance, assignment, renunciation, or disclaimer of any asset or income in which the individual had or was entitled to claim an interest of any kind.

12. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for Medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home care and long-term care coverage, purchased on or before July 31, 2003, with a daily benefit at least equal to 1.25 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

a. For each such month during which the individual is not eligible for Medicare benefits, the individual has in force a major medical policy that provides a lifetime maximum benefit of one million dollars or more, an annual aggregate deductible of five thousand dollars or less, and an out-of-pocket maximum annual expenditure per qualifying individual of five thousand dollars or less; and

b. For each such month during which the individual is eligible for Medicare benefits, the individual has in force a Medicare supplement policy offering plan F benefits, or their equivalent.

13. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for Medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage, purchased on or after August 1, 2003, with a daily benefit at least equal to 1.57 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

a. For each month during which the individual is not eligible for Medicare benefits, the individual has in force a major medical policy that provides a lifetime maximum benefit of one million dollars or more, an annual aggregate deductible of five thousand dollars or less, and an out-of-pocket maximum annual expenditure per qualifying individual of five thousand dollars or less; and

b. For each such month during which the individual is eligible for Medicare benefits, the individual has in force a Medicare supplement policy offering plan F benefits, or their equivalent.

~~14. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for Medicaid, if the asset was used to acquire an annuity, only if:~~

~~a. The annuity is irrevocable and cannot be assigned to another person;~~

~~b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;~~

~~c. The annuity provides substantially equal payments, no less frequently than annually, such that the total annual payment in any year varies by five percent or less from the total annual payment of the previous year and does not provide for a balloon or deferred payment of principal or interest;~~

~~d. The annuity, if purchased before August 1, 2005, will return the full principal and interest within the purchaser's life expectancy as determined by the department; and~~

~~e. The annuity, if purchased after July 31, 2005, and before February 8, 2006, will return the full principal and has a guaranteed period that is equal to at least eighty-five percent of the purchaser's life expectancy as determined by the life expectancy tables used by the department and, if the applicant is age fifty-five or older, the department is irrevocably named as the primary beneficiary following the death of the applicant and the applicant's spouse, not to exceed the amount of medical assistance benefits paid on behalf of the applicant after age fifty-five.~~

~~15. This section applies to transfers of income or assets made before February 8, 2006.~~

~~**History:** Effective October 1, 1993; amended effective December 1, 1996; July 1, 2003; June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2010; April 1, 2012; April 1, 2018.~~
~~**General Authority:** NDCC 50-06-16, 50-24.1-04~~
~~**Law Implemented:** NDCC 50-24.1-02; 42 USC 1396p(c)~~

75-02-02.1-33.2. Disqualifying transfers made on or after February 8, 2006.

1. This section applies to transfers of income or assets made on or after February 8, 2006.

2. Except as provided in subsections 7 and 16, an individual is ineligible for skilled nursing care, swing-bed, or home and community-based benefits if the individual or the individual's spouse disposes of assets or income for less than fair market value on or after the look-back date. The look-back date is a date that is sixty months before the first date on which the individual is both receiving skilled nursing care, swing-bed, or home and community-based services and has applied for benefits under this chapter, without regard to the action taken on the application.

3. An applicant, recipient, or anyone acting on behalf of an applicant or recipient, has a duty to disclose any transfer of any asset or income made by or on behalf of the applicant or recipient, or the spouse of the applicant or recipient, for less than full fair market value:

   a. When making an application;

   b. When completing a redetermination; and

   c. If made after eligibility has been established, by the end of the month in which the transfer was made.

4. The date that a period of ineligibility begins is the latest of:

   a. The first day of the month in which the income or assets were transferred for less than fair market value;

b. The first day on which the individual is receiving nursing care services and would otherwise have been receiving benefits for institutional care but for the penalty; ~~or~~

c. The first day thereafter which is not in a period of ineligibility; or

d. The date of discovery after eligibility has been established.

5. a. The number of months and days of ineligibility for an individual shall be equal to the total cumulative uncompensated value of all income and assets transferred by the individual, or individual's spouse, on or after the look-back date divided by the average monthly cost or average daily cost, as appropriate, of nursing facility care in North Dakota at the time of the individual's application.

b. A fractional period of ineligibility may not be rounded down or otherwise disregarded with respect to any disposal of assets or income for less than fair market value.

c. Notwithstanding any contrary provisions of this section, in the case of an individual or an individual's spouse who makes multiple fractional transfers of assets or income in more than one month for less than fair market value on or after the look-back date established under subsection 2, the period of ineligibility applicable to such individual must be determined by treating the total, cumulative uncompensated value of all assets or income transferred during all months on or after the look-back date as one transfer and one penalty period must be imposed beginning on the earliest date applicable to any of the transfers.

d. Any portion of the transferred asset or income returned prior to the imposition of the period of ineligibility reduces the total amount of the disqualifying transfer.

6. For purposes of this section, "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

7. An individual may not be ineligible for Medicaid by reason of subsection 2 to the extent that:

a. The assets transferred were a home, and title to the home was transferred to:

(1) The individual's spouse;

(2) The individual's son or daughter who is under age twenty-one, blind, or disabled;

(3) The individual's brother or sister who has an equity interest in the individual's home and who was residing in the individual's home for a period of at least one year immediately before the date the individual became an institutionalized individual; or

(4) The individual's son or daughter, other than a child described in paragraph 2, who was residing in the individual's home for a period of at least two years immediately before the date the individual began receiving nursing care services, and who provided care to the individual which permitted the individual to avoid receiving nursing care services;

b. The income or assets:

(1) Were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

(2) Were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

(3) Were transferred to, or to a trust established solely for the benefit of, the individual's child who is blind or disabled; or

(4) Were transferred to a trust established solely for the benefit of an individual less than sixty-five years of age who is disabled;

c. The individual makes a satisfactory showing that:

(1) The individual intended to dispose of the income or assets, either at fair market value or other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;

(2) The income or assets were transferred exclusively for a purpose other than to qualify for Medicaid; or

(3) For periods after the return, all income or assets transferred for less than fair market value have been returned to the individual; or

d. The asset transferred was an asset excluded for Medicaid purposes other than:

(1) The home or residence of the individual or the individual's spouse;

(2) Property that is not saleable without working an undue hardship;

(3) Excluded home replacement funds;

(4) Excluded payments, excluded interest on those payments, and excluded in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets;

(5) Life estate interests;

(6) Mineral interests;

(7) An asset received from a decedent's estate during any period it is considered to be unavailable under subsection 5 of section 75-02-02.1-25;

(8) An annuity; or

(9) A motor vehicle.

8. a. An individual shall not be ineligible for Medicaid by reason of subsection 2 to the extent the individual makes a satisfactory showing that an undue hardship exists for the individual. Upon imposition of a period of ineligibility because of a transfer of assets or income for less than fair market value, the department shall notify the applicant or recipient of the right to request an undue hardship exception. An individual may apply for an exception to the transfer of asset penalty if the individual claims that the ineligibility period will cause an undue hardship to the individual. A request for a determination of undue hardship must be made within ninety days after the circumstances upon which the claim of undue hardship is made were known or should have been known to the affected individual or the person acting on behalf of that individual if incompetent. The individual must provide to the department sufficient documentation to support the claim of undue hardship. The department shall determine whether a hardship exists upon receipt of all necessary documentation submitted in support of a request for a hardship exception. An undue hardship exists only if the individual shows that all of the following conditions are met:

(1) Application of the period of ineligibility would deprive the individual of food, clothing, shelter, or other necessities of life or would deprive the individual of medical care such that the individual's health or life would be endangered;

(2) The individual who transferred the assets or income, or on whose behalf the assets or income were transferred, has exhausted all reasonable means to recover the assets or income or the value of the transferred assets or income, from the transferee, a fiduciary, or any insurer; and

(3) The individual's remaining available assets and the remaining assets of the individual's spouse are less than the asset limit in subsection 1 of section 75-02-02.1-26, or if applicable, the minimum allowed under section 75-02-02.1-24, counting the value of all assets except:

(a) A home, exempt under section 75-02-02.1-28, but not if the individual or the individual's spouse has equity in the home in excess of twenty-five percent of the amount established in the approved state plan for medical assistance which is allowed as the maximum home equity interest for nursing facility services or other long-term care services;

(b) Household and personal effects;

(c) One motor vehicle if the primary use is for transportation of the individual, or the individual's spouse or minor, blind, or disabled child who occupies the home; and

(d) Funds for burial up to the amount excluded in subsection 10 of section 75-02-02.1-28 for the individual and the individual's spouse.

b. Upon the showing required by this subsection, the department shall state the date upon which an undue hardship begins and, if applicable, when it ends.

c. The agency shall terminate the undue hardship exception, if not earlier, at the time an individual, the spouse of the individual, or anyone with authority to act on behalf of the individual, makes any uncompensated transfer of income or assets after the undue hardship exception is granted. The agency shall deny any further requests for an undue hardship exception due to either the disqualification based on the transfer upon which the initial undue hardship determination was based, or a disqualification based on any subsequent transfer.

9. If a request for an undue hardship waiver is denied, the applicant or recipient may request a fair hearing in accordance with the provisions of chapter 75-01-03.

10. There is a presumption that a transfer for less than fair market value was made for purposes that include the purpose of qualifying for Medicaid:

a. In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer produce income which, when added to other income available to the individual and to the individual's spouse, total an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred by the individual and by the individual's spouse in the month of transfer and in the fifty-nine months following the month of transfer;

b. In any case in which an inquiry about Medicaid benefits was made, by or on behalf of the individual to any person, before the date of the transfer;

c. In any case in which the individual or the individual's spouse was an applicant for or recipient of Medicaid before the date of transfer;

d. In any case in which a transfer is made by or on behalf of the individual or the individual's spouse, if the value of the transferred income or asset, when added to the value of the individual's other countable assets, would exceed the asset limits in section 75-02-02.1-26; or

e. In any case in which the transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney in fact, to a relative of the individual or the individual's spouse, or to the guardian, conservator, or attorney in fact or to any parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew, whether by birth, adoption, and whether by whole or half-blood, of the guardian, conservator, or attorney in fact or the spouse or former spouse of the guardian, conservator, or attorney in fact.

11. An applicant or recipient who claims that income or assets were transferred exclusively for a purpose other than to qualify for Medicaid must show that a desire to receive Medicaid benefits played no part in the decision to make the transfer and must rebut any presumption arising under subsection 10. The fact, if it is a fact, that the individual would be eligible for the Medicaid coverage for nursing care services, had the individual or the individual's spouse not transferred income or assets for less than fair market value, is not evidence that the income or assets were transferred exclusively for a purpose other than to qualify for Medicaid.

12. If a transfer results in a period of ineligibility under this section for an individual receiving nursing care services, and if the individual's spouse is otherwise eligible for Medicaid and requires nursing care services, the remaining period of ineligibility shall be apportioned equally between the spouses. If one such spouse dies or stops receiving nursing care services, any months remaining in that spouse's apportioned period of ineligibility must be assigned or reassigned to the spouse who continues to receive nursing care services.

13. No income or asset transferred to a parent, stepparent, child, stepchild, grandparent, grandchild, brother, sister, stepsister, stepbrother, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew of the individual or the individual's spouse, purportedly for services or assistance furnished by the transferee to the individual or the individual's spouse, may be treated as consideration for the services or assistance furnished unless:

a. The transfer is made pursuant to a valid written contract entered into prior to rendering the services or assistance or in absence of a valid written contract, evidence is provided the services were required and provided;

b. The contract was executed by the individual or the individual's fiduciary who is not a provider of services or assistance under the contract;

c. Compensation is consistent with rates paid in the open market for the services or assistance actually provided; and

d. The parties' course of dealing included paying compensation upon rendering services or assistance, or within thirty days thereafter.

14. A transfer is complete when the individual or the individual's spouse making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

15. For purposes of this section:

a. "Annuity" means a policy, certificate, contract, or other arrangement between two or more parties whereby one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future, but does not mean an employee benefit that qualifies for favorable tax treatment under the Internal Revenue Code or a plan described in the Internal Revenue Code as a retirement plan under which contributions must end and withdrawals must begin by age seventy and one-half.

b. "Average monthly cost of nursing facility care" means the cost determined by the department under section 1917(c)(1)(E)(i)(II) of the Act [42 U.S.C. 1396p(c)(1)(E)(i)(II)].

c. "Fair market value" means:

(1) In the case of a liquid asset that is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and fungible commodities, one hundred percent of apparent fair market value;

(2) In the case of real or personal property that is subject to reasonable dispute concerning its value, seventy-five percent of the estimated fair market value; and

(3) In the case of income, one hundred percent of apparent fair market value.

d. "Major medical policy" includes any policy, certificate, or subscriber contract issued on a group or individual basis by any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization, which provides a plan of health insurance or health benefit coverage, including medical, hospital, and surgical care, approved for issuance by the insurance regulatory body in the state of issuance, but does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance or automobile medical payment insurance, or a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance.

e. "Medicare" means the Health Insurance for the Aged and Disabled Act, title XVIII of the Social Security Act of 1965, as amended [42 U.S.C. 1395 et seq; Pub. L. 92-603; 86 Stat. 1370].

f. "Medicare supplement policy offering plan F benefits" means a policy, group, or individual accident and health insurance policy or a subscriber contract of a health service corporation or a health care plan of a health maintenance organization or preferred provider organization, other than a policy issued pursuant to a contract under section 1876 or 1833 of the Social Security Act [42 U.S.C. 1395 et seq.] or an issued policy under a demonstration project authorized pursuant to amendments to the Social Security Act that:

(1) Is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare;

(2) Is not a policy or contract of one or more employers or labor organizations, or the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organization;

(3) Is approved for issuance by the insurance regulatory body in the state of issuance; and

(4) Includes:

(a) Hospitalization benefits consisting of Medicare part A coinsurance plus coverage for three hundred sixty-five additional days after Medicare benefits end;

(b) Medical expense benefits consisting of Medicare part B coinsurance;

(c) Blood provision consisting of the first three pints of blood each year;

(d) Skilled nursing coinsurance;

(e) Medicare part A deductible coverage;

(f) Medicare part B deductible coverage;

(g) Medicare part B excess benefits at one hundred percent coverage; and

(h) Foreign travel emergency coverage.

g. "Relative" means a parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, nephew, great-great-grandparent, great-great-grandchild, great-aunt, great-uncle, first cousin, grandniece, or grandnephew, whether by birth or adoption, and whether by whole or half-blood, of the individual or the individual's current or former spouse.

h. "Uncompensated value" means the difference between fair market value and the value of any consideration received.

16. The provisions of this section do not apply in determining eligibility for Medicare savings programs.

17. An individual disposes of assets or income when the individual, or anyone on behalf of the individual or at the request of the individual, acts or fails to act in a manner that effects a transfer, conveyance, assignment, renunciation, or disclaimer of any asset or income in which the individual had or was entitled to claim an interest of any kind.

18. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for Medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home care and long-term care coverage, purchased on or before July 31, 2003, with a daily benefit at least equal to 1.25 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

a. For each such month during which the individual is not eligible for Medicare benefits, the individual has in force a major medical policy that provides a lifetime maximum benefit of one million dollars or more, an annual aggregate deductible of five thousand dollars or less, and an out-of-pocket maximum annual expenditure per qualifying individual of five thousand dollars or less; and

b. For each such month during which the individual is eligible for Medicare benefits, the individual has in force a Medicare supplement policy offering plan F benefits, or their equivalent.

19. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for Medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage, purchased on or after August 1, 2003, and before January 1, 2007, with a daily benefit at least equal to

1.57 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

a. For each month during which the individual is not eligible for Medicare benefits, the individual has in force a major medical policy that provides a lifetime maximum benefit of one million dollars or more, an annual aggregate deductible of five thousand dollars or less, and an out-of-pocket maximum annual expenditure per qualifying individual of five thousand dollars or less; and

b. For each such month during which the individual is eligible for Medicare benefits, the individual has in force a Medicare supplement policy offering plan F benefits, or their equivalent.

20. With respect to an annuity transaction which includes the purchase of, selection of an irrevocable payment option, addition of principal to, elective withdrawal from, request to change distribution from, or any other transaction that changes the course of payments from an annuity which occurs on or after February 8, 2006, an individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for Medicaid, if the asset was used to acquire an annuity, only if:

a. The owner of the annuity provides documentation satisfactory to the department that names the department as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant or the department is named in the second position after the community spouse or minor or disabled child, and that establishes that any attempt by such spouse or a representative of such child to dispose of any such remainder shall cause the department to become the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant;

b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;

c. The annuity is irrevocable and neither the annuity nor payments due under the annuity may be assigned or transferred;

d. The annuity provides substantially equal payments of principal and interest, no less frequently than annually, that vary by five percent or less from the total annual payment of the previous year, and does not have a balloon or deferred payment of principal or interest; and

e. The annuity will return the full principal and interest within the purchaser's life expectancy as determined in accordance with actuarial publications of the office of the chief actuary of the social security administration.

History: Effective April 1, 2008; amended effective January 1, 2010; January 1, 2011; April 1, 2012; April 1, 2014; April 1, 2018; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

75-02-02.1-40. Income levels.

1. Levels of income for maintenance shall be used as a basis for establishing financial eligibility for Medicaid. The income levels applicable to individuals and units are:

a. Categorically needy income levels.

(1) Family coverage income levels established in the Medicaid state plan are applied to the family coverage group. The family size is increased for each unborn child when determining the appropriate family size.

(2) Except for individuals subject to the nursing care income level, the income level for categorically needy aged, blind, or disabled recipients is that which establishes supplemental security income eligibility.

b. Medically needy income levels.

(1) Medically needy income levels established in the Medicaid state plan are applied when a Medicaid individual or unit resides in the individual's or the unit's own home or in a specialized facility, and when a Medicaid individual has been screened as requiring nursing care, but elects to receive home and community-based services. The family size is increased for each unborn child when determining the appropriate family size.

(2) The nursing care income levels established in the Medicaid state plan are applied to residents receiving care in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, the state hospital, an institution for mental disease, a psychiatric residential treatment facility, or receiving swing-bed care in a hospital.

(3) The community spouse income level for a Medicaid eligible community spouse is subject to subdivision a, paragraph 1 of subdivision b, or subdivision c. The level for an ineligible community spouse is the greater of two thousand ~~two~~five hundred ~~sixty-seven~~fifty dollars per month or the minimum amount permitted under section 1924(d)(3)(c) of the Act [42 U.S.C. 1396r-5(d)(3)(C)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)].

(4) The income level for each ineligible family member in a spousal impoverishment prevention case is equal to one-third of an amount determined in accordance with section 1924(d)(3)(A)(i) of the Act [42 U.S.C. 1396r-5(d)(3)(A)(i)], less the monthly income of that family member. For purposes of this paragraph, "family member" has the meaning given in subsection 1 of section 75-02-02.1-24.

c. Poverty income level.

(1) The income level for children under age six is equal to one hundred forty-seven percent of the poverty level applicable to a family of the size involved. The family size is increased for each unborn child when determining the appropriate family size.

(2) The income level for pregnant women is equal to one hundred ~~fifty-seven~~seventy percent of the poverty level applicable to a family of the size involved. The family size is increased for each unborn child when determining the appropriate family size.

(3) Qualified Medicare beneficiaries. The income level for qualified Medicare beneficiaries is equal to one hundred percent of the poverty level applicable to the family of the size involved. The income level applies regardless of living arrangement.

(4) The income level for children aged six to nineteen and adults aged nineteen to sixty-five is equal to one hundred thirty-three percent of the poverty level applicable to a family of the size involved. The family size is increased for each unborn child when determining the appropriate family size.

(5) The income level for transitional Medicaid benefits is equal to one hundred and eighty-five percent of the poverty level applicable to a family of the size involved. The family size is increased for each unborn child when determining the appropriate family size.

(6) The income level for qualified working and disabled individuals is equal to two hundred percent of the poverty level applicable to the family of the size involved. The income level applies regardless of living arrangement.

(7) The income level for specified low-income Medicare beneficiaries is equal to one hundred twenty percent, of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

(8) The income level for qualified individuals is equal to one hundred thirty-five percent of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

(9) The income level for workers with disabilities is two hundred twenty-five percent of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

(10) The income level for children with disabilities is two hundred fifty percent of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

2. Determining the appropriate income level in special circumstances.

a. During a month in which an individual enters a specialized facility or leaves a specialized facility to return home, the individual shall be included in the family unit in the home for the purpose of determining the family size and the appropriate income level. An individual residing in a specialized facility shall be allowed the appropriate medically needy, workers with disabilities, or children with disabilities income level for one during all full calendar months in which the individual resides in the facility.

b. During a month in which an individual with eligible family members in the home enters or leaves a nursing facility to return home, or elects to receive home and community-based services or terminates that election, the individual shall be included in the family unit in the home for the purpose of determining the family size and the appropriate medically needy, workers with disabilities, or children with disabilities income level. An individual in a nursing facility shall be allowed ~~sixty-five~~one hundred dollars to meet maintenance needs during all full calendar months in which the individual resides in the nursing facility. A recipient of home and community-based services shall be allowed the medically needy income level for one during all full calendar months in which the individual receives home and community-based services. In determining eligibility for workers with disabilities or children with disabilities coverage, individuals in a nursing facility, or in receipt of home and community-based services, will be allowed the appropriate workers with disabilities or children with disabilities income level for one during all full calendar months in which the individual resides in the facility.

c. For an institutionalized spouse with an ineligible community spouse, the ~~sixty-five~~one hundred dollar income level is effective in the month of entry, during full calendar months, and in the month of discharge. The ineligible community spouse and any other family members remaining in the home shall have the income levels described in paragraphs 3 and 4 of subdivision b of subsection 1.

d. For a spouse electing to receive home and ~~community based~~community-based services, who has an ineligible community spouse, the medically needy income level for one is effective in the month the home and community-based services begin, during full calendar months, and in the month the home and community-based services are terminated. The ineligible community spouse and any other family members remaining in the home shall have the income levels described in paragraphs 3 and 4 of subdivision b of subsection 1.

e. An individual with no spouse, disabled adult child, or child under age twenty-one at home who enters a nursing facility may receive the medically needy income level for one if a physician certifies that the individual is likely to return to the individual's home within six months. The six-month period begins with the first full calendar month the individual is in the nursing facility. If, at any time during the six-month period, the individual's status changes and the stay in the nursing facility is expected to exceed the six months, the individual may have only the nursing care income level beginning in the month following the month of the status change. An individual may receive the medically needy income level for only one six-month period per stay in a nursing facility. If an individual is discharged, then readmitted to a nursing facility, there must be a break of at least one full calendar month between the periods of institutionalization in order for the new stay to be considered a new period of institutionalization.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2010; January 1, 2011; July 1, 2012; January 1, 2014; January 1, 2020; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.7, 50-24.1-21, 50-24.1-37, 50-24.1-41

75-02-02.1-44. Children's health insurance program.

1. **Eligibility criteria.**

   a. Children ages birth through eighteen years of age are eligible for plan coverage provided all other eligibility criteria are met. Coverage for children who are eighteen years of age will continue through the last day of the month in which the child turns nineteen years of age.

   b. A child who has current creditable health insurance coverage or has coverage, which is available at no cost, as defined in section 2701 (c) of the Public Health Service Act [42 U.S.C. 300gg(c)] is not eligible for plan coverage.

   c. If the department estimates available funds are insufficient to allow plan coverage for additional applicants, the department may take any action appropriate to avoid commitment of funds in excess of available funds, including denying applications and establishing waiting lists not forbidden by title XXI of the Social Security Act [42 U.S.C. section 1397aa et seq.] or regulations adopted thereunder. If federal children's health insurance program funding decreases, the department may decrease the income eligibility limit to accommodate the decrease in federal funding.

2. **Asset considerations.** Assets may not be considered in determining eligibility for plan coverage.

3. **Children's health insurance program unit.** This subsection applies to applications and reviews received and processed for those requesting benefits prior to January 1, 2014. A plan unit may consist of one individual, a married couple, or a family with children under twenty-one years of age, or if disabled, under age eighteen, whose income is considered in determining eligibility for any member of that unit, without regard to whether the members of the unit all

physically reside in the same location. A parent or other caretaker of children under twenty-one years of age may select the children who will be included in the plan unit. Anyone who is included in the unit for any month is subject to all plan requirements that may affect the unit. The financial responsibility of relatives must be considered with respect to all members of the assistance unit.

4. **Income considerations.** This subsection applies to applications and reviews received and processed for those requesting benefits prior to January 1, 2014.

   a. All income that is actually available must be considered. Income is actually available when it is at the disposal of an applicant, recipient, or responsible relative when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available; or when the applicant, recipient, or responsible relative has the lawful power to make the income available or to cause the income to be made available.

   b. It is presumed all parental income is actually available to a child under twenty-one years of age. This presumption may be rebutted by a showing that the child is:

      (1) Living independently; or

      (2) Living with a parent who is separated from the child's other parent, with or without court order, if the parents did not separate for the purpose of securing plan coverage.

   c. As a condition of eligibility, an applicant, recipient, and financially responsible relative must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include veterans' compensation and pensions; old-age, survivors, and disability insurance benefits; railroad retirement benefits; and unemployment compensation.

      (1) Good cause under this section exists if receipt of the annuity, pension, retirement, or disability benefit would result in a loss of health insurance coverage. Good cause must be documented in the case file.

      (2) Application for needs-based payments such as social security supplemental security income benefits or temporary aid to needy families benefits cannot be imposed as a condition of eligibility.

   d. The financial responsibility of any individual for any other member of the plan unit is limited to the responsibility of spouse for spouse and parents for children under age twenty-one or under age eighteen if the child is disabled. Such responsibility is imposed as a condition of plan eligibility. Except as otherwise provided in this subsection, the income of the spouse and parents is considered available even if that income is not actually contributed. Natural and adoptive parents, but not stepparents, are treated as parents.

   e. Income may be received weekly, biweekly, monthly, intermittently, or annually. A monthly income amount must be computed by the department or county agency regardless of how often income is received.

   f. The following types of income must be disregarded in determining eligibility for plan coverage:

      (1) Supplemental security income benefits provided by the social security administration.

(2) Income disregards in section 75-02-02.1-38.2.

g. (1) In determining ownership of income from a document, income must be considered available to each individual as provided in the document or in the absence of a specific provision in the document:

(a) Income is considered available only to the individual if payment of the income was made solely to that individual; and

(b) Income is considered available to each individual in proportion to the individual's interest if payment of income is made to more than one individual.

(2) One-half of income is considered available to each spouse in the case of income available to a married couple in which there is no document establishing ownership otherwise.

(3) Except in the case of income from a trust, the rules for determining ownership of income are superseded to the extent the applicant or recipient can establish the ownership interests are otherwise than as provided in subdivision f of subsection 4.

h. To determine the appropriate income level for a plan unit:

(1) The size of the household is increased by one for each unborn child of a household member;

(2) A child who is away at school is not treated as living independently, but is allowed a separate income level for one in addition to the income level applicable for the family unit remaining at home;

(3) A child who is living outside of the parental home but who is not living independently; or a spouse who is temporarily living outside of the home to attend training or college, to secure medical treatment, because of temporary work relocation required by an employer, or for other reasons beyond the control of the spouse, is allowed a separate income level. This does not apply to situations in which an individual simply decides to live separately;

(4) An individual in a specialized facility is allowed a separate income level for one during all full calendar months in which the individual resides in the facility;

(5) An individual in a nursing facility is allowed a separate income level for one; and

(6) A recipient of home and community-based services is allowed a separate income level for one.

i. For a child to be eligible for plan coverage, the income remaining after allowing the appropriate disregards and deductions must be equal to or below the income level set by the department in accordance with state law and federal authorization and must be based on the size of the household. If federal children's health insurance program funding decreases, the department may decrease the income eligibility limit to accommodate the decrease in federal funding.

5. **Income deductions.** This subsection applies to applications and reviews received and processed for those requesting benefits prior to January 1, 2014. The following deductions must be subtracted from monthly income to determine adjusted gross income:

a. For household members with countable earned income:

(1) Actual mandatory payroll deductions, including federal, state, or social security taxes or ninety dollars per month, whichever is greater;

(2) Mandatory retirement plan deductions;

(3) Union dues actually paid; and

(4) Expenses of a nondisabled blind individual, reasonably attributable to earning income;

b. Reasonable child care expenses, not otherwise reimbursed by third parties if necessary to engage in employment or training. Reasonable child care expenses do not include payments to parents to care for their own children;

c. Except for a support payment withheld from an extra check that is disregarded, nonvoluntary child and spousal support payments if actually paid by a parent on behalf of an individual who is not a member of the household;

d. With respect to each individual in the unit who is employed or in training, thirty dollars as a work or training allowance, but only if the individual's income is counted in the eligibility determination;

e. The cost of premiums for health insurance may be deducted from income in the month the premium is paid or may be prorated and deducted from income in the months for which the premium affords coverage. This deduction applies primarily for premiums paid for health insurance coverage of members in the unit who are not eligible for this plan coverage. For eligible members, this deduction may be allowed if the health insurance coverage is not creditable health insurance coverage for hospital, medical, or major medical coverage; and

f. The cost of medical expenses for necessary medical or remedial care for members of the unit who are not eligible for this plan coverage.

History: Effective January 1, 2020; amended effective January 1, 2024.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-24.1-37, 50-29; 42 U.S.C. 1397aa et seq.

CHAPTER 75-02-06

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 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.

17. "Department" means the department of health and human services.

18. "Depreciable asset" means a capital asset for which the cost must be capitalized for ratesetting purposes.

19. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

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.

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.

22. "Direct care costs" means the cost category for allowable nursing and therapy costs.

23. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

24. "Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the nursing facility premises.

25. "Effective age" means a facility's building chronological age reduced by allowable projects for improvements to land, building, and fixed equipment. A facility's effective age must be calculated annually based upon improvements made during the cost report period.

26. "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.

27. "Established rate" means the rate paid for services.

28. "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.

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

30. "Fair rental value" means the depreciated replacement value of the building, land improvements, and fixed equipment based on the facility's effective age; land as a percentage of the building replacement value; and a moveable equipment replacement value based on licensed beds. The calculation of the fair rental value of the building, land improvements, and fixed equipment must include a location factor, annual depreciation, and an annual replacement cost inflation factor. The fair rental value must be calculated using any limitations identified in sections 75-02-06-16 and 75-02-06-16.3.

31. "Fair rental value rate" means the per diem rate calculated using the fair rental value.

32. "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.

33. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.

34. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

35. "Freestanding facility" means a nursing facility which does not share basic services with a hospital-based provider.

36. "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.

37. "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.

38. "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.

39. "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.

40. "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.

41. "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".

42. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.

43. "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.

44. "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.

45. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

46. "Limit rate" means the rate established as the maximum allowable rate for a cost category.

47. "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.

48. "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)].

49. "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.

50. "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.

51. "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.

52. "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.

53. "Noncovered day" means a resident day that is not payable by medical assistance but is counted as a resident day.

54. "Other direct care costs" means the cost category for allowable activities, social services, laundry, and food costs.

55. "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.

56. "Passthrough costs" means the cost category for allowable reasonable legal and related expenses, startup costs, bad debt, education expense, and computer software and related technology costs.

57. "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.

58. "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.

59. "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.

60. "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.

61. "Private room" means a room equipped for use by only one resident.

62. "Property costs" means the cost category for allowable real property costs and lease and rental costs.

63. "Provider" means the organization or individual who has executed a provider agreement with the department.

64. "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.

65. "Rate year" means the calendar year from January first through December thirty-first.

66. "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.

67. "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.

68. "Report year" means the fiscal year from July first through June thirtieth of the year immediately preceding the rate year.

69. "Resident" means ~~a person~~an individual who has been admitted to the facility, but not discharged.

70. "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.

71. "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.

72. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting, and setting.

73. "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.

74. "Standardized resident day" means a resident day times the classification weight for the resident.

75. "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.

76. "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.

77. "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; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-05. Compensation.

1. Compensation on an annual basis for top management personnel must be limited, prior to allocation, if any, to the highest market-driven compensation of an administrator employed by a freestanding facility, with licensed capacity, during the previous report year, at least equal to the licensed capacity of the smallest facility within the top quartile of all facilities ranked by licensed capacity, increased by the consumer price index for all urban consumers (all items, United States city average). Compensation for top management personnel employed for less than a year must be limited to an amount equal to the limitation divided by three hundred sixty-five times the number of calendar days the individual was employed.

2. Compensation includes:

a. Salary for managerial, administrative, professional, and other services.

b. Amounts paid for the personal benefits of the ~~person~~individual, e.g., housing allowance, flat-rate automobile allowance.

c. The cost of assets and services the ~~person~~individual receives from the facility.

d. Deferred compensation, pensions, and annuities.

e. Supplies and services for the personal use of the ~~person~~individual.

f. The cost of a domestic or other employee who works in the home of the ~~person~~individual.

g. Life and health insurance premiums paid for the ~~person~~individual and medical services furnished at facility expense.

3. Reasonable compensation for a person with at least five percent ownership, ~~persons~~individuals on the governing board, or any ~~person~~individual related within the third degree of kinship to top management personnel must be considered an allowable cost if services are actually performed and required to be performed. The amount to be allowed must be an amount determined by the department to be equal to the amount normally required to be paid for the same services if provided by a nonrelated employee. Reasonableness also requires that functions performed be necessary in that, had the services not been rendered, the facility would have to employ another person to perform them. Reasonable compensation on an hourly basis may not exceed the amount determined to be the limitation in subsection 1, divided by two thousand eighty.

4. Costs otherwise nonallowable under this chapter may not be included as personal compensation.

History: Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; September 1, 1987; January 1, 1990; November 22, 1993; January 1, 1996; January 1, 1999; January 1, 2020; January 1, 2024.
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. Rate determination.

a. For the direct cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 5 divided by standardized resident days. The actual rate as calculated is compared to the limit rate 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.

b. For the other direct cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 4 divided by resident days. The actual rate as calculated is compared to the limit rate to determine the lesser of the actual rate or the limit rate.

c. For the indirect cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 4 divided by resident days subject to the adjustments provided for in subdivision g of subsection 4. The actual rate as calculated is compared to the limit rate to determine the lesser of the actual rate or the limit rate.

d. For the passthrough costs category, the actual rate is calculated using allowable historical operating costs divided by resident days subject to the adjustments provided for in subdivision g of subsection 4.

e. The property rate must be the greater of the fair rental value rate or the rate calculated using allowable property costs. The property rate must be calculated using resident days subject to the adjustments provided for in subdivision g of subsection 4. The fair rental value rate must be the rate established under subdivision e of subsection 1 of section 75-02-06-16.3.

f. The lesser of the actual rate or the limit rate for other direct care and indirect care, the passthrough rate, the property rate, and the adjustments provided for in subsections 3 and 4 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

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 December 31, 2021, and four and four-tenths percent effective 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.

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, 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, 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 January 1, 2021, the limit rate for each cost category is:

(a) For the direct care cost category, two hundred four dollars and eighty-four cents;

(b) For the other direct care cost category, twenty-nine dollars and eighty-four cents; and

(c) For the indirect care cost category, 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, passthrough costs, and the fair rental value rate 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.

h. The department may waive or reduce the application of subdivision 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 g.

i. The department may waive the application of paragraph 2 of subdivision 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.

5. An adjustment factor shall be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care under subsection 2 and for purposes of adjusting the limit rates for direct care costs, other direct care costs, and indirect care costs under subsection 4, but may not be used to adjust passthrough costs and the fair rental value under either subsection 2 or 4. The adjustment factor for the January 1, 2023, rates must be reduced by one-half percent.

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.

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.

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, passthrough, 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 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 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) The fair rental value rate established for property for the previous owner must be retained.

b. For a new facility placed into service before December 31, 2022, the department shall establish 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 projected property rate. The projected property rate is subject to subdivision d of subsection 8. 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 the cost report must include applicable incentives, margins, phase-ins, 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. The facility shall file by March first a cost report for the period July first through December thirty-first of the subsequent rate year.

(3) 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 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.

d. For a projected property rate in place before January 1, 2023, at such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate 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 projected property rate reduced by one-twelfth of that difference.

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~~department's public health division 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~~department's public health division. 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~~department's public health divsion'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 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 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 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.

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; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-16.3. Rate determinations for price.

1. Rate determination.

   a. For the direct cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 4 divided by standardized resident days. The actual rate must include the margin cap. The actual rate as calculated is compared to the price rate 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.

   b. For the other direct cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 5 divided by resident days. The actual rate must include the margin cap. The actual rate as calculated is compared to the price rate to determine the lesser of the actual rate or the price rate.

   c. For the indirect cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 5 divided by resident days subject to the adjustments provided for in subdivision i of subsection 3. The actual rate must include the margin cap. The actual rate as calculated is compared to the price rate to determine the lesser of the actual rate or the price rate.

   d. For the passthrough costs category, the actual rate is calculated using allowable historical operating costs divided by resident days subject to the adjustments provided for in subdivision i of subsection 3.

   e. The property rate must be the greater of the fair rental value rate or the rate calculated using allowable property costs subject to subsection 2. The property rate must be

calculated using resident days subject to the adjustments provided for in subdivision i of subsection 3.

f. The lesser of the actual rate or the price rate for other direct care and indirect care, the passthrough rate, the property rate, and the adjustments provided for in subsection 3 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

2. Effective with the 2023 rate year and subsequent rate years:

a. If the fair rental value rate is greater than the rate calculated using allowable property costs:

(1) The increase must be phased in over a four-year period.

(2) The increase must be reserved for renovations or replacements that enhance the fair rental value.

(3) The increase must be reserved until a renovation or replacement of at least two thousand dollars per licensed bed is placed in service. Only allowable costs for building, land improvements, and fixed equipment may be used in calculating the amount per licensed bed.

b. If the fair rental value rate is less than the rate calculated using allowable property costs:

(1) The department shall inform the facility of the property rate using allowable property costs and the fair rental value rate.

(2) Annually by November twenty-eighth, the facility shall inform the department if they want to accept the rate calculated using allowable property costs as the property rate.

c. Once the fair rental value rate is equal to or greater than the rate calculated using allowable property costs, or the facility does not inform the department they want to accept the rate calculated using allowable property costs, the department no longer may inform the facility of the rate calculated using allowable property costs and the property rate must be the fair rental value rate.

3. 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 4.

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 4.

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, passthrough costs, and the fair rental value rate 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.

l. When calculating the fair rental value rate:

(1) The maximum allowable square footage must be nine hundred fifty square feet [88.26 square meters] per licensed bed.

(2) The replacement value of land will be ten percent of the building replacement cost.

(3) The maximum allowable moveable equipment replacement value must be fifteen thousand dollars per licensed bed.

(4) The maximum annual replacement cost inflation factor for building and land must be two percent.

(5) The maximum annual depreciation factor for building must be two percent.

(6) The location factor must be the city of Minneapolis.

(7) The minimum allowable project to impact a facility's effective age must be one thousand dollars per licensed bed. Only allowable costs for building, land improvements, and fixed equipment may be used in calculating the amount per licensed bed.

(8) The maximum allowable rental rate must be eight percent.

(9) The building replacement cost must be calculated by multiplying a facility's allowable square footage times the cost per square foot adjusted for the location factor. The building replacement cost per square foot must be for a thirty thousand square foot [2787.09 square meter] building with exterior walls of precast concrete for the calendar year before the end of the cost report year.

(10) A facility's effective age may be updated due to a renovation project reported in the cost report year the project was completed. The following will be used when calculating the update:

(a) The cost per square foot adjusted for the location factor for the cost report year in which the renovation project was completed.

(b) Additional square footage added due to the renovation project must be included in the total square footage.

(c) Only allowable renovation project costs for building, land improvements, and fixed equipment.

4. 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 3, but may not be used to adjust passthrough costs and the fair rental value under either subsection 1 or 3.

5. 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.

6. 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, the facility, within thirty days, 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.

7. 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, and passthrough 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 5; 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) The fair rental value rate established for the previous owner must be retained.

b. For a new facility placed into service before December 31, 2022, 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 projected property rate. The projected property rate is subject to subdivision f. 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 new facility placed into service after December 31, 2022, 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 fair rental value rate.

d. For a facility with a major renovation of at least fifteen thousand dollars per licensed bed:

(1) If the renovation is placed into service between July first and December thirty-first, a fair rental value rate must be calculated including the major renovation. The fair rental value rate must be effective July first of the subsequent rate year.

(2) If the renovation is placed into service between January first and June thirtieth, a fair rental value rate must be calculated including the major renovation. The fair rental value rate must be effective January first of the subsequent rate year.

e. 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.

f. For a projected property rate in place before January 1, 2023, at such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate 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 projected property rate reduced by one-twelfth of that difference.

8. 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~~department's public health division 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~~department's public health division. 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~~department's public health division'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 5.

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 5.

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 5.

(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.

9. 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; amended effective October 1, 2022; January 1, 2024.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4

CHAPTER 75-02-07.1

75-02-07.1-01. Definitions.

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 legislatively approved inflation rate for basic care services ~~used to develop the legislative appropriation for the department for the applicable rate year~~.

4. "Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.

5. "Aid to vulnerable aged, blind, and disabled ~~persons~~individuals" means a program that supplements the income of an eligible beneficiary who resides in a facility.

6. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by basic care regulations.

7. "Alzheimer's and related dementia facility" means a licensed basic care facility which primarily provides services specifically for individuals with Alzheimer's disease or related dementia.

8. "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 4 of section 75-02-07.1-13;

   b. A sale and leaseback to the same licensee;

   c. A transfer of an interest to a trust;

   d. Gifts or other transfer for nominal or no consideration;

   e. A change in the legal form of doing business;

   f. The addition or deletion of a partner, owner, or shareholder; or

   g. A sale, merger, reorganization, or any other transfer of interest between related organizations.

9. "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 if used directly for resident care.

10. "Capital assets" 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.

11. "Chain organization" means a group of two or more basic care or 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 basic care or health care.

12. "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.

13. "Community contribution" means contributions to civic organizations and sponsorship of community activities. It does not include donations to charities.

14. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, determination of cost limitations, and determination of rates.

15. "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 decided for purposes of cost assignment and allocations.

16. "Cost report" means the department-approved form for reporting costs, statistical data, and other relevant information of the facility.

17. "Department" means the department of health and human services.

18. "Depreciable asset" means a capital asset for which the cost must be capitalized for ratesetting purposes.

19. "Depreciation" means an allocation of the cost of a depreciable asset over its estimated useful life.

20. "Depreciation guidelines" means the American hospital association's depreciation guidelines as published by American hospital publishing, inc., in "Estimated Useful Lives of Depreciable Hospital Assets", revised 2018 edition.

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.

22. "Direct care costs" means the cost category for allowable resident care, activities, social services, and laundry costs.

23. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

24. "Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the facility premises.

25. "Eligible beneficiary" means a facility resident who is eligible for aid to vulnerable aged, blind, and disabled ~~persons~~individuals.

26. "Employment benefits" means fringe benefits and other employee benefits including vision insurance, disability insurance, long-term care insurance, employee assistance programs, employee child care benefits, and payroll taxes.

27. "Facility" means a provider licensed as a basic care facility, not owned or administered by state government, which does not meet the definition of an Alzheimer's and related dementia facility, traumatic brain injury facility, or institution for mental disease, which is enrolled with the department as a basic care assistance program provider.

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

29. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.

30. "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. "Food and plant costs" means the cost category for allowable food, utilities, and maintenance and repair costs.

32. "Freestanding facility" means a facility that does not share basic services with a hospital-based provider or a nursing facility.

33. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits, uniform allowances, and medical services furnished at facility expense.

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.

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.

36. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.

37. "In-house resident day" for basic care, swing bed, and nursing facilities means a day that a resident was actually residing in the facility. "In-house resident day" for hospitals means an inpatient day.

38. "Institution for mental disease" means a facility with a licensed capacity of seventeen or more beds which provides treatment or services primarily to individuals with a primary diagnosis of mental disease.

39. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

40. "Limit rate" means the rate established as the maximum allowable rate for direct care and indirect care.

41. "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.

42. "Medical care leave day" means any day that a resident is not in the facility but is in a licensed health care facility, including a hospital, swing bed, nursing facility, or transitional care unit, and is expected to return to the facility.

43. "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.

44. "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.

45. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

46. "Personal care rate" means a per diem rate that is the sum of the rates established for direct personal care costs, indirect personal care costs, and the operating margin for personal care.

47. "Private-pay resident" means a resident on whose behalf the facility is not receiving any aid to vulnerable aged, blind, and disabled ~~persons~~individuals program payments and whose payment rate is not established by any governmental entity with ratesetting authority.

48. "Private room" means a room equipped for use by only one resident.

49. "Property costs" means the cost category for allowable real property costs and passthrough costs.

50. "Provider" means the organization or individual who has executed a provider agreement with the department.

51. "Rate year" means the year from July first through June thirtieth.

52. "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 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.

53. "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 when an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.

54. "Report year" means the fiscal year from July first through June thirtieth of the year immediately preceding the rate year.

55. "Resident" means ~~a person~~an individual who has been admitted to the facility but not discharged.

56. "Resident day" in a facility means any day for which service is provided or for which payment in any amount is ordinarily sought, including medical care leave 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. The amount of remuneration has no bearing on whether a day should be counted as a resident day. "Resident day" for assisted living or any other residential services provided means a day for which payment is sought by the provider regardless of remuneration.

57. "Room and board rate" means a per diem rate that is the sum of the rates established for property costs, direct room and board costs, indirect room and board costs, the operating margin for room and board and food and plant costs.

58. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting, and setting.

59. "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. It does not mean an

increase by a facility which reduces the number of its licensed beds and thereafter relicenses those beds. It does not mean an increase in a facility's capacity resulting from converting beds formerly licensed as nursing facility beds.

60. "Specialized facility for individuals with mental disease" means a licensed basic care facility with a licensed capacity of less than seventeen which provides treatment or services primarily to individuals with mental disease.

61. "Therapeutic leave day" means any day that a resident is not in the facility or in a licensed health care facility.

62. "Top management personnel" means corporate officers, general, regional, and district managers, administrators, and any other person performing functions ordinarily performed by such personnel.

63. "Traumatic brain injury facility" means a licensed basic care facility which primarily provides services to individuals with traumatic brain injuries.

64. "Working capital debt" means debt incurred to finance 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 July 1, 1996; amended effective July 1, 1998; January 1, 2000; July 1, 2001; February 1, 2007; October 1, 2011; July 1, 2014; April 1, 2018; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-02. Financial reporting requirements.

1. Records.

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

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

   c. Each provider shall maintain, for a period of not less than five years following the date of submission of the cost report to the department, accurate financial and statistical records of the period covered by such cost report in sufficient detail to substantiate the cost data reported. Each provider shall make such records available upon reasonable demand to representatives of the department.

   d. Except for motor vehicles used exclusively for resident-related activities, the provider shall maintain a mileage log for all motor vehicles that identifies mileage and purpose of each trip. Vehicle mileage for nonresident-related activities must be documented.

2. Accounting and reporting requirements.

a. The accrual basis of accounting, in accordance with generally accepted accounting principles, must be used for cost reporting purposes. A facility may maintain its accounting records on a cash basis during the year, but adjustments must be made to reflect proper accrual accounting procedures at yearend and when subsequently reported. Ratesetting procedures must prevail if conflicts occur between ratesetting procedures and generally accepted accounting principles.

b. To properly facilitate auditing, the accounting system must be maintained in a manner that allows cost accounts to be grouped by cost category and readily traceable to the cost report.

c. No later than December first of each year, each facility shall provide to the department:

(1) A cost report on forms prescribed by the department.

(2) A copy of the facility's financial statement. For provider organizations that operate more than one facility, a consolidated financial report can be provided. The information must be reconciled to each facility's cost report.

(3) A statement of ownership for the facility, including the name, address, and proportion of ownership of each owner.

(a) If a privately held or closely held corporation or partnership has an ownership interest in the facility, the facility shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in the facility's cost report must be identified regardless of the proportion of ownership interest.

(b) If a publicly held corporation has an ownership interest of fifteen percent or more in the facility, the facility shall report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of ten percent or more.

(4) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the facility or a certification that the content of any such document remains unchanged since the most recent statement given pursuant to this subsection.

(5) Supplemental information reconciling the costs on the financial statements with costs on the cost report.

(6) The following information, upon request by the department:

(a) Access to certified public accountant's workpapers that support audited, reviewed, or compiled financial statements.

(b) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services claimed as allowable costs.

(c) Separate financial statements for any organization, excluding individual facilities of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconcile costs on the financial statements to costs for the report year.

(d) Separate financial statements for any organization with which the facility conducts business and is owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconcile costs on the financial statements to costs for the report year.

d. If a facility fails to file the required cost report on or before the due date, the department may reduce the current payment rate to eighty percent of the facility's most recently established rate. Reinstatement of the current payment rate must occur on the first of the month beginning after receipt of the required information, but is not retroactive.

e. A facility shall make all adjustments, allocations, and projections necessary to arrive at allowable costs. The department may reject any cost report when the information filed is incomplete or inaccurate. If a cost report is rejected, the department may reduce the current payment rate to eighty percent of its most recently established rate until the information is completely and accurately filed.

f. Costs reported must include total costs and be adjusted to allowable costs. Adjustments made by the department, to attain allowable cost, may, if repeated on future cost filings, be considered as possible fraud and abuse. The department may forward all such items identified to the appropriate investigative group.

g. The department may grant an extension of the reporting deadline to a facility for good cause. To receive an extension, a facility shall submit a written request to the department. The deadline for filing may not be extended past ~~April~~January fifteenth of the year following the report year.

3. In order to properly validate the accuracy and reasonableness of cost information reported by the facility, the department may provide for an onsite audit.

4. Penalties for false reports.

a. A false report is one where a facility knowingly supplies inaccurate or false information in a required report that results in an overpayment. If a false report is received, the department may:

(1) Immediately adjust the facility's payment rate to recover the entire overpayment within the rate year;

(2) Terminate the department's agreement with the provider;

(3) Prosecute under applicable state or federal law; or

(4) Use any combination of the foregoing actions.

b. The department may determine a report is a false report if a provider claims previously adjusted costs as allowable costs. Previously adjusted costs being appealed must be identified as nonallowable costs. The provider may indicate that the costs are under appeal and not claimed under protest to perfect a claim if the appeal is successful.

History: Effective July 1, 1996; amended effective October 1, 2011; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-04. Participation requirement.

A facility may not receive aid to vulnerable aged, blind, and disabled ~~persons~~individuals assistance payments unless it complies with all provisions of this section.

1. A facility shall have an effective provider agreement with the department.

2. A facility may charge to hold a bed for a period in excess of the periods covered under subsection 2 or 3 of section 75-02-07.1-05 if:

   a. The resident, or a person acting on behalf of the resident, has requested the bed be held and the facility informs the person making the request, at the time of the request, of the amount of the charge; and

   b. For an eligible beneficiary, the payment comes from sources other than from the beneficiary's monthly income.

3. A facility may not violate any resident rights as set forth in North Dakota Century Code section 50-10.2-02. Collection and use by a facility of financial information of any applicant pursuant to a screening process does not raise an inference that the facility is using that information for any purpose prohibited by North Dakota Century Code section 50-10.2-02 or this section.

4. A facility may not require any vendor of medical care, who is paid by medical assistance under a separate fee schedule, to pay any portion of the vendor's fee to the facility except as payment for the fair market value of renting or leasing space or equipment of the facility or purchasing support services, if those agreements are disclosed to the department.

5. A facility shall file on behalf of each resident or assist each resident in filing requests for any third-party benefits to which the resident may be entitled.

6. If a facility does not comply with this section, the department, if extreme hardship to the residents would otherwise result, may continue to make medical assistance and aid to vulnerable aged, blind, and disabled ~~persons~~individuals program payments to the facility for a period not to exceed ninety days from the date of mailing a written notice of a violation of this section. The facility may seek reconsideration of or appeal the department's action.

7. A facility may charge a higher rate for a private room used by an eligible beneficiary if:

   a. The private room is not necessary to meet the eligible beneficiary's care needs;

   b. The eligible beneficiary, or a person acting on behalf of the eligible beneficiary, has requested the private room;

   c. The facility informs the individual making the request, at the time of the request, of the amount of payment and that the payment must come from sources other than the eligible beneficiary's monthly income;

   d. The payment does not exceed the amount charged to private-pay individuals for use of a private room; and

   e. Appropriate semiprivate accommodations are available at the time the first charges for a private room apply.

History: Effective July 1, 1996; amended effective July 1, 2001; October 1, 2011; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-05. Resident census.

1. Adequate census records must be prepared and maintained on a daily basis by the facility to allow for proper audit of the census data. The daily census records must include:

   a. Identification of the resident;

   b. Entries for all days, and not just by exception;

   c. Identification of type of day, i.e., medical care, in-house; and

   d. Monthly totals by resident and by type of day.

2. A maximum of thirty days per occurrence may be allowed for payment of the room and board rate for medical care leave. Medical care leave days in excess of thirty consecutive days not billable to the aid to vulnerable aged, blind, and disabled ~~persons~~individuals program are not resident days unless any payment is sought as provided for in subsection 2 of section 75-02-07.1-04.

3. A maximum of twenty-eight therapeutic leave days per rate year may be allowed for payment of the room and board rate. Nonbillable therapeutic leave days in excess of twenty-eight are not resident days unless any payment is sought as provided for in subsection 2 of section 75-02-07.1-04.

4. Residents admitted to the facility through a hospice program, or electing hospice benefits while in a facility, must be identified as hospice residents for census purposes.

5. Payment may not be sought for payment of the personal care rate for any day in which an eligible beneficiary is not in the facility or for the day of discharge. Payment of the personal care rate may be sought for the day of death.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2001; April 1, 2018; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-08.1. Food and plant costs.

Food and plant costs include only those costs identified in this section.

1. The cost of consumable food products and dietary supplements.

2. The cost of heating and cooling, electricity, water, sewer and garbage, and cable television.

3. Repairs and maintenance contracts and purchased services.

4. Supplies necessary for repairs and maintenance of the facility, including hardware, building materials and tools, other maintenance-related supplies, and noncapitalized equipment not included elsewhere.

5. Allowable bad debt expense in the report year in which it was determined to be uncollectible with no likelihood of future recovery. The allowable bad debt expense may not exceed three hundred sixty-five days per individual.

History: Effective July 1, 2001; amended effective January 1, 2024.
General Authority: NDCC ~~50-06-15~~50-06-16
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-10. Nonallowable costs.

Costs not related to resident care are costs not appropriate or necessary and proper in developing and maintaining the operation of the facility and its activities. These costs are not allowed in computing the rates. Nonallowable costs include:

1. Political contributions;

2. Salaries or expenses of a lobbyist;

3. Advertising designed to encourage potential residents to select a particular facility;

4. Fines or penalties, including interest charges on the penalty, bank overdraft charges, and late payment charges;

5. Legal and related expenses for challenges to decisions made by governmental agencies except for successful challenges as provided for in section 75-02-07.1-08;

6. Costs incurred for activities directly related to influencing employees with respect to unionization;

7. Cost of memberships in sports, health, fraternal, or social clubs or organizations such as elks, YMCA, country clubs, or knights of columbus;

8. Assessments made by or the portion of dues charged by associations or professional organizations for lobbying costs, contributions to political action committees or campaigns, or litigation, except for successful challenges to decisions made by governmental agencies, including all dues unless an allocation of dues to such costs is provided;

9. Community contributions, employer sponsorship of sports teams, and dues to civic and business organizations, i.e., lions, chamber of commerce, kiwanis, in excess of one thousand five hundred dollars per cost reporting period;

10. Home office costs not otherwise allowable if incurred directly by the facility;

11. Stockholder servicing costs incurred primarily for the benefit of stockholders or other investors that include annual meetings, annual reports and newsletters, accounting and legal fees for consolidating statements for security exchange commission purposes, stock transfer agent fees, and stockbroker and investment analysis;

12. Corporate costs not related to resident care, including reorganization costs; costs associated with the acquisition of capital stock, except otherwise allowable interest and depreciation expenses associated with the transaction described in subsection 4 of section 75-02-07.1-13; and costs relating to the issuance and sale of capital stock or other securities;

13. The full cost of items or services such as telephone, radio, and television, including cable hookups or satellite dishes, located in resident accommodations, excluding common areas, furnished solely for the personal comfort of the residents;

14. Fundraising costs, including salaries, advertising, promotional, or publicity costs incurred for such a purpose;

15. The cost of any equipment, whether owned or leased, not exclusively used by the facility except to the extent that the facility demonstrates, to the satisfaction of the department, that any portion of the use of equipment was related to resident care;

16. Costs, including, by way of illustration and not by way of limitation, legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies, attributed to the

negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to any health care facility or basic care facility;

17. Costs incurred by the provider's subcontractors or by the lessor of property that the provider leases, that are an element in the subcontractor's or lessor's charge to the provider, if the costs would not have been allowable had the costs been incurred by a provider directly furnishing the subcontracted services, or owning the leased property, except no facility shall have a particular item of cost disallowed under this subsection if that cost arises out of a transaction completed before July 1, 1995;

18. The cost, in excess of charges, of providing meals and lodging to facility personnel living on premises;

19. Depreciation expense for facility assets not related to resident care;

20. Nonbasic care facility operations and associated administration costs;

21. All costs for services paid directly by a government entity to an outside provider, such as prescription drugs;

22. Travel costs involving the use of vehicles not exclusively used by the facility except to the extent:

    a. The facility supports vehicle travel costs with sufficient documentation to establish that the purpose of the travel is related to resident care;

    b. Resident-care related vehicle travel costs do not exceed a standard mileage rate established by the internal revenue service; and

    c. The facility documents all costs associated with a vehicle not exclusively used by the facility;

23. Travel costs other than vehicle-related costs unless supported, reasonable, and related to resident care;

24. Additional compensation paid to an employee, who is a member of the board of directors, for service on the board;

25. Fees paid to a member of a board of directors for meetings attended to the extent that the fees exceed the compensation paid, per day, to a member of the legislative council, pursuant to North Dakota Century Code section 54-35-10;

26. Travel costs associated with a board of directors meeting to the extent the meeting is held in a location where the organization has no facility;

27. The costs of deferred compensation and pension plans that discriminate in favor of certain employees, excluding the portion which relates to costs that benefit all eligible employees;

28. Premiums for top management personnel life insurance policies, except that the premiums must be allowed if the policy is included within a group policy provided for all employees, or if the policy is required as a condition of mortgage or loan and the mortgagee or lending institution is listed as the sole beneficiary;

29. Personal expenses of owners and employees, including vacations, personal travel, and entertainment;

30. Costs not adequately documented through written documentation, date of purchase, vendor name, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or facilities;

31. The following taxes:

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

    b. State or local income and excess profit taxes;

    c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes on the issuance of bonds, property transfers, or issuance or transfer of stocks, which are generally either amortized over the life of the securities or depreciated over the life of the asset, but not recognized as tax expense;

    d. Taxes, including real estate and sales tax, for which exemptions are available to the provider;

    e. Taxes on property not used in the provision of covered services;

    f. Taxes, including sales taxes, levied against the residents and collected and remitted by the provider; and

    g. Self-employment (FICA) taxes, applicable to persons such as individual proprietors, partners, or members of a joint venture;

32. The unvested portion of a facility's accrual for sick or annual leave;

33. Salaries accrued at a facility's fiscal yearend but not paid within seventy-five days of the facility's fiscal yearend;

34. Employment benefits associated with salary costs not includable in a rate set under this chapter;

35. The cost, including depreciation, of equipment or items purchased with funds received from a government agency;

36. Hair care, other than routine hair care, furnished by the facility;

37. The cost of education unless:

    a. The education was provided by an accredited academic or technical educational facility;

    b. The expenses were for materials, books, or tuition;

    c. The employee was enrolled in a course of study intended to prepare the employee for a position at the facility and is in that position; and

    d. The facility claims the cost of the education at a rate that does not exceed one dollar per hour of work performed by the employee in the position for which the employee received education at the facility's expense, provided the amount claimed per employee may not exceed two thousand dollars per year, or an aggregate of eight thousand dollars, and in any event may not exceed the cost to the facility of the employee's education;

38. Repealed effective July 1, 1999.

39. Increased lease costs of a provider except to the extent:

a. The lessor incurs increased costs related to the ownership of the facility or a resident-related asset;

b. The increased costs related to the ownership are charged to the lessee; and

c. The increased costs related to the ownership would be allowable had the costs been incurred directly by the lessee;

40. Bad debts expense in excess of subsection 5 of section 75-02-07.1-08.1;

41. Costs associated with or paid for the acquisition of licensed basic care capacity; and

42. Goodwill.

History: Effective July 1, 1996; amended effective July 1, 1998; January 1, 2000; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-14. Compensation.

1. Compensation on an annual basis for top management personnel must be limited, prior to allocation, if any, to the greatest of:

   a. The highest market-driven compensation of an administrator employed by a freestanding not-for-profit facility during the previous report year increased by the consumer price index for all urban consumers, United States city average, all items;

   b. If the facility is combined with a nursing facility or hospital, the compensation limit for top management personnel as determined by chapter 75-02-06, except the allocation of the compensation to the basic care facility may not exceed subdivision a; or

   c. For a facility licensed before July 1, 2016, which is located in North Dakota and shares a home office that is also located in North Dakota with no more than two nursing facilities that are located in North Dakota, but whose cost report does not include nursing facility costs, the compensation limit for top management personnel as determined by chapter 75-02-06, except the allocation of the compensation to the basic care facility may not exceed subdivision a.

2. Compensation for top management personnel employed for less than a year must be limited to an amount equal to the limitation described in subsection 1, divided by three hundred sixty-five times the number of calendar days the individual was employed.

3. Compensation includes:

   a. Salary for managerial, administrative, professional, and other services;

   b. Amounts paid for the personal benefit of the ~~person~~individual, e.g., housing allowance, flat-rate automobile allowance;

   c. The cost of assets and services the ~~person~~individual receives from the provider;

   d. Deferred compensation, pensions, and annuities;

   e. Supplies and services provided for the personal use of the ~~person~~individual;

   f. The cost of a domestic or other employee who works in the home of the ~~person~~individual; or

g. Life and health insurance premiums paid for the ~~person~~individual and medical services furnished at facility expense.

4. Reasonable compensation for a person with at least five percent ownership, ~~persons~~individuals on the governing board, or any ~~person~~individual related within the third degree of kinship to top management personnel must be considered an allowable cost if services are actually performed and required to be performed. The amount to be allowed must be an amount determined by the department to be equal to the amount required to be paid for the same services if provided by a nonrelated employee to a North Dakota facility. Reasonableness also requires that functions performed be necessary in that, had the services not been rendered, the facility would have to employ another person to perform them. Reasonable hourly compensation may not exceed the amount determined under subsection 1, divided by two thousand eighty.

5. Costs otherwise nonallowable under this chapter may not be included as compensation.

History: Effective July 1, 1996; amended effective July 1, 1998; October 1, 2011; July 1, 2011; April 1, 2018; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3), 50-24.5-10
Law Implemented: NDCC 50-24.5-02(3), 50-24.5-10

75-02-07.1-21. Adjustment factor for direct care, indirect care, and food and plant costs.

~~1.~~ The adjustment factor will be applied to adjust historical costs. The adjustment factor will be used to adjust direct care, indirect care, and food and plant costs, exclusive of bad debt expense.

~~2. Costs reported for a period other than twelve months ended December thirty-first of a report year will be adjusted to December thirty-first using:~~

~~a. The increase, if any, in the consumer price index, urban wage earners and clerical workers, all items, United States city average, over the period ending December thirty-first of the report year, and beginning at the end of the month within which the report period ends.~~

~~b. The increase, if any, identified in subsection a of this section shall be applied prior to any application of the adjustment factor.~~

History: Effective July 1, 1996; amended effective July 1, 2001; July 2, 2002; October 1, 2011; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-22. Rate limitations.

Historical costs, as adjusted, for all facilities for which a rate is established excluding specialized facilities for individuals with mental disease, must be used in the establishment of a limit rate for the direct care and indirect care cost categories. The actual rate for each cost category for each facility must be determined in accordance with this chapter. When establishing a facility's rate:

1. Except for a specialized facility for individuals with mental disease, a facility with an actual rate that exceeds the limit rate for direct care cost category shall receive the limit rate for that cost category;

2. A specialized facility for individuals with mental disease with an actual rate that exceeds two times the limit rate for the direct care cost category shall receive the limit rate times two for that cost category; and

3. A facility with an actual rate that exceeds the limit rate for the indirect care cost category shall receive the limit rate for that cost category. A facility shall receive an operating margin of three percent based on the lesser of the actual direct care rate, exclusive of the adjustment factor, or the direct care limit rate, exclusive of the adjustment factor, established for the rate year. ~~For purposes of this subsection, the adjustment factor does not include the factor necessary to adjust reported costs to December thirty-first.~~

4. The July 1, ~~2017~~2023, direct care limit rate is ~~fifty-seven~~seventy-six dollars and ~~thirty-two~~ninety-one cents.

5. The July 1, ~~2017~~2023, indirect care limit rate is ~~forty-nine~~sixty-two dollars and ~~ninety-five~~seventy-nine cents.

6. The department may use an adjustment factor to calculate the direct care and indirect care limits for future rate years within legislative appropriation.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 1999; amendments partially voided by the Administrative Rules Committee effective June 5, 2000; amended July 1, 2001; February 1, 2007; October 1, 2011; July 1, 2014; April 1, 2018; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-25. Special rates.

1. For a new facility, the department shall establish an interim rate equal to the lesser of the limit rates for direct and indirect care for the rate year in which the facility begins operation, plus the maximum operating margin, plus a room and board rate equal to the average food and plant rate, of all facilities for which a rate was established for the rate year, plus a projected property rate calculated based on projected property costs and imputed census, or a rate established based on an annual budget submitted by the facility. The interim rate may be in effect for no more than eighteen months. No retroactive adjustment may be made to the rate.

   a. If the effective date of the interim rate is on or after September first and on or before December thirty-first, the interim rate must be effective for the remainder of that rate year and must continue through December thirty-first of the subsequent rate year. By August thirty-first, the facility shall file an interim cost report for the period ending June thirtieth of the period in which the facility first provides services. The interim cost report is used to establish the actual rate to be effective January first of the subsequent rate year.

   b. If the effective date of the interim rate is on or after January first and on or before June thirtieth, the interim rate must remain in effect through the end of the subsequent rate year. By March first, the facility shall file a cost report for the partial report year ending December thirty-first of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year.

   c. If the effective date of the interim rate is on or after July first and on or before August thirty-first, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. By March first, the facility shall file a cost report for the period ending December thirty-first of the current rate year. This cost report must be used to establish the rate for the subsequent rate year.

2. For a facility with renovations or replacements in excess of fifty thousand dollars, and without a significant capacity increase, the rate established for direct care, indirect care, food and plant, and the operating margin, 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 of the month following the time the

project is completed and placed into service or on the first of the month following submission of a request for a projected property rate, 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 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 percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

3. For a facility with a significant capacity increase, the rate established for direct care, indirect care, food and plant, and the operating margin, based on the last report year, must be applied to all licensed beds. A property rate must be established based on projected property costs and projected census. The 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~~department's public health division through the end of the rate year.

4. For a facility with no significant capacity increase and no renovations or replacements in excess of fifty thousand dollars, the established rate based on the report year must be applied throughout the rate year for all licensed beds.

5. Rates for a facility changing ownership during the rate period are set under this subsection. The total rate established by adding the components of the rate may not exceed the limit rate established under subsection 1 of section 75-02-07.1-22.

   a. The rates established for direct care, indirect care, food and plant, and the operating margin 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:

      (1) For a facility with four or more months of operation under the new ownership during the report year, through use of a cost report for the period; or

      (2) For a facility with less than four months of operations under the new ownership during the report year:

         (a) By indexing the rate established for the previous owner forward using the adjustment factors as set forth in section 75-02-07.1-21; or

         (b) If the previous owner submits a cost report and allows the audit of that cost report, and if the change of ownership occurred after the report year end but prior to the beginning of the next rate year, by establishing a rate based on the previous owner's cost report.

   b. Unless a facility elects to have a property rate established under subdivision c, 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:

      (1) For a facility with four or more months of operation under the new ownership during the report year, through use of a cost report for the period; and

      (2) For a facility with less than four months of operation under the new ownership during the report year:

         (a) By using the rate established for the previous owner for the previous rate year; or

(b) If the previous owner submits a cost report and allows the audit of that cost report, and if the change of ownership occurred after the report year end but prior to the beginning of the next rate year, by establishing a rate based on the previous owner's cost report.

c. 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 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 subdivision b, multiplied by actual census for the period, must be determined. The property rate established in each of the twelve years, beginning with the first rate year following the use of a property rate established using this subdivision, may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

6. For a facility terminating its participation in the aid to vulnerable aged, blind, and disabled ~~persons~~individuals program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until eligible beneficiaries can be relocated.

7. At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using subsection 2 or 3 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 subsection 2 or 3 may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

8. For purposes of this section, "new facility" means a facility operated in a premises for which no costs were claimed and no rate was set under this chapter for any period prior to July 1, 1995, but does not mean a facility with:

a. Renovations or replacements;

b. A capacity increase; or

c. A change of ownership.

9. When a nursing facility converts licensed bed capacity to basic care bed capacity and the nursing facility does not share basic services with a licensed basic care facility prior to the conversion:

a. For the rate year in which the conversion occurs, the personal care rate shall be the sum of the limit rates for the direct and indirect cost category, the maximum operating margin, and the room and board rate shall be calculated using the nursing facility's food and plant and property costs and census applicable to the rate year;

b. For the first rate year following the rate year in which the conversion occurs, the personal care rate shall be the sum of the limit rates for the direct and indirect cost category, the maximum operating margin, and the room and board rate shall be calculated using the nursing facility's food and plant and property costs and census applicable to the rate year; and

c. A cost report must be used to establish the rates for all subsequent rate years.

10. When a nursing facility converts licensed bed capacity to basic care bed capacity and the nursing facility shares basic services with a licensed basic care facility prior to the conversion,

the rates established for the licensed basic care facility shall apply to the converted bed capacity.

11. A facility that meets the definition of a specialized facility for individuals with mental disease as a result of a reduction in licensed capacity to less than seventeen may choose to have an interim rate established for the remainder of the rate year following the capacity decrease and the subsequent rate based on the lesser of the limit rates for a specialized facility for individuals with mental disease for the rate year in which the institution for mental disease decreases its licensed capacity, plus the maximum operating margin, plus a room and board rate equal to the average food and plant rate, of all facilities for which a rate was established for the rate year, plus a projected property rate calculated based on projected property costs and imputed census, or a rate established based on an annual budget submitted by the facility. The interim rate may be in effect for no more than eighteen months. Retroactive adjustments may not be made to the rate.

    a. If the effective date of the interim rate is on or after September first and on or before December thirty-first, the interim rate must be effective for the remainder of that rate year and must continue through December thirty-first of the subsequent rate year. By August thirty-first, the facility shall file an interim cost report for the period ending June thirtieth of the period in which the facility first provides services. The interim cost report is used to establish the actual rate to be effective January first of the subsequent rate year.

    b. If the effective date of the interim rate is on or after January first and on or before June thirtieth, the interim rate must remain in effect through the end of the subsequent rate year. By March first, the facility shall file a cost report for the partial report year ending December thirty-first of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year.

    c. If the effective date of the interim rate is on or after July first and on or before August thirty-first, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. By March first, the facility shall file a cost report for the period ending December thirty-first of the current rate year. This cost report must be used to establish the rate for the subsequent rate year.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2001; February 1, 2007; October 1, 2011; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-26. One-time adjustments.

1. **Adjustments to meet licensure standards.**

    a. The department may provide for an increase in the established rate for additional costs incurred to meet licensure standards. The survey conducted by the ~~state department of~~department's public health division must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary or other costs increased to correct the deficiencies cited in the survey process.

    b. The facility shall submit a written request to the department within thirty days of submitting the plan of correction to the ~~state department of~~department's public health division. The request must:

        (1) Include a statement that costs or staff numbers have not been reduced for the report year immediately preceding the ~~state department of health's~~department's public health division's licensure survey;

(2) Identify the number of new staff or additional staff hours and the associated costs required to meet the licensure standards;

(3) Provide a detailed list of any other costs necessary to meet licensure standards;

(4) Describe how the facility shall meet licensure standards if the adjustment is received, including the number and type of staff to be added to the current staff and the projected salary and fringe benefit cost for the additional staff; and

(5) Document that all available resources, including efficiency incentives, if used to increase staffing, are not sufficient to meet licensure standards.

c. The department shall review the submitted information and may request additional documentation or conduct onsite visits.

d. If an increase in costs is approved, the adjustment must be calculated based on the costs necessary to meet licensure standards less any incentives included when calculating the established rate. The net increase must be divided by resident days and the amount calculated must be added to the established rate. This rate must then be subject to any rate limitations that may apply.

e. 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 that the funds were not used for the intended purpose, an adjustment must be made in accordance with section 75-02-07.1-23.

f. If the actual cost of implementation exceeds the amount included in the adjustment, no retroactive settlement may be made.

2. **Adjustments for unforeseeable expenses.**

a. 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 beyond the control of those responsible for the management of the facility.

b. Within sixty days after first incurring the unforeseeable expense, the facility shall submit to the department a written request containing:

(1) An explanation as to why the facility believes the expense was unforeseeable;

(2) An explanation as to why the facility believes the expense was beyond the managerial control of the owner or administrator of the facility; and

(3) A detailed breakdown of the unforeseeable expenses by expense line item.

c. 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 their background and knowledge of basic care industry and business trends.

d. 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.

e. 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 section 75-02-07.1-23.

3. **One-time adjustments for cost increases approved by the legislative assembly.**

   a. 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.

   b. 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 legislatively prescribed purpose, an adjustment must be made in accordance with section 75-02-07.1-23.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2001; July 1, 2009; October 1, 2011; July 1, 2014; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

ARTICLE 75-03
COMMUNITY SERVICES

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.~~5. "Department" means the North Dakota department of health and human services.

~~7.~~6. "Designee" means a person that enrolls as a qualified service provider to provide case management services for the Medicaid waiver program.

~~8.~~7. "Disability due to trauma" means a disability that results from an injury or assault to the body by an external force.

~~9.~~8. "Disability that is acquired" means a disability that results from an assault that occurs internally within the body.

~~10.~~9. "Disabled" means under age sixty-five with a congenital disability, a disability due to trauma, or a disability that is acquired.

10. "Eligible individual" 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.

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~~individuals sixty-five years and older, and individuals who are 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~~eligible individual.

18. "Pattern of absenteeism" means an agency or individual provider who has been absent three or more times without notifying the eligible individual or their legal decisionmaker or rescheduling the appointment.

19. "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.

~~19.~~20. "Service fee" means the amount a ~~SPED client~~SPED-eligible individual is required to pay toward the cost of the ~~client's~~eligible individual's SPED services.

~~20.~~21. "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~~individuals sixty-five years and older, and individuals who are disabled ~~persons~~.

~~21.~~22. "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~~individuals sixty-five years and older, and individuals who are disabled ~~individuals~~.

~~22.~~23. "SPED program pool" means the list maintained by the department which contains the names of ~~clients~~eligible individuals for whom SPED program funding is available when the ~~clients'~~eligible individuals' 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; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-03. Eligibility determination - Authorization of services.

1. ~~A person~~An individual 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~~individual 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~~individual 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~~individual 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~~individual 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 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; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-04. Eligibility criteria for Medicaid waiver program.

An applicant is eligible to receive services funded by the Medicaid waiver program if:

1. The applicant is ~~either aged~~sixty-five years and older; or ~~disabled,~~

2. The applicant is under age sixty-five with a congenital disability, a disability due to trauma, or a disability that is acquired and~~, if disabled~~:

   a. The disability must not be the result of mental illness as the primary diagnosis or the result of mental retardation, or a closely related condition; and

   b. The disability must meet the social security administration's definition of disability or the individual must be determined physically disabled by the state review team under section 75-02-02.1-14.

~~2.~~3. The applicant is receiving Medicaid;

~~3.~~4. The applicant is evaluated to be in need of a nursing facility level of care;

~~4.~~5. The applicant's needs may be met by one or more of the covered services, as determined by an assessment conducted in accordance with department policies and procedures;

~~5.~~6. The applicant's service provider is not the applicant's spouse, except when allowed by an approved waiver, or, if the applicant is less than eighteen years old, the applicant's service provider is not the applicant's parent, stepparent, or a person legally responsible for the care of the individual unless allowed by an approved waiver;

~~6.~~7. The applicant agrees to accept services provided under the Medicaid waiver program instead of nursing home care; and

~~7.~~8. The applicant agrees to the plan of care developed for the provision of home and community-based services.

History: Effective June 1, 1995; amended effective January 1, 2009; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5), 50-06.2-03(6)

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~~an eligible individual:

1. The department may provide adult day care services to ~~a client~~an eligible individual:

   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~~eligible individual 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~~an eligible individual 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~~an eligible individual for one-time, intermittent, or occasional activities which would enable the ~~client~~eligible individual 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~~Eligible individuals 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~~eligible individual and not the responsibility of the landlord.

4. The department may provide environmental modification to ~~a client~~an eligible individual:

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~~eligible individual to complete the ~~client's~~eligible individual's own personal care or to receive care and allow the ~~client~~eligible individual to safely stay in the home.

5. a. The department may provide extended personal care services to ~~a client~~an eligible individual 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~~eligible individual 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~~an eligible individual 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~~eligible individual: 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~~an eligible individual 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~~an eligible individual who lives alone and is unable to prepare an adequate meal for ~~himself or herself~~themselves, or who lives with an individual who is unable or not available to prepare an adequate meal for the ~~client~~eligible individual.

9. The department may provide homemaker services to ~~a client~~an eligible individual who needs assistance with environmental maintenance activities including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis. The department may pay a provider for laundry, shopping, meal preparation, money management, or communication, if the activity benefits the ~~client~~eligible individual. The department may pay a provider for housekeeping activities involving the ~~client's~~eligible individual's personal private space and if the ~~client~~eligible individual is living with an adult, the ~~client's~~eligible individual'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~~eligible individuals residing in that household.

10. Nonmedical transportation services may be provided to ~~clients~~eligible individuals 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~~an eligible individual who needs help or supervision with personal care activities if:

    a. The ~~client~~eligible individual is at least eighteen years of age; and

    b. The services are provided in the ~~client's~~eligible individual's home or in a provider's home if the provider meets the definition of a relative as defined in subdivision c of subsection 6 of section 75-03-23-05.

12. a. The department may provide respite care services to ~~a client~~an eligible individual in the ~~client's~~eligible individual'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~~eligible individual has a full-time primary caregiver;

        (2) The ~~client~~eligible individual 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~~An eligible individual 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~~eligible individual's respite provider.

13. The department may provide companionship services up to ten hours per month to eligible individuals who live alone and could benefit from services to help reduce social isolation.

14. 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; January 1, 2024.
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~~an eligible individual:

1. The department may provide adult day care services to ~~a client~~an eligible individual:
   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~~eligible individual does not live alone, the ~~client's~~eligible individual'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~~an eligible individual 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~~an eligible individual 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~~an eligible individual for one-time, intermittent, or occasional activities that would enable the ~~client~~eligible individual 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~~eligible individual and not the responsibility of the landlord.

~~6.~~5. The department may provide an emergency response system to ~~a client~~an eligible individual who lives alone or with an adult who is incapacitated ~~adult~~, or who lives with an individual whose routine absences from the home present a safety risk for the ~~client~~eligible individual, and the ~~client~~eligible individual is cognitively and physically capable of activating the emergency response system.

~~7.~~6. The department may provide environmental modification to ~~a client~~an eligible individual, if the ~~client~~eligible individual owns or rents the home to be modified and when the modification will enable the ~~client~~eligible individual to complete the ~~client's~~eligible individual's own personal

care or to receive care and will allow the ~~client~~eligible individual 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.~~7. a. The department may provide family personal care to ~~a client~~an eligible individual 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, laundry, meal preparation, money management, shopping, social appropriateness, or transportation unless the activity benefits the ~~client~~eligible individual. Family personal care payment may not be made for assistance with the activity of housework unless the activity is for the ~~client's~~eligible individual's personal space or if the ~~client~~eligible individual is living with an adult, the ~~client's~~eligible individual's share of common living space.

~~9.~~8. The department may provide home and community-based services case management services to ~~a client~~an eligible individual 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.~~9. The department may provide home-delivered meals to ~~a client~~an eligible individual who lives alone and is unable to prepare an adequate meal for ~~himself or herself~~themselves or who lives with an individual who is unable or not available to prepare an adequate meal.

~~11.~~10. The department may provide homemaker services to ~~a client~~an eligible individual who needs assistance with environmental maintenance activities, including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis. The department may pay a provider for laundry, shopping, meal preparation, money management, or communication, if the activity benefits the ~~client~~eligible individual. The department may pay a provider for housekeeping activities involving the ~~client's~~eligible individual's personal private space and if the ~~client~~eligible individual is living with an adult, the ~~client's~~eligible individual'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~~eligible individuals residing in that household.

~~12.~~11. a. The department may provide extended personal care services to ~~a client~~an eligible individual 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~~eligible individual 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.~~12. The department may provide nonmedical transportation services to ~~a client~~an eligible individual who is unable to provide ~~his or her~~their 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.~~13. The department may provide up to twenty-four hours per day of supervision to ~~a client~~an eligible individual who has a cognitive or physical impairment that results in the ~~client~~eligible individual needing monitoring to assure the ~~client's~~eligible individual's continued health and safety.

~~15.~~14. a. The department may provide respite care services to ~~a client~~an eligible individual in the ~~client's~~eligible individual'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~~eligible individual has a full-time primary caregiver;

(2) The ~~client~~eligible individual 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~~An eligible individual 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~~eligible individual's respite provider.

~~16.~~15. The department may provide specialized equipment and supplies to ~~a client~~an eligible individual, if:

a. The ~~client's~~eligible individual's need for the items is based on an adaptive assessment;

b. The items directly benefit the ~~client's~~eligible individual'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~~eligible individual care needs;

d. The items are necessary to prevent the ~~client's~~eligible individual's institutionalization;

e. The items are not available under the Medicaid state plan; and

f. The ~~client~~eligible individual is motivated to use the item.

~~17.~~16. The department may provide supported employment to ~~a client~~an eligible individual who is unlikely to obtain competitive employment at or above the minimum wage; who, because of the ~~client's~~eligible individual'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.~~17. The department may provide transitional living services to ~~a client~~an eligible individual 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~~eligible individual's independent living skills development has been met or until an interdisciplinary team determines the service is no longer appropriate for the ~~client~~eligible individual.

~~19.~~18. The department may provide community transition services to ~~a client~~an eligible individual who is transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the ~~client~~eligible individual is directly responsible for ~~his or her~~their 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~~an eligible individual 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~~eligible individual'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~~eligible individual 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.~~19. 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.~~20. The department may provide residential habilitation up to twenty-four hours per day to ~~a client~~an eligible individual who 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~~eligible individual'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~~an eligible individual or their family member.

~~24.~~21. The department may provide community support services up to twenty-four hours per day to ~~a client~~an eligible individual 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~~eligible individual'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~~an eligible individual or their family member.

~~25.~~22. The department may provide companionship services up to ten hours per month to ~~clients~~eligible individuals who live alone and could benefit from services to help reduce social isolation.

23. The department may provide personal care services to an eligible individual who needs supervision and help with personal care services.

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; January 1, 2024.
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~~eligible individuals 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, using applicable forms and providing documentation as required by the department:

(1) Revalidate qualified service provider enrollment except as provided in paragraph 3, within the time period as required by the Medicaid state plan option for personal care services or Medicaid waiver program, whichever occurs first; and

(2) Provide evidence of competency, except as provided in paragraph 3, at least every sixty months for an agency enrolled as a qualified service provider or at least every thirty months for an individual enrolled as a qualified service provider, and within the time period as required by the Medicaid state plan option for personal care services or Medicaid waiver program, whichever occurs first; or

(3) Revalidate qualified service provider enrollment only every sixty months for an individual enrolled as a qualified service provider providing family home care services under the SPED program and expanded service payments for elderly and disabled;

f. Must be physically capable of performing the service for which they were contracted with or hired as an independent contractor; and

g. Must be at least eighteen years of age.

h. A representative of an enrolled qualified service provider agency or an individual qualified service provider must complete a department-approved qualified service provider orientation prior to initial enrollment.

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~~provider 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 individuals 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~~eligible individual who is incontinent;

   g. Feeding or assisting ~~a client~~an eligible individual with eating;

   h. Basic meal planning and preparation;

   i. Assisting ~~a client~~an eligible individual with the self-administration of medications;

   j. Maintaining a kitchen, bathroom, and other rooms used by ~~a client~~an eligible individual 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~~an eligible individual with bill paying and balancing a check book;

m. Dressing and undressing ~~a client~~an eligible individual;

n. Assisting with toileting;

o. Routine eye care;

p. Proper care of fingernails;

q. Caring for skin;

r. Turning and positioning ~~a client~~an eligible individual in bed;

s. Transfer using a belt, standard sit, or bed to wheelchair;

t. Assisting ~~a client~~an eligible individual 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~~eligible individual-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~~eligible individual's need for services has been determined, the ~~client~~eligible individual 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~~eligible individuals they serve.

14. Agency providers who have accepted an authorization to provide twenty-four-hour supports to an eligible individual must give a thirty-day written notice before they can involuntarily discharge the eligible individual from their care, unless otherwise approved by the department.

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; October 1, 2022; January 1, 2024.
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 previously has been terminated for inactivity and does not have a prospective public ~~pay client~~pay-eligible individual;

15. The applicant previously has been terminated for inactivity and has not provided valid reason for the inactivity; or

16. 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; October 1, 2022; January 1, 2024.
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~~eligible individuals.

   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 refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

n. There has been no billing activity within the twelve months since the qualified service provider's enrollment or most recent re-enrollment date.

o. The qualified service provider has demonstrated a pattern of absenteeism by failing to provide care they have been authorized and agreed to provide per subsection 11 of section 75-03-23-07 to an eligible individual.

p. For other good cause.

History: Effective January 1, 2020; amended effective January 1, 2022; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-09. Payment under the SPED program and the Medicaid waiver program.

1. The department shall establish provider rates for home and community-based service in accordance with a procedure that factors in:

   a. Whether a provider is an individual or an agency; and

   b. The range of rates submitted by various providers.

2. The rate for a specific qualified service provider is established at the time the provider agreement is signed.

3. The department shall grant a request for a rate decrease when the department receives a written request for the decrease from the qualified service provider.

4. The department shall grant in full or in part, or shall deny, a request for a rate increase when the department receives a written request for the rate increase from the qualified service provider.

5. The department shall determine the maximum amount allowable per ~~client~~eligible individual each month for a specific service.

6. The department shall establish the aggregate maximum amount allowable per ~~client~~eligible individual each month for all services. The aggregate maximum amount per ~~client~~eligible individual depends on whether the ~~client~~eligible individual is receiving services under the SPED program, under the Medicaid waiver program, or under both programs.

7. The department or designee may grant approval to exceed the monthly service program maximum for a specific ~~client~~eligible individual who is only receiving SPED funds and no Medicaid funds if the ~~client~~eligible individual has a special or unique circumstance; the ~~SPED client~~SPED-eligible individual is not eligible for Medicaid; and the need for additional service program funds will not initially exceed three months. Under emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

8. The department may grant approval to exceed the monthly service program maximum for a specific ~~client~~eligible individual who is receiving SPED funds and Medicaid funds or only Medicaid funds if the ~~client~~eligible individual has a special or unique circumstance; and the need for additional service program funds does not exceed three months. Under emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

9. The department's designee shall notify the ~~client~~eligible individual of the department's determination regarding the request to exceed the monthly service program maximum. If the department denies the request to exceed the monthly aggregate maximum, the department's designee shall inform the ~~client~~eligible individual in writing of the reason for the denial, the ~~client's~~eligible individual's right to appeal, and the appeal process, as provided in chapter 75-01-03.

10. The department will grant approval to exceed the monthly program maximum or service maximum for eligible individuals receiving SPED funds or Medicaid funds, or both, whose service units exceed the program caps as a result of the qualified service provider rate increase. This extension is limited to eligible individuals who were receiving services prior to July 1, 2007.

11. Upon written application and good cause shown to the satisfaction of the department, the department may grant a variance to the three months extension and one-time extension limitation in subsections 7 and 8 upon such terms as the department may prescribe, except no variance may permit or authorize a danger to the health or safety of a client and no variance may be granted except at the discretion of the department. A refusal to grant a variance is not subject to appeal.

History: Effective June 1, 1995; amended effective September 27, 2007; January 1, 2009; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-11. Denial, reduction, and termination of services - Appeal.

1. The department or its designee shall inform ~~a person~~an individual who is determined to be ineligible for covered services or who becomes ineligible while receiving services in writing of the denial, termination, or reduction, the reasons for the denial, termination, or reduction, the right to appeal, and the appeal process as provided in chapter 75-01-03.

2. ~~A client~~An eligible individual must receive ten calendar days' written notice before termination of services occurs. The ten-day notice is not required if:

   a. The ~~client~~eligible individual enters a basic care facility or a nursing facility;

   b. The termination is due to changes in federal or state law;

   c. The ~~client~~eligible individual requests termination of services; or

   d. The ~~client~~eligible individual moves from the service area.

3. An applicant denied services or ~~a client~~an eligible individual terminated from services should be given an appropriate referral to other public or private service providers and should be assisted in finding other resources.

4. The department shall deny or terminate SPED program and Medicaid waiver program services when service to the ~~client~~eligible individual presents an immediate threat to the health or safety of the ~~client~~eligible individual, 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~~eligible individual, the provider of services, or others. Examples of health and safety threats include physical abuse of the provider by the ~~client~~eligible individual, ~~client~~eligible individual self-neglect, an unsafe living environment for the ~~client~~eligible individual, or contraindicated practices, like smoking while using oxygen.

History: Effective June 1, 1995; amended effective January 1, 2009; July 1, 2020; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5), 50-06.2-03(6), 50-06.2-04(1), 50-06.2-04(3)

75-03-23-14. Disqualifying transfers.

1. An individual is not eligible for SPED benefits under this chapter if the department determines that the individual or the spouse of the individual has made any assignment or transfer of any asset for the purpose of making the individual eligible for benefits before or after making application for SPED services except as provided in subsection 2.

2. An individual is not ineligible for SPED benefits under this chapter by reason of subsection 1 to the extent that:

   a. The value of the transferred assets when added to the value of the individual's other assets would not otherwise make the individual ineligible for SPED or does not decrease the individual's service fee.

   b. The asset transferred was a home, and title to the home was transferred to:

      (1) The individual's spouse; or

      (2) The individual's son or daughter who is under the age of twenty-one or who is blind or disabled.

   c. The assets:

(1) Were transferred to the individual's spouse or to another person for the sole benefit of the individual's spouse; or

(2) Were transferred from the individual's spouse to another person for the sole benefit of the individual's spouse.

d. The individual makes a satisfactory showing that:

(1) The individual intended to dispose of the assets at fair market value or for other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;

(2) The assets were transferred exclusively for a purpose other than to qualify for SPED benefits under this chapter; or

(3) All assets transferred for less than fair market value have been returned to the individual.

e. If a disqualifying transfer occurred five years prior to the date an individual initially applies for SPED services, the department will presume that the transfer was not for the purpose of obtaining SPED benefits.

3. There is a presumption that a transfer was made for purposes of making an individual eligible for SPED services under this chapter:

a. If an inquiry about SPED benefits or benefits under this chapter was made, by or on behalf of the individual to any other individual, before the date of transfer;

b. If the individual or the individual's spouse was an applicant for or ~~recipient~~an eligible individual of SPED benefits under this chapter before the date of transfer;

c. If a transfer is made by or on behalf of the individual's spouse, if the value of the transferred asset, when added to the value of the individual's other assets, would exceed SPED asset limits; or

d. If the transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the guardian, conservator, or attorney-in-fact or to any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney-in-fact.

4. An applicant or ~~recipient~~eligible individual who claims that assets were transferred exclusively for a purpose other than to qualify for SPED benefits under this chapter must show a desire to receive SPED benefits under this chapter played no part in the decision to make the transfer and must rebut any presumption arising under subsection 3.

5. If the transferee of any assets is the child, grandchild, brother, sister, niece, nephew, parent, grandparent, stepparent, stepchild, son-in-law, daughter-in-law, or grandchild-in-law of the individual or the individual's spouse, services or assistance furnished by the transferee to the individual or the individual's spouse may not be treated as consideration for the transferred asset unless the transfer is made pursuant to a valid written contract entered into prior to rendering the services.

6. A transfer is complete when the individual, or the individual's spouse, making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

7. For purposes of this section, fair market value is received:

a. When one hundred percent of apparent fair market value is received for an asset whose value is not subject to reasonable dispute, such as cash, bank deposits, stocks, and fungible commodities;

b. When seventy-five percent of estimated fair market value is received for an asset whose value may be subject to reasonable dispute; and

c. When one hundred percent of fair market value is received for an asset considered to be income to the individual or individual's spouse.

8. If an applicant or ~~client~~eligible individual is denied Medicaid based on a disqualifying transfer of assets, the SPED applicant or ~~client~~eligible individual is also ineligible for SPED-funded services.

History: Effective January 1, 2009; amended effective January 1, 2024.
General Authority: NDCC 50-06.2-07
Law Implemented: NDCC 50-06.2-07

75-03-23-15. Application - Applicant required to provide proof of eligibility.

1. An individual wishing to apply for benefits under this chapter must have the opportunity to do so, without delay.

2. An application is a request made to the department or its designee by an individual seeking services under this chapter, or by an individual properly seeking services on behalf of another individual. "An individual properly seeking services" means an individual of sufficient maturity and understanding to act responsibly on behalf of the individual for whom services are sought.

3. An application must include a functional assessment.

4. The individual seeking services under this chapter, or an individual properly seeking services on behalf of that individual, shall sign the application.

5. The department or its designee shall provide information concerning eligibility requirements, available services, and the rights and responsibilities of individuals seeking services under this chapter and of ~~recipients~~eligible individuals to all who require it.

6. The date of application is the date the department or its designee receives the properly signed application.

7. The individual seeking services under this chapter shall provide information sufficient to establish eligibility for benefits, including a social security number and proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and other information required under this chapter.

History: Effective October 1, 2014; amended effective July 1, 2020; January 1, 2024.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03

CHAPTER 75-03-24

75-03-24-01. Definitions.

For purposes of this chapter, unless the context requires otherwise:

1. "Activities of daily living" means bathing, dressing, toileting, transferring, eating, bed mobility, medication management, and personal hygiene.

2. "Blind" has the same meaning as the term has when used by the social security administration in the supplemental security income program under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

3. "Department" means the department of health and human services.

4. "Disabled" has the same meaning as the term has when used by the social security administration in the supplemental security income program under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

5. "Ex-SPED program pool" means the list maintained by the department which contains the names of ~~clients~~eligible individuals for whom ex-SPED program funding is available when the ~~clients'~~eligible individuals' names are transferred from the ex-SPED program pool to ex-SPED program active status.

6. "Institution" means an establishment that makes available some treatment or services beyond food or shelter to four or more individuals who are not related to the proprietor.

7. "Instrumental activities of daily living" means activities to support independent living, including housekeeping, shopping, laundry, transportation, and meal preparation.

History: Effective April 1, 2012; amended effective July 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.7-02
Law Implemented: NDCC 50-24.7

75-03-24-03. Eligibility determination - Authorization of services.

1. The department is responsible for:

   a. Verifying that the ~~person~~individual 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 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; January 1, 2024.
General Authority: NDCC 50-24.7-02
Law Implemented: NDCC 50-24.7

75-03-24-04. Application.

1. All individuals wishing to make application for benefits under this chapter must have the opportunity to do so, without delay.

2. An application is a request made by an individual desiring benefits under this chapter, or by a proper individual seeking such benefits on behalf of another individual, to the department. A proper individual means any individual of sufficient maturity and understanding to act responsibly on behalf of the applicant.

3. An application consists of an application for services, which includes a functional assessment.

4. Application forms must be signed by the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

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

6. The date of application is the date an application, signed by an appropriate individual, is received by the department.

History: Effective April 1, 2012; amended effective July 1, 2020; January 1, 2024.
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~~an eligible individual:

1. The department may provide adult day care services to ~~a client~~an eligible individual:

   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~~eligible individual 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~~an eligible individual 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~~an eligible individual for one-time, intermittent, or occasional activities which would enable the ~~client~~eligible individual 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~~Eligible individuals 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~~eligible individual and not the responsibility of the landlord.

4. The department may provide environmental modification to ~~a client~~an eligible individual:

   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~~eligible individual to complete the ~~client's~~eligible individual's own personal care or to receive care and allow the ~~client~~eligible individual to safely stay in the home.

5. The department may provide family home care services to ~~a client~~an eligible individual:

   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~~an eligible individual who lives alone and is unable to prepare an adequate meal for ~~himself or herself~~themselves, or who lives with an individual who is unable or not available to prepare an adequate meal for the ~~client~~eligible individual.

7. The department may provide homemaker services to ~~a client~~an eligible individual who needs assistance with environmental maintenance activities including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis. The department may pay a provider for laundry, shopping, meal preparation, money management, or communication, if the activity benefits the ~~client~~eligible individual. The department may pay a provider for housekeeping activities involving the ~~client's~~eligible individual's personal private space and if the ~~client~~eligible individual is living with an adult, the ~~client's~~eligible individual'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~~eligible individuals residing in that household.

8. Nonmedical transportation services may be provided to ~~clients~~eligible individuals 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~~an eligible individual in the ~~client's~~eligible individual'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~~eligible individual has a full-time primary caregiver;

   b. The ~~client~~eligible individual 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 companionship services up to ten hours per month to eligible individuals who live alone and could benefit from services to help reduce social isolation.

11. The department may provide other services as the department determines appropriate.

History: Effective April 1, 2012; amended effective October 1, 2014; January 1, 2022; January 1, 2024.
General Authority: NDCC 50-24.7-02
Law Implemented: NDCC 50-24.7

75-03-24-09. Denial, reduction, and termination of services - Appeal.

1. The department shall inform ~~a person~~an individual who is determined to be ineligible for covered services or who becomes ineligible while receiving services in writing of the denial, termination, or reduction, the reasons for the denial, termination, or reduction, the right to appeal, and the appeal process as provided in chapter 75-01-03.

2. ~~A client~~An eligible individual must receive ten calendar days' written notice before termination of services occurs. The ten-day notice is not required if:

   a. The ~~client~~eligible individual enters a basic care facility or a nursing facility;

   b. The termination is due to changes in federal or state law;

   c. The ~~client~~eligible individual requests termination of services;

   d. The ~~client~~eligible individual moves from the service area; or

   e. The ~~client~~eligible individual is deceased.

3. An applicant denied services or ~~a client~~an eligible individual terminated from services should be given an appropriate referral to other public or private service providers and should be assisted in finding other resources.

4. The department shall deny or terminate ex-SPED program services when service to the ~~client~~eligible individual presents an immediate threat to the health or safety of the ~~client~~eligible individual, 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~~eligible individual, the provider of services, or others. Examples of health and safety threats include physical abuse of the provider by the ~~client~~eligible individual, ~~client~~eligible individual self-neglect, an unsafe living environment for the ~~client~~eligible individual, or contraindicated practices, like smoking while using oxygen.

5. Errors made by public officials and delays caused by the actions of public officials do not create eligibility and may not form the basis for the award of any benefit to an adversely affected applicant or ~~recipient~~eligible individual who would not otherwise be eligible to receive that benefit.

History: Effective April 1, 2012; amended effective July 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.7-02
Law Implemented: NDCC 50-24.7

75-03-24-10. Payment under the ex-SPED program.

1. Payment for ex-SPED services may only be made to an enrolled qualified service provider who meets the standards described in chapter 75-03-23.

2. The department shall establish provider rates for home and community-based services in accordance with a procedure that factors in:

   a. Whether a provider is an individual or an agency; and

   b. The range of rates submitted by various providers.

3. The rate for a specific qualified service provider is established at the time the provider agreement is signed.

4. The department shall grant a request for a rate decrease when the department receives a written request for the decrease from the qualified service provider.

5. The department shall grant in full or in part, or shall deny, a request for a rate increase, when the department receives a written request for the rate increase from the qualified service provider.

6. The department shall determine the maximum amount allowable per ~~client~~eligible individual each month for a specific service.

7. The department shall establish the aggregate maximum amount allowable per ~~client~~eligible individual each month for all services.

8. The department may grant approval to exceed the monthly service program maximum for a specific ~~client~~eligible individual who is only receiving ex-SPED funds if:

   a. The ~~client~~eligible individual has a special or unique circumstance; and

   b. The need for additional service program funds will not initially exceed three months. Under emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

9. The department shall notify the ~~client~~eligible individual of the department's determination regarding the request to exceed the monthly service program maximum. If the department denies the request to exceed the monthly aggregate maximum, the department shall inform the ~~client~~eligible individual in writing of the reason for the denial, the ~~client's~~eligible individual's right to appeal, and the appeal process, as provided in chapter 75-01-03.

10. The department will grant approval to exceed the monthly program maximum or service maximum for eligible individuals receiving ex-SPED funds whose service units exceed the program caps as a result of the qualified service provider rate increase. This extension is limited to eligible individuals who were receiving services prior to July 1, 2007.

History: Effective April 1, 2012; amended effective July 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.7-02
Law Implemented: NDCC 50-24.7

75-03-24-12. Administration.

The department must be responsible for the administration of the program with respect to that applicant or ~~recipient~~eligible individual.

History: Effective April 1, 2012; amended effective July 1, 2020; January 1, 2024.
General Authority: NDCC 50-24.7-02
Law Implemented: NDCC 50-24.7

CHAPTER 75-03-38
AUTISM SPECTRUM DISORDER VOUCHER PROGRAM

[Repealed effective January 1, 2024]

~~Section~~
~~75-03-38-01 Definitions~~
~~75-03-38-02 Eligibility~~
~~75-03-38-03 Application~~
~~75-03-38-04 Voucher Administration~~
~~75-03-38-05 Denials - Terminations - Appeals~~
~~75-03-38-06 Variance~~

CHAPTER 75-03-39
AUTISM SERVICES WAIVER

75-03-39-01. Definitions.

1. "Department" means the department of health and human services.
2. "Division" means the medical services division of the department.
3. "Qualified professional" means a primary care provider or licensed medical care provider qualified to diagnose autism spectrum disorder.

History: Effective July 1, 2014; amended effective April 1, 2018; January 1, 2024.
General Authority: NDCC ~~50-24.1-26~~50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-26

75-03-39-02. Eligibility for services under the Medicaid autism spectrum disorder birth through ~~fifteen~~seventeen waiver.

1. A child is eligible for autism services under the department's Medicaid autism spectrum disorder birth through ~~fifteen~~seventeen waiver if the following conditions are met:
   a. The age of the child is birth through ~~fifteen~~seventeen years of age;
   b. The child has an autism spectrum disorder diagnosis from a qualified professional able to determine diagnosis;
   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; January 1, 2024.
General Authority: NDCC ~~50-24.1-26~~50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-26

75-04-05-09. Rate payments.

1. The direct care hourly rate and components for each service are issued in a rate matrix established by the department. The components are:

   a. The direct care hourly rate for intermediate care facilities for individuals with developmental disabilities must include direct care wage, employment-related costs, relief staff, administrative cost, vacancy factor, and program support, including room and board. Building depreciation and related interest costs will be calculated either by an established percentage, or if a facility is acquired or built after January 1, 2010, the provider agency may choose the actual building depreciation and related interest costs relating to the facility for the life of the building to be added to the rate. For facilities acquired after January 1, 2010, subdivision c of subsection 3 of section 75-04-05-15 must be followed in determining remaining useful life. After the depreciable life is complete the established percentage for building depreciation and related interest costs will be utilized.

   b. The direct care hourly rate for residential habilitation must include direct care wage, employment-related expenses, relief staff, program support, administrative costs, and a vacancy factor.

   c. The direct care hourly rate for independent habilitation, day habilitation, prevocational services, individual employment supports, and small group employment supports must include direct care wage, employment-related expenses, relief staff, program support, and administrative costs.

2. For residential habilitation, intermediate care facility for individuals with intellectual disabilities, independent habilitation, day habilitation, prevocational services, and employment supports, the maximum authorized assessment score hours for a client must be calculated by multiplying the rate from the rate matrix times the hours identified by the multiplier based on the client's assessment score from the standard assessment tool, except for residential supports provided in an intermediate care facility for individuals with intellectual disabilities, for which the established rate shall be the sum of all services identified for the client. A provider may request and the department may grant an outlier request for clients who have needs exceeding the client's assessment score.

3. Self-directed services or provider agency directed in-home supports do not require prior authorization based on the assessment score. Hours must be estimated by the program manager based on the person-centered services planning process with input from the client and the client-authorized representative, if applicable. These services are subject to the maximum annual hours as prescribed by the department.

4. Base staffing rate:

   a. A provider agency may receive a base staffing rate when opening a new licensed group home or intermediate care facility for individuals with intellectual disabilities, including prior to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] certification and survey requirements.

   b. A base staffing rate must be calculated based on minimum required staffing levels identified by the department.

   c. A base staffing rate is effective for an intermediate care facility for individuals with intellectual disabilities on the date it is licensed by the department.

d. A provider agency shall receive a base staffing rate until the setting is fully occupied, or for three months, whichever comes first.

5. Room and board charges to clients may not exceed the maximum supplemental security income payment less one hundred thirty-five dollars for the personal incidental costs of the client, plus the average dollar value of supplemental nutrition assistance program to the eligible clientele in the facility.

6. In group homes where rental assistance is available to individual clients or the facility, the rate for room costs chargeable to individual clients are established by the governmental unit providing the subsidy.

7. In group homes where energy assistance program benefits are available to individual clients or the facility, room and board rates are reduced to reflect the average annual dollar value of such benefits.

8. Income from client production must be applied to client wages and the cost of production. The department will not participate in the gains or losses associated with client production conducted pursuant to the applicable provision of title 29, Code of Federal Regulations, part 525.

9. A provider agency may not solicit or receive a payment from a client or any other individual to supplement the established rate of payment.

10. The rate of payment established must be no greater than the rate charged to a private payor for the same or similar service.

11. Limitations:

a. The department shall accumulate and analyze statistics on costs incurred by provider agencies. Statistics may be used to establish reasonable ceiling limitations for needed services. Limitations may be established on the basis of cost of comparable facilities and services, or audited costs, and may be applied as ceilings on the overall costs, on the costs of providing services, or on the costs of specific areas of operations. The department may implement ceilings at any time, based upon the statistics available, or as required by guidelines, regulations, rules, or statutes.

b. The department shall review, on an ongoing basis, aggregate payments to intermediate care facilities for the intellectually disabled to determine that payments do not exceed an amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. If aggregate payments to facilities exceed estimated payments under Medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under Medicare payment principles.

c. Provider agencies may not be reimbursed for services, rendered to a client, which exceed the rated occupancy of any facility as established by a fire prevention authority.

d. Provider agencies of residential habilitation and intermediate care facilities for individuals with intellectual disabilities shall offer services to each client three hundred sixty-five days per year, except for leap years in which three hundred sixty-six days must be offered. Provider agencies may not be reimbursed for those days in which services are not offered to a client.

e. Provider agencies of day services shall offer services to each client eight hours per day two hundred sixty days per year, except leap years in which two hundred sixty-one days must be offered, less any state-recognized holidays, unless a holiday exception is

approved by the department. Provider agencies may not be reimbursed for hours of service in which the client is not in attendance.

f. Provider agencies of day services to clients of intermediate care facilities for individuals with intellectual disabilities shall bill the intermediate care facility for individuals with intellectual disabilities the day habilitation rate established for the client.

12. Adjustments and review procedures are as follows:

a. Adjustments may be made to correct errors. Statement of costs must be reviewed taking into consideration prior years' adjustments. The provider agency must be notified by facsimile transmission or electronic mail of any adjustments based on the desk review. A provider agency may submit information, within thirty days after notification, to explain why the desk adjustment is incorrect. The department shall review the information and make appropriate adjustments.

b. A provider agency may submit a request for reconsideration of the final statement of costs review in writing to the developmental disabilities division within fifteen days of the date of the final statement of costs review notification. A request for reconsideration must provide new evidence indicating why a new determination should be made or explain how the department has incorrectly interpreted the law. The department shall respond to a properly submitted request for reconsideration within ninety days of receipt of the request. The department may revise the final statement of costs review on its own motion.

c. A provider agency may appeal the decision within thirty days after the department mails the written notice of the decision on a request for reconsideration of the final review of the statement of costs.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 1995; April 1, 1996; August 1, 1997; July 1, 2001; May 1, 2006; July 1, 2012; January 1, 2013; April 1, 2018; April 1, 2020; January 1, 2024.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-18-03, 50-24.1-01

TITLE 92

WORKFORCE SAFETY AND INSURANCE

JANUARY 2024

CHAPTER 92-01-02
RULES OF PROCEDURE - NORTH DAKOTA WORKERS' COMPENSATION ACT

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 eighty-five~~one hundred ninety-five dollars per hour for all actual and reasonable time other than travel time. The organization shall pay attorney travel time at ~~ninety-three~~ninety-eight 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~~one hundred fifteen dollars per hour for all actual and reasonable time other than travel time. The organization shall pay travel time at ~~fifty-four~~fifty-seven dollars per hour. A "legal assistant" means any person with a bachelor's degree, associate's degree, or correspondence degree in a legal assistant or paralegal program from an accredited college or university or other accredited agency, or a legal assistant certified by the national association of legal assistants or the national federation of paralegal associations. The term may also include a person employed as a paralegal or legal assistant who has a bachelor's degree in any field and experience working as a paralegal or legal assistant.

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

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

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

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

   d. ~~Twelve thousand forty~~Twelve thousand six hundred fifty dollars, plus reasonable costs incurred, if the employee's North Dakota supreme court appeal is settled prior to hearing. ~~Thirteen thousand two hundred thirty~~Thirteen thousand nine hundred dollars, plus reasonable costs incurred, if the employee prevails after hearing by the supreme court.

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

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

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

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

6. If the organization is obligated to pay the employee's attorney's fees, the attorney shall submit to the organization a final statement upon resolution of the matter. All statements must show the name of the employee, claim number, date of the statement, the issue, date of each service or charge, itemization and a reasonable description of the legal work performed for each service or charge, time and amount billed for each item, and total time and amounts billed. The employee's attorney must sign the fee statement. The organization may deny fees and costs that are determined to be excessive or frivolous.

7. The following costs will be reimbursed:

   a. Actual postage, if postage exceeds three dollars per parcel.

   b. Actual toll charges for long-distance telephone calls.

   c. Copying charges, at eight cents per page.

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

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

8. The following costs will not be reimbursed:

   a. Facsimile charges.

   b. Express mail.

   c. Additional copies of transcripts.

   d. Costs incurred to obtain medical records.

   e. Online computer-assisted legal research.

   f. Copy charges for documents provided by the organization.

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

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

92-01-02-12. Mileage and per diem for travel to and from medical treatment.

Workforce safety and insurance recognizes payment for travel and lodging to and from medical treatment if reasonable and necessary. These expenses will be paid according to North Dakota Century Code section 65-05-28. The number of miles actually traveled is rebuttably presumed to be the least number of miles listed by ~~MapQuest at www.mapquest.com~~Google Maps between the start and end points of travel.

History: Effective August 1, 1988; amended effective April 1, 1997; July 1, 2010; April 1, 2012; April 1, 2014; July 1, 2017; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-05-28

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~~fifty 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~~Google Maps 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; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1, 65-05.1-01(2), 65-05.1-06.3

92-01-02-25. Permanent impairment evaluations and disputes.

1. Definitions:

   a. Amputations and loss as used in subsection 11 of North Dakota Century Code section 65-05-12.2.

"Amputation of a thumb" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the second or distal phalanx of the thumb" means disarticulation at or proximal to the interphalangeal joint.

"Amputation of the first finger" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the first finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the third or distal phalanx of the first finger" means disarticulation at or proximal to the distal interphalangeal joint.

"Amputation of the second finger" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the second finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the third or distal phalanx of the second finger" means disarticulation at or proximal to the distal interphalangeal joint.

"Amputation of the third finger" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the third finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the fourth finger" means disartriculation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the fourth finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the leg at the hip" means disarticulation at or distal to the hip joint (separation of the head of the femur from the acetabulum).

"Amputation of the leg at or above the knee" means disarticulation at or proximal to the knee joint (separation of the femur from the tibia).

"Amputation of the leg at or above the ankle" means disarticulation at or proximal to the ankle joint (separation of the tibia from the talus).

"Amputation of a great toe" means disarticulation at the metatarsal phalangeal joint.

"Amputation of the second or distal phalanx of the great toe" means disarticulation at or proximal to the interphalangeal joint.

"Amputation of any other toe" means disarticulation at the metatarsal phalangeal joint.

"Loss of an eye" means enucleation of the eye.

b. "Maximum medical improvement" means the injured employee's recovery has progressed to the point where substantial further improvement is unlikely, based on reasonable medical probability and clinical findings indicate the medical condition is stable.

c. "Medical dispute" means an employee has reached maximum medical improvement in connection with a work injury and has been evaluated for permanent impairment, and there is a disagreement between health care providers arising from the physical

evaluation that affects the amount of the award. The dispute to be reviewed must clearly summarize the underlying medical condition. It does not include disputes regarding proper interpretation or application of the American medical association guides to the evaluation of permanent impairment, sixth edition. It does not include disputes arising from an impairment percentage rating or an impairment opinion given by a health care provider when the health care provider is not trained in the American medical association guides to the evaluation of permanent impairment, sixth edition, and when the health care provider's impairment percentage rating or impairment opinion do not meet the requirements of subsection 5 of North Dakota Century Code section 65-05-12.2.

d. "Potentially eligible for an impairment award" means the medical evidence in the claim file indicates an injured employee has reached maximum medical improvement and has a permanent impairment caused by the work injury that will likely result in a monetary impairment award.

e. "Treating health care provider" means an allied health care professional who has physically examined or provided direct care or treatment to the injured employee.

2. Permanent impairment evaluations must be performed in accordance with the American medical association guides to the evaluation of permanent impairment, sixth edition, and modified by this section. All permanent impairment reports must include the opinion of the health care provider on the cause of the impairment and must contain an apportionment if the impairment is caused by both work-related and non-work-related injuries or conditions.

3. The organization shall schedule an evaluation with a health care provider who has the training and experience necessary to conduct an evaluation of permanent impairment and apply the American medical association guides to the evaluation of permanent impairment, sixth edition. The organization may not use nor consider a permanent impairment evaluation conducted by the employee's treating health care provider or any health care provider who has treated the injured employee for the work-related injury. In the event of a medical dispute, the organization will identify qualified specialists and submit all objective medical documentation regarding the dispute to specialists who have the knowledge, training, and experience in the application of the American medical association guides to the evaluation of permanent impairment, sixth edition.

4. Upon receiving a permanent impairment rating report from the health care provider, the organization shall audit the report and shall issue a decision awarding or denying permanent impairment benefits.

a. Pain impairment ratings. A permanent impairment award may not be made upon a rating solely under chapter 3 of the sixth edition.

b. Mental and behavioral disorders are not independently compensable and are encompassed within the rating for physical impairment.

c. In chapters that include assessment of the functional history as one of the nonkey factors to adjust the final impairment rating within a class by using a self-report tool, the examining health care provider is to score the self-report tool and assess results for consistency and credibility before adjusting the impairment rating higher or lower than the default value. The evaluating health care provider must provide rationale for deciding that functional test results are clinically consistent and credible.

d. A functional history grade modifier may be applied only to the single, highest diagnosis-based impairment.

e. All permanent impairment reports must include an apportionment if the impairment is caused by both work and non-work injuries or conditions.

5. Pollicization procedures will be rated as an impairment under subsection 11 of North Dakota Century Code section 65-05-12.2, relating to scheduled injury, and may not be rated as a whole body impairment, unless otherwise specified under subsection 11 of North Dakota Century Code section 65-05-12.2.

~~6. Errata sheets and guides updates. Any updates, additions, or revisions by the editors of the sixth edition of the guides to the evaluation of permanent impairment as of April 1, 2012, are adopted as an update, addition, or revision by the organization.~~

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; May 1, 1998; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2009; July 1, 2010; April 1, 2012; July 1, 2017; January 1, 2018; April 1, 2020; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-12.2

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. "Pharmacy services" means ~~any prescribed medication, including over the counter variations requested at the direction of an allied health care professional's rendered treatment~~services rendered by a pharmacist in pharmaceutical care, selection, counseling, dispensing, use, administration, prescription monitoring, medication therapy management, disease state management, drug utilization evaluation or review, vaccination, testing, or collaborative therapy management provided in a pharmacy, clinic, hospital or medical institution.

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

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.

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

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

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.

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.

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.

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

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

92-01-02-29.6. Footwear.

1. An injured employee shall obtain the primary health care provider's order of medical necessity supported by objective medical findings before the purchase of footwear may be approved by the organization. The primary health care provider's order must contain the following:

   a. Patient's name;

   b. Date of patient's face-to-face examination;

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

   d. Specific description of the type or brand or both of footwear being requested;

   e. Primary health care provider's signature; and

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

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

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

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

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

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

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

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

92-01-02-29.7. Prosthetics.

1. For the initial prosthesis, an injured employee shall obtain the primary health care provider's order of medical necessity supported by objective medical findings before the purchase of a prosthesis may be approved by the organization. The primary health care provider's order must contain the following:

a. Patient's name;

b. Date of patient's face-to-face examination;

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

d. Specific description of the type of prosthetic being requested;

e. Primary health care provider's signature; and

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

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

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

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

5. Initial prosthetic apparatus must be body powered.

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

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

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

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

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

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

92-01-02-30. Medical services.

1. Medical services.

   a. Medical services that are not medically necessary are not reimbursable.

   b. Frequency and extent of treatment may not be more than the nature of the injury or process of recovery requires, and must be provided in accordance with utilization and treatment standards as prescribed by the organization or the managed care vendor. The organization may require evidence of the efficacy of treatment.

2. Medical services may be reimbursed only when provided according to a written treatment plan. A copy of the treatment plan, signed by the allied health care professional, must be provided to the organization within fourteen days of beginning the treatment or within fourteen days of learning that the treatment is claimed to be work-related, whichever occurs later. However, a treatment plan is not required for a short course of treatment consisting of one or two visits.

3. For purposes of this section, a treatment plan must include:

   a. Objectives, including the degree of restoration anticipated.

   b. Measurable goals.

   c. Modalities and specific therapies to be used.

   d. Frequency and duration of treatments to be provided.

   e. Condition of the claimant which may require periodic modification of the plan of care based on:

      (1) Improvements in the claimant's status.

(2) Failure of the claimant to improve as expected.

(3) Intervention of care rendered, including education of the claimant, when appropriate.

(4) Specific operative reports, test results, and consultation reports.

4. The cost of preparing a written treatment plan and supplying progress notes under this section is included in the fee for the medical service.

5. The treatment plan requirements of this section may be modified or waived by the organization.

6. X-ray ~~films~~images must be of diagnostic quality. Billings for x-rays are not reimbursable without a report of the findings. Upon request of either the organization or the managed care vendor, original x-ray ~~films~~images must be forwarded to the organization or the managed care vendor. ~~Films must be returned to the vendor.~~ A reasonable charge may be made for the costs of delivery of ~~films~~images.

7. A generic brand of therapeutic equivalence must be dispensed, provided the generic medication costs less. If the injured employee does not accept the generic equivalent at a lower price, the injured employee is responsible for the cost difference between the generic and brand name prescription medication. A branded equivalent of a generically available medication requires prior approval by the organization and will be covered only when objective medical evidence exists that the injured employee developed an adverse response to the generic medication.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; October 1, 2006; April 1, 2020; January 1, 2024.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

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

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

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

   a. The injured employee's name.

   b. The claim number.

   c. The date of service.

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

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

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

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

   a. The injured employee's name.

   b. The claim number.

   c. All relevant medical information and documentation.

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

   e. The specific relief sought.

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

   a. The injured employee's name.

   b. The claim number.

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

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

   e. The specific relief sought.

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

6. The organization may request review by allied health care professionals, at least one of whom must be licensed or certified in the same profession as the allied health care professional

whose treatment is being reviewed, or by an external expert in medical coding or other aspects of medical treatment or billing, to assist with its review of the request. The organization may request an independent medical examination to assist with its review of a request.

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

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

92-01-02-53. Workforce safety and insurance scholarship fund - Application criteria - Refund.

An applicant for a workers' compensation scholarship offered under North Dakota Century Code section 65-05-20.1 must complete the application form required by the organization. The form, at a minimum, must require the applicant provide:

1. Name, address, date of birth, sex, social security number;
2. Educational history, including transcripts if requested;
3. ~~SAT/ACT scores or other institutionally accepted testing program;~~
~~4.~~ Proof of association to the organizational claim leading to the application;
~~5.~~4. Access to receive information regarding other financial aid or assistance; and
~~6.~~5. Any other information the organization requires to administer this program.

The scholarship committee will use the information on the application form to determine which applicants receive the scholarship and may require an applicant to submit additional supporting information. The minimum required grade point average is a two point zero on a four point zero scale, or its equivalent. The organization may award individual scholarships in any amount up to the maximum amounts provided in North Dakota Century Code section 65-05-20.1. Applicants who are awarded the scholarship one year must reapply to receive the scholarship in a subsequent year. If the amount awarded to the applicant is greater than the amount owed the institution over the course of the school year, the excess award must be refunded to the organization. If the applicant who is awarded a scholarship withdraws from the institution and there are scholarship funds to be refunded, the institution shall refund those funds to the organization according to the refund priorities of the institution.

History: Effective August 1, 1997; amended effective May 1, 2000; July 1, 2006; April 1, 2016; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-20.1

92-01-02-55. Dividend programs.

The organization may offer dividends to qualifying employers. Eligibility and distribution:

1. Dividends are not guaranteed.
2. If an employer's account has been in effect for less than an entire premium year, any dividend offered shall be prorated by the number of months the employer's account has been active

with the organization. Premiums paid and losses incurred during a dividend review period defined by the organization, and other criteria identified by the organization, may be used to determine the amount of the dividend. Minimum premium and volunteer accounts are not eligible for dividend payments.

3. The organization shall offset past-due balances on any account by the dividend earned on that account.

4. ~~The distribution of a~~A dividend is distributed in the form of a premium credit to an employer's account and may not reduce an employer's premium below the minimum premium. No monetary disbursements of dividends can be made by the organization.

5. An employer who is noncompliant, delinquent, uninsured, or who has failed to submit a payroll report may be ineligible for a dividend for the payroll period following the year in which the employer was noncompliant, delinquent, uninsured, or failed to submit a payroll report.

History: Effective May 1, 2000; amended effective July 1, 2004; July 1, 2006; July 1, 2010; April 1, 2020; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.3

92-01-02-56. Retrospective rating program.

Repealed effective January 1, 2024.

~~The organization and an employer may elect to contract for a retrospective rating program. Under a retrospective rating program, the employer's retrospective rating premium is calculated using factors including claims costs and actual standard premium and basic premium factors. The organization shall calculate basic premium factors for each level of premium and maximum employer liability.~~

~~Retrospective rating contracts may provide for the calculation of employer or organization interest credits and debits pertaining to claims payments, deposits, or premium balances.~~

~~1. **Eligibility.** Eligibility for participation in a retrospective rating program is based on the financial stability and resources of the employer. Participating employers must be in good standing with the organization.~~

~~The organization may require participating employers to submit to a financial audit performed to ensure financial stability. The audit may include a credit check and review of company financial reports.~~

~~The organization shall analyze each proposed contract based on risk analysis and sound business practices. The organization may refuse a retrospective rating program if it is determined that the proposed contract does not represent a sound business practice or decision.~~

~~Past participation in a retrospective rating program does not guarantee continued eligibility. The organization may decline renewal of any retrospective rating program.~~

~~2. **Retrospective rating program.** A participating employer chooses one maximum liability limit per retrospective rated period. The retrospective rating program applies to the account's entire premium period. The retrospective rating program option is based on aggregate claims costs for all claims for injury or death occurring in the contract year.~~

~~3. **Claim payment.** The organization shall process and pay claims in accordance with North Dakota Century Code title 65. If a third-party recovery on a claim is made, the organization's subrogation interest must first be applied to the amounts paid on the claim by the~~

organization. If the subrogation recovery reduces the retrospective premium, the organization shall provide a refund to the employer.

4. **Premium payment.** Premium is due at policy inception.

5. **Financial security.** The organization may require an employer to provide a bond, letter of credit, or other security approved by the organization to guarantee payment of future employer obligations incurred by a retrospective rating contract. The amount of the security may not exceed the initial nonpaid portion of the maximum possible retrospective premium.

History: Effective May 1, 2000; amended effective May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2012.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-17.1

ARTICLE 92-05
WORKFORCE SAFETY AND INSURANCE RISK MANAGEMENT PROGRAM

CHAPTER 92-05-02

92-05-02-01. Definitions.

As used in this article:

1. ~~"Baseline period" means the period of time immediately preceding the premium period being rated for risk management programs. The baseline period may not be less than six months and not more than eighteen months.~~

~~2.~~ "Employer" means employer as defined in North Dakota Century Code section 65-01-02.

~~3. "Frequency rate" means the total number of claims accepted by the organization attributable to an employer in that employer's premium period multiplied by one million dollars and divided by the employer's gross payroll for mandatory coverage and the current wage cap for optional coverage.~~

~~4.~~2. "Good standing" for purposes of this article means an employer account that is not in default pursuant to North Dakota Century Code section 65-04-22.

~~5. "Measurement year" means the premium period being rated for the risk management programs.~~

~~6.~~3. "Organization" means workforce safety and insurance.

~~7.~~4. "Risk management programs" means all premium reduction and premium calculation programs offered and approved by the organization. Participants in the deductible ~~and retrospective rating~~ program are not eligible for discounts under this chapter.

~~8.~~5. "Safety intervention" means any program, practice, or initiative approved by the organization intended to eliminate workplace hazards.

~~9. "Severity rate" means the rate calculated by multiplying the total number of days for which disability benefits were paid by the organization because of a workplace injury during the measurement year by one million dollars and divided by the employer's gross payroll for mandatory coverage and the current wage cap for optional coverage. The total number of lost time days incurred during the employer's premium period will be calculated only for those claims with acceptance dates in the measurement year and preceding four premium billing periods. Death claims shall be assessed three hundred sixty-five lost time days during the premium billing period in which the workplace death occurs and an additional three hundred sixty-five lost time days for the subsequent premium billing period.~~

History: Effective July 1, 2006; amended effective July 1, 2007; July 1, 2010; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-03-04, 65-04-19.1

92-05-02-03. Eligibility - Billing.

All employers, except participants in the ~~retrospective rating and~~ deductible programs are eligible to participate in the organization's risk management programs.

~~An employer may elect, subject to the organization's approval, to participate in an alternative risk management program.~~

~~The organization, in its discretion, shall determine eligibility for the risk management program. Pursuant to this program, the organization will serve the sector of industry and business that has historically generated high frequency or severity rates, or both.~~

Volunteer accounts are not eligible for participation in risk management programs.

At the organization's discretion, an employer account that is delinquent, uninsured, or not in good standing pursuant to section 92-05-02-01 may not be eligible for discounts under this article.

Discounts are automatically calculated by the organization and are applied as a credit to the employer's premium billing statement.

History: Effective July 1, 2006; amended effective April 1, 2008; July 1, 2010; April 1, 2012; April 1, 2014; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-03-04, 65-04-19.1

CHAPTER 92-05-03
~~GRANT~~SAFETY AND HEALTH PROGRAMS

Section
92-05-03-01 ~~Grant~~Safety and Health Programs - Purpose
92-05-03-02 Eligibility
92-05-03-03 Administration
92-05-03-04 Transitional Return-to-Work Program
92-05-03-05 ~~Ergonomic~~Ergonomic Program
92-05-03-06 Hazard Elimination Learning Program [Repealed]
92-05-03-07 Safety Training and Education Program

92-05-03-01. ~~Grant~~Safety and health programs - Purpose.

The organization may ~~create grant~~establish safety and health programs to fund safety interventions and disbursements, or develop other programs to ~~reduce workplace injury and illness~~promote safety practices. A decision to discontinue a ~~grant~~safety and health program is at the discretion of the organization. ~~A grant~~An award under this section is within the discretion of the organization.

History: Effective July 1, 2006; amended effective April 1, 2008; April 1, 2009; April 1, 2014; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-03-04

92-05-03-02. Eligibility.

A North Dakota-based employer ~~who has~~with an active ~~employer~~workforce safety and insurance account, a volunteer organization that has elected volunteer coverage with the organization, ~~or~~ an association or group comprised of North Dakota employers or employees ~~active and~~ in good standing with the North Dakota secretary of state for at least one year ~~are~~, or person is eligible to apply for ~~an organization grant. An~~a safety and health program. Depending on the initiative an applicant ~~must~~may be required to submit a completed application. ~~An applicant must demonstrate a need for grant moneys pursuant to the terms of the grant application~~A safety and health program applicant must complete all program requirements for eligibility consideration of an award.

The organization may require the applicant to submit proof of ~~its~~ financial ability to support a matching grant program. A grant award under this chapter rests solely within the discretion of the organization. The organization may consider all aspects of an employer's history, including whether the employer account is in good standing, in determining eligibility for a grant award under this chapter.

History: Effective July 1, 2006; amended effective July 1, 2007; April 1, 2009; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-03-04

92-05-03-03. Administration.

~~Grant~~Safety and health awards must be determined by a ~~grant~~ review board established by the organization. ~~Grants awarded~~At the organization's discretion, safety and health awards by the organization are subject to the terms of a signed agreement executed by the organization and the recipient of the ~~grant moneys~~award. No ~~grant money~~award may be distributed until a signed agreement is fully executed. If the review board determines that ~~a grant~~an application or supporting documentation contains erroneous or misrepresented facts, and ~~a grant~~an award was made based on those facts, the organization may decline to process ~~a grant~~the application or revoke ~~a grant~~the award. The applicant shall refund all ~~grant~~award dollars to the organization.

History: Effective July 1, 2006; amended effective April 1, 2009; January 1, 2024.

General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-03-04