TITLE 92

WORKFORCE SAFETY AND INSURANCE

JULY 2017

CHAPTER 92-01-02
RULES OF PROCEDURE - NORTH DAKOTA WORKERS' COMPENSATION ACT

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92-01-02-11. Attorneys.

Any party has a right to be represented by an attorney at any stage in the proceedings regarding a claim. An attorney who represents an injured worker in a proceeding regarding a claim shall file a notice of legal representation prior to or together with the attorney's first communication with the organization. The notice of legal representation remains in effect for five years from the date it is signed by the injured worker or until revoked by the injured worker, whichever occurs first.

History: Amended effective June 1, 1990; April 1, 1997; April 1, 2008; July 1, 2017.

General Authority: NDCC 65-02-08, 65-10-03
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 as a reasonable and necessary medical expense. Lodging expenses will be reimbursed if they are necessary and reasonable. These expenses will be paid according to North Dakota Century Code section 65-05-28~~, except that reimbursement for out-of-state lodging may not exceed one hundred twenty-five percent of the allowance for in-state lodging~~. The number of miles actually traveled is rebuttably presumed to be the least number of miles listed by MapQuest at www.mapquest.com between the start and end points of travel.

History: Effective August 1, 1988; amended effective April 1, 1997; July 1, 2010; April 1, 2012; April 1, 2014; July 1, 2017.
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 e of subsection 2 of North Dakota Century Code section 65-05.1-06.1 or under subsection 3 of North Dakota Century Code section 65-05.1-06.1 only when the employee identifies the job the employee will perform, the employee's employer, and the employee's destination. A relocation award must be the actual cost of moving the household to the location where work has been obtained. A minimum of two bids detailing the costs of relocation must be submitted to the organization for approval prior to incurring the cost. The organization shall pay per diem expenses, as set forth under subsection 2 of North Dakota Century Code section 65-05-28, for the employee only. Reimbursement for mileage expenses may not be paid for more than one motor vehicle.

3. When the rehabilitation award is for retraining, the organization shall pay the actual cost of books, tuition, and school supplies required by the school. The school must provide documentation of the costs necessary for completion of the program in which the employee is enrolled. Reimbursable school costs may not exceed those charged to other students participating in the same program. The award for school supplies may not exceed twenty-five dollars per quarter or thirty dollars per semester unless the employee obtains prior approval of the organization by showing that the expenses are reasonable and necessary. A rehabilitation award for retraining may include tutoring assistance to employees who require tutoring to maintain a passing grade. Payment of tutoring services will be authorized when these services are not available as part of the training program. The award for tutoring services may not exceed the usual and customary rate established by the school. Expenses such as association dues or subscriptions may be reimbursed only if that expense is a course requirement.

4. An award for retraining which includes an additional rehabilitation allowance as provided in subdivision b of subsection 2 of North Dakota Century Code section 65-05.1-06.1 may continue only while the employee is actually enrolled or participating in the training program.

5. An award of a specified number of weeks of training means training must be completed during the specified period of weeks, and rehabilitation benefits may be paid only for the specified number of weeks of training.

6. The organization may reimburse an employee's travel and personal expenses for attendance at an adult learning center or skill enhancement program at the request of the employee and upon the approval of the organization. All claims for reimbursement must be supported by the original vendor receipt, when appropriate, and must be submitted within one year of the date the expense was incurred. The organization shall reimburse these expenses at the rates in effect on the date of travel or the date the expense was incurred at which state employees are paid per diem and mileage, or reimburse the actual cost of meals and lodging plus mileage, whichever is less. The calculation for reimbursement for travel by motor vehicle must be calculated using miles actually and necessarily traveled. The number of miles actually traveled is rebuttably presumed to be the least number of miles listed by MapQuest at www.mapquest.com between the start and end points of travel. The organization may not reimburse mileage or travel expenses when the distance traveled is less than fifty miles [80.47 kilometers] one way, unless the total mileage in a calendar month equals or exceeds two hundred miles [321.87 kilometers].

7. The organization may pay for retraining equipment required by an institution of higher education or an institution of technical education on behalf of a student attending that institution. The organization will award retraining candidates one thousand two hundred dollars for the purchase of computer, warranty, software, maintenance, and internet access. Securing and maintaining these items are the injured employee's responsibility. Failure to maintain or secure these items does not constitute good cause for noncompliance with vocational rehabilitation. Improper maintenance of the equipment does not constitute good cause for noncompliance with vocational rehabilitation.

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.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1

92-01-02-25. Permanent impairment evaluations and disputes.

1. Definitions:

   a. Amputations and loss as used in subsection 11 of North Dakota Century Code section 65-05-12.2.

      "Amputation of a thumb" means disarticulation at the metacarpal phalangeal joint.

      "Amputation of the second or distal phalanx of the thumb" means disarticulation at or proximal to the interphalangeal joint.

      "Amputation of the first finger" means disarticulation at the metacarpal phalangeal joint.

      "Amputation of the middle or second phalanx of the first finger" means disarticulation at or proximal to the proximal interphalangeal joint.

      "Amputation of the third or distal phalanx of the first finger" means disarticulation at or proximal to the distal interphalangeal joint.

      "Amputation of the second finger" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the second finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the third or distal phalanx of the second finger" means disarticulation at or proximal to the distal interphalangeal joint.

"Amputation of the third finger" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the third finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the fourth finger" means disartriculation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the fourth finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the leg at the hip" means disarticulation at or distal to the hip joint (separation of the head of the femur from the acetabulum).

"Amputation of the leg at or above the knee" means disarticulation at or proximal to the knee joint (separation of the femur from the tibia).

"Amputation of the leg at or above the ankle" means disarticulation at or proximal to the ankle joint (separation of the tibia from the talus).

"Amputation of a great toe" means disarticulation at the metatarsal phalangeal joint.

"Amputation of the second or distal phalanx of the great toe" means disarticulation at or proximal to the interphalangeal joint.

"Amputation of any other toe" means disarticulation at the metatarsal phalangeal joint.

"Loss of an eye" means enucleation of the eye.

b. "Maximum medical improvement" means the injured employee's recovery has progressed to the point where substantial further improvement is unlikely, based on reasonable medical probability and clinical findings indicate the medical condition is stable.

c. "Medical dispute" means an employee has reached maximum medical improvement in connection with a work injury and has been evaluated for permanent impairment, and there is a disagreement between doctors arising from the physical evaluation that affects the amount of the award. The dispute to be reviewed must clearly summarize the underlying medical condition. It does not include disputes regarding proper interpretation or application of the American medical association guides to the evaluation of permanent impairment, sixth edition. It does not include disputes arising from an impairment percentage rating or an impairment opinion given by a doctor when the doctor is not trained in the American medical association guides to the evaluation of permanent impairment, sixth edition, and when the doctor's impairment percentage rating or impairment opinion do not meet the requirement's of subsection 5 of North Dakota Century Code section 65-05-12.2.

d. "Potentially eligible for an impairment award" means the medical evidence in the claim file indicates an injured employee has reached maximum medical improvement and has a permanent impairment caused by the work injury that will likely result in a monetary impairment award.

e. "Treating doctor" means a doctor of medicine or osteopathy, chiropractor, dentist, optometrist, podiatrist, or psychologist acting within the scope of the doctor's license who has physically examined or provided direct care or treatment to the injured employee.

2. Permanent impairment evaluations must be performed in accordance with the American medical association guides to the evaluation of permanent impairment, sixth edition, and modified by this section. All permanent impairment reports must include the opinion of the doctor 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 establish a list of medical specialists who have 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. When an employee requests an evaluation of impairment, the organization shall schedule an evaluation with a doctor from the list. The organization may not schedule a permanent impairment evaluation with the employee's treating doctor. The organization and employee may agree to an evaluation by a doctor not on the current list. 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. To the extent more than one doctor is identified, the organization will consult with the employee before appointment of the doctor.

4. Upon receiving a permanent impairment rating report from the doctor, the organization shall audit the report and shall issue a decision awarding or denying permanent impairment benefits.

   a. Pain impairment ratings. A permanent impairment award may not be made upon a rating solely under chapter 3 of the sixth edition.

   b. Mental and behavioral disorder impairment ratings. Any evaluating doctor determining permanent mental or behavioral disorder impairment per chapter 14 of the sixth edition shall include a written summary of the mental evaluation in the evaluation report.

   c. In chapters that include assessment of the functional history as one of the nonkey factors to adjust the final impairment rating within a class by using a self-report tool, the examining doctor is to score the self-report tool and assess results for consistency and credibility before adjusting the impairment rating higher or lower than the default value. The evaluating doctor 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. 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.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-12.2

92-01-02-29.1. Medical necessity.

1. A medical service or supply necessary to diagnose or treat a compensable injury, which is appropriate to the location of service, is medically necessary if it is widely accepted by the practicing peer group and has been determined to be safe and effective based on published, peer-reviewed, scientific studies.

2. Services that present a hazard in excess of the expected medical benefits are not medically necessary. Services that are controversial, obsolete, experimental, or investigative are not reimbursable unless specifically preapproved or authorized by the organization. Requests for authorization must contain a description of the treatment and the expected benefits and results of the treatment.

3. The organization will not authorize or pay for the following treatment:

   a. Massage therapy or acupuncture unless specifically preapproved or otherwise authorized by the organization. Massage therapy must be provided by a licensed physical therapist, licensed occupational therapist, or licensed chiropractor~~, or licensed massage therapist~~.

   b. Chemonucleolysis; acupressure; reflexology; rolfing; injections of colchicine except to treat an attack of gout precipitated by a compensable injury; injections of chymopapain; injections of fibrosing or sclerosing agents except where varicose veins are secondary to a compensable injury; and injections of substances other than cortisone, anesthetic, or contrast into the subarachnoid space (intrathecal injections).

   c. Treatment to improve or maintain general health (i.e., prescriptions or injections of vitamins, nutritional supplements, diet and weight loss programs, programs to quit smoking) unless specifically preapproved or otherwise authorized by the organization. Over-the-counter medications may be allowed in lieu of prescription medications when approved by the organization and prescribed by the attending doctor and dispensed and processed according to the current pharmacy transaction standard. Dietary supplements, including minerals, vitamins, and amino acids are reimbursable if a specific compensable dietary deficiency has been clinically established in the claimant. Vitamin B-12 injections are reimbursable if necessary because of a malabsorption resulting from a compensable gastrointestinal disorder.

   d. Articles such as beds, hot tubs, chairs, Jacuzzis, vibrators, heating pads, home furnishings, waterbeds, exercise equipment, cold packs, hot packs, and gravity traction devices are not compensable except at the discretion of the organization under exceptional circumstances.

   e. Vertebral axial decompression therapy (Vax-D treatment).

   f. Intradiscal electrothermal annuloplasty (IDET).

   g. Prolotherapy (sclerotherapy).

   h. Surface electromyography (surface EMG).

   i. Athletic trainer services that are provided to a claimant via an agreement, or a contract of employment between a trainer and a claimant's employer, or an entity closely associated with the employer.

   j. Spine strengthening program (e.g. MedX or SpineX or other substantially equivalent program).

k. Electrodiagnostic studies performed by electromyographers who are not certified or eligible for certification by the American board of electrodiagnostic medicine, American board of physical medicine and rehabilitation, or the American board of neurology and psychiatry's certification in the specialty of clinical neurophysiology. Nerve conduction study reports must include either laboratory reference values or literature-documented normal values in addition to the test values to be eligible for payment.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012; April 1, 2014; April 1, 2016; July 1, 2017.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-29.3. Motor vehicle purchase ~~or~~and modification.

1. An injured worker must obtain ~~a~~an attending doctor's order of medical necessity supported by objective medical findings before the purchase of a specially equipped motor vehicle or modification of a vehicle may be approved. The attending doctor's order must contain the following:

   a. Patient's name;

   b. Date of patient's face-to-face examination;

   c. Pertinent diagnosis or conditions that relate to the need for device or modification;

   d. Description of what is ordered;

   e. Length of need;

   f. Attending doctor's signature; and

   g. Date of attending doctor's signature.

2. The organization may require assessments to determine the functional levels of an injured worker who is being considered for a specially equipped motor vehicle or vehicle modification and to determine what modifications are medically necessary.

3. If an existing vehicle cannot be repaired or modified, the organization, in its sole discretion, may approve the purchase of a specially equipped motor vehicle.

4. A minimum of two itemized cost quotes may be requested by the organization. The organization may decrease or add the number of cost quotes needed accordingly.

5. Actual vehicle or modification purchase may not occur until the organization reviews the request and issues recommendations or decisions as to whether eligible for the benefit.

6. Cost quotes must be itemized.

7. Any available vehicle rebates or tax exemptions shall be applied back to the lifetime benefit amount as provided in subsection 5 of North Dakota Century Code section 65-05-07.

8. Any appeal of a decision under this section shall be adjudicated pursuant to North Dakota Century Code section 65-02-20.

History: Effective April 1, 2009; amended effective April 1, 2012; April 1, 2014; July 1, 2017.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-07(5)(b)

92-01-02-29.4. Home modifications.

1. An injured worker must obtain ~~a~~an attending doctor's order of medical necessity supported by objective medical findings before the payment for home modifications can be approved. The attending doctor's orders must contain the following:

   a. Patient's name;

   b. Date of patient's face-to-face examination;

   c. Pertinent diagnosis or conditions that relate to the need for device or modification;

   d. Description of what is ordered;

   e. Length of need;

   f. Attending doctor's signature; and

   g. Date of attending doctor's signature.

2. The organization may require assessments to determine the functional levels of an injured worker who is being considered for home modifications and to determine what modifications are medically necessary.

3. A minimum of two itemized cost quotes may be requested by the organization. The organization may decrease or add the number of cost quotes needed accordingly.

4. Actual construction or modification cannot occur until the organization reviews the request and issues recommendations or decisions as to eligibility for the benefit.

5. Cost quotes must be itemized.

6. Payment by the organization may not occur until the modification work is completed, or at least, completed in documented phases or at the discretion of the organization.

7. The organization may request that the contractor for proposed home modification be in good standing (example: licensed in the state, bonded, etc.)

8. Real estate modifications to driveways, sidewalks, or passageways may only be approved if evidence supports that those routes are needed to provide safe passageway for the injured worker.

9. Any appeal of a decision under this section shall be adjudicated pursuant to North Dakota Century Code section 65-02-20.

10. Modifications will only be considered upon receipt of documentation establishing injured employee's ownership of the residence to be permanently modified.

11. Modifications within new construction will be considered upon receipt of the original floor plan/specifications and cost estimate, as well as the modified floor plan and cost estimate.

History: Effective April 1, 2012; amended effective April 1, 2014; April 1, 2016; July 1, 2017.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-07

92-01-02-29.5. Power mobility devices.

1. An injured employee shall obtain an attending doctor's order of medical necessity supported by objective medical findings before the purchase of a power mobility device may be approved by the organization. The attending doctor's order must contain the following:

   a. Patient's name;

   b. Date of patient's face-to-face examination;

   c. Pertinent diagnosis or conditions that relate to the need for device or modification;

   d. Description of what is ordered;

   e. Length of need;

   f. Attending doctor's signature; and

   g. Date of attending doctor's signature.

2. There must be clear medical documentation of functional limits of standing and walking with an assistive device. Documentation must support reasons why a cane, walker, or manual wheelchair cannot be used to complete activities of daily living.

3. An attending doctor must make a referral for a mobility assessment and the assessment must be performed by a licensed or certified occupational therapist or physical therapist with specific training and experience in rehabilitation mobility or wheelchair evaluations. The assessment must be completed prior to the approval of a power mobility device.

4. When the power mobility device is primarily intended for outdoor use or recreational purposes, the device is not medically necessary.

5. Upgrades to a power mobility device are not considered medically necessary if the upgrade is primarily intended for luxury, outdoor, or recreational purposes. Specific items such as power tilt or recline seating will only be approved if the injured employee is at risk of additional medical complications, has issues with transfer, or an upgrade will help manage the injured employee's tone and spasticity.

6. An injured employee who has been approved for a power mobility device must independently qualify for a motor vehicle purchase or home modification as provided in subsection 5 of North Dakota Century Code section 65-05-07, section 92-01-02-29.3, and section 92-01-02-29.4.

7. If an injured employee does not sustain a catastrophic injury or if exceptional circumstances do not exist as provided in subsection 5 of North Dakota Century Code section 65-05-07, but the injured employee is approved for a power mobility device, the organization, in its sole discretion, may approve a vehicle modification or adaptation for the injured employee, but may not approve a vehicle purchase.

8. All initial and replacement requests for power mobility devices must meet the criteria in this section.

9. An appeal of a decision made by the organization under this section must be adjudicated pursuant to North Dakota Century Code section 65-02-20.

History: Effective July 1, 2017.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-07

92-01-02-31. Who may be reimbursed.

1. Only treatment that falls within the scope and field of the treating medical service provider's license to practice is reimbursable.

2. Paraprofessionals who are not independently licensed must practice under the direct supervision of a licensed medical service provider whose scope of practice and specialty training includes the service provided by the paraprofessional, in order to be reimbursed.

3. Health care providers may be refused reimbursement to treat cases under the jurisdiction of the organization.

4. Reasons for holding a medical service provider ineligible for reimbursement include one or more of the following:

   a. Failure, neglect, or refusal to submit complete, adequate, and detailed reports.

   b. Failure, neglect, or refusal to respond to requests by the organization for additional reports.

   c. Failure, neglect, or refusal to respond to requests by the organization for drug testing.

   d. Failure, neglect, or refusal to observe and comply with the organization's orders and medical service rules, including cooperation with the organization's managed care vendors.

   ~~d.~~e. Failure to notify the organization immediately and prior to burial in any death if the cause of death is not definitely known or if there is question of whether death resulted from a compensable injury.

   ~~e.~~f. Failure to recognize emotional and social factors impeding recovery of claimants.

   ~~f.~~g. Unreasonable refusal to comply with the recommendations of board-certified or qualified specialists who have examined the claimant.

   ~~g.~~h. Submission of false or misleading reports to the organization.

   ~~h.~~i. Collusion with other persons in submission of false or misleading information to the organization.

   ~~i.~~j. Pattern of submission of inaccurate or misleading bills.

   ~~j.~~k. Pattern of submission of false or erroneous diagnosis.

   ~~k.~~l. Billing the difference between the maximum allowable fee set forth in the organization's fee schedule and usual and customary charges, or billing the claimant any other fee in addition to the fee paid, or to be paid, by the organization for individual treatments, equipment, and products.

   ~~l.~~m. Failure to include physical conditioning in the treatment plan. The medical service provider should determine the claimant's activity level, ascertain barriers specific to the claimant, and provide information on the role of physical activity in injury management.

   ~~m.~~n. Failure to include the injured worker's functional abilities in addressing return-to-work options during the recovery phase.

~~n.~~o. Treatment that is controversial, experimental, or investigative; which is contraindicated or hazardous; which is unreasonable or inappropriate for the work injury; or which yields unsatisfactory results.

~~o.~~p. Certifying disability in excess of the actual medical limitations of the claimant.

~~p.~~q. Conviction in any court of any offense involving moral turpitude, in which case the record of the conviction is conclusive evidence.

~~q.~~r. The excessive use, or excessive or inappropriate prescription for use, of narcotic, addictive, habituating, or dependency inducing drugs.

~~r.~~s. Declaration of mental incompetence by a court of competent jurisdiction.

~~s.~~t. Disciplinary action by a licensing board.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; July 1, 2010; July 1, 2017.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-32.1. Physical therapy assistants, certified occupational therapy assistants, and certified athletic trainers.

Physical therapist assistants, certified occupational therapist assistants, and certified athletic trainers may be reimbursed when providing treatment under the direction and general supervision of the physical therapist or occupational therapist. Physical and occupational therapists are responsible for the assistants under their direction and supervision. Examination, evaluation, diagnosis, prognosis, and outcomes are the sole responsibility of the physical therapist and occupational therapist. Physical therapist assistants, certified occupational therapist assistants, and certified athletic trainers are not allowed to perform functional capacity evaluations.

History: Effective July 1, 2017.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-33. Utilization review and quality assurance.

The organization has instituted a program of utilization review and quality assurance to monitor and control the use of health care services.

1. Prior authorization for services must be obtained from the organization or its managed care vendor at least ~~twenty-four~~seventy-two hours or ~~the next~~three business ~~day~~days in advance of providing certain medical treatment, equipment, or supplies. Medical services requiring prior authorization or preservice review are outlined in section 92-01-02-34. Emergency medical services may be provided without prior authorization, but notification is required within twenty-four hours of, or by the end of the next business day following, initiation of emergency treatment. Reimbursement may be withheld, or recovery of prior payments made, if utilization review does not confirm the medical necessity of emergency medical services.

2. Documentation of the need for and efficacy of continued medical care by the medical service provider is required at the direction or request of the organization or the managed care vendor while a claim is open.

3. The organization may require second opinion consultations prior to the authorization of reimbursement for surgery and for conservative care which extends past sixty days following the initial visit.

4. The organization may require preoperative psychosocial screens and psychological evaluations prior to the authorization of reimbursement for surgery. The organization may select the evaluators who will perform the screens and evaluations.

5. The organization may use the Official Disability Guidelines, the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Guide to Physical Therapy Practice, The Medical Disability Advisor, Diagnosis and Treatment for Physicians and Therapists Upper Extremity Rehabilitation, Treatment Guidelines of the American Society of Hand Therapists, or any other treatment and disability guidelines or standards it deems appropriate to administer claims.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; July 1, 2006; April 1, 2012; July 1, 2017.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-34. Treatment requiring authorization, preservice review, and retrospective review.

1. Certain treatment procedures require prior authorization or preservice review by the organization or its managed care vendor. Requests for authorization or preservice review must include a statement of the condition diagnosed; their relationship to the compensable injury; the medical documentation supporting medical necessity, an outline of the proposed treatment program, its length and components, and expected prognosis.

2. Requesting prior authorization or preservice review is the responsibility of the medical service provider who provides or prescribes a service for which prior authorization or preservice review is required.

3. Medical service providers shall request prior authorization directly from the claims analyst for the items listed in this subsection. The claims analyst shall respond to requests within fourteen days.

   a. Durable medical equipment.

      (1) The organization will pay rental fees for equipment if the need for the equipment is for a short period of treatment during the acute phase of a compensable work injury. The claims analyst shall grant or deny authorization for reimbursement of equipment based on whether the claimant is eligible for coverage and whether the equipment prescribed is appropriate and medically necessary for treatment of the compensable injury. Rental extending beyond thirty days requires prior authorization from the claims analyst. If the equipment is needed on a long-term basis, the organization may purchase the equipment. The claims analyst shall base its decision to purchase the equipment on a comparison of the projected rental costs of the equipment to its purchase price. The organization shall purchase the equipment from the most cost-efficient source.

      (2) The claims analyst will authorize and pay for prosthetics and orthotics as needed by the claimant because of a compensable work injury when substantiated by the attending doctor. If those items are furnished by the attending doctor or another provider, the organization will reimburse the doctor or the provider pursuant to its fee schedule. Providers and doctors shall supply the organization with a copy of their original invoice showing actual cost of the item upon request of the organization. The organization will repair or replace originally provided damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices upon documentation from the attending doctor that replacement or repair is needed. Prior authorization for replacements is required.

(3) ~~If submitted charges for supplies and implants exceed the usual and customary rates, charges will be reimbursed at the provider's purchase invoice plus twenty percent.~~

~~(4)~~ Equipment costing less than five hundred dollars does not require prior authorization~~. This includes crutches, cervical collars, lumbar and rib belts, and other commonly used orthotics, but specifically excludes tens units.~~ except for the following: adult undergarments, ambulatory aids (including roller aids and scooters, walkers and walker accessories and attachments, wheelchairs and wheelchair accessories), catheters, commodes and bath and toilet aids (including chairs and railings), continuous passive motion devices (CPM), CPAP units, electromedical devices (including combination units [All-Stim], neuromuscular stimulators, and TENS units), eyewear (including frames, lenses, contact lenses, anti-reflective coating, polarization, progressive lenses, and scratch resistant or tinting coating), hearing aids and hearing aid batteries and filters, home traction units, nebulizers, orthotic footwear (including inserts [customized or molded], shoes or boots, and miscellaneous customized shoe additions), paraffin bath units, prosthetics, and wound VAC dressings.

~~(5)~~(4) An injured worker must obtain a doctor's order of medical necessity before the purchase of a mobility assistance device.

~~(6)~~(5) The organization may require assessments to determine the functional levels of an injured worker who is being considered for a mobility assistance device.

b. Biofeedback programs; pain clinics; psychotherapy; physical rehabilitation programs, including health club memberships and work hardening programs; chronic pain management programs; and other programs designed to treat special problems.

c. Concurrent care. In some cases, treatment by more than one medical service provider may be allowed. The claims analyst will consider concurrent treatment when the accepted conditions resulting from the injury involve more than one system or require specialty or multidisciplinary care. When requesting consideration for concurrent treatment, the attending doctor must provide the claims analyst with the name, address, discipline, and specialty of all other medical service providers assisting in the treatment of the claimant and with an outline of their responsibility in the case and an estimate of how long concurrent care is needed. When concurrent treatment is allowed, the organization will recognize one primary attending doctor, who is responsible for prescribing all medications if the primary attending doctor is a physician authorized to prescribe medications; directing the overall treatment program; providing copies of all reports and other data received from the involved medical service providers; and, in time loss cases, providing adequate certification evidence of the claimant's ability to perform work. The claims analyst will approve concurrent care on a case-by-case basis. Except for emergency services, all treatments must be authorized by the claimant's attending doctor to be reimbursable.

d. Telemedicine. The organization may pay for audio and video telecommunications instead of a face-to-face "hands on" appointment for the following appointments: office or other outpatient visits~~ that fall within CPT codes 99241 through 99275, inclusive~~; new and established evaluation and management visits~~ that fall within CPT codes 99201 through 99215, inclusive~~; individual psychotherapy visits~~ that fall within CPT codes 90804 through 90809, inclusive~~; and pharmacologic management visits~~ that fall within CPT code 90862~~. As a condition of payment, the patient must be present and participating in the telemedicine appointment. The professional fee payable is equal to the fee schedule

amount for the service provided. The organization may pay the originating site a facility fee, not to exceed twenty dollars.

4. Notwithstanding the requirements of subsection 5, the organization may designate certain exemptions from preservice review requirements in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured workers and providers.

5. Medical service providers shall request preservice review from the utilization review department for:

   a. All nonemergent inpatient hospital admissions or nonemergent inpatient surgery and outpatient surgical procedures.

   b. All nonemergent major surgery. When the attending doctor or consulting doctor believes elective surgery is needed to treat a compensable injury, the attending doctor or the consulting doctor with the approval of the attending doctor, shall give the utilization review department actual notice at least ~~twenty-four~~seventy-two hours prior to the proposed surgery. Notice must give the medical information that substantiates the need for surgery, an estimate of the surgical date and the postsurgical recovery period, and the hospital where surgery is to be performed. When elective surgery is recommended, the utilization review department may require an independent consultation with a doctor of the organization's choice. The organization shall notify the doctor who requested approval of the elective surgery, whether or not a consultation is desired. When requested, the consultation must be completed within thirty days after notice to the attending doctor. Within seven days of the consultation, the organization shall notify the surgeon of the consultant's findings. If the attending doctor and consultant disagree about the need for surgery, the organization may request a third independent opinion pursuant to North Dakota Century Code section 65-05-28. If, after reviewing the third opinion, the organization believes the proposed surgery is excessive, inappropriate, or ineffective and the organization cannot resolve the dispute with the attending doctor, the requesting doctor may request binding dispute resolution in accordance with section 92-01-02-46.

   c. Magnetic resonance imaging, a myelogram, discogram, bonescan, arthrogram, or computed axial tomography. Tomograms are subject to preservice review if requested in conjunction with a myelogram, discogram, bonescan, arthrogram, computed axial tomography scan, or magnetic resonance imaging. Computed axial tomography completed within thirty days from the date of injury may be performed without prior authorization. The organization may waive preservice review requirements for procedures listed in this subdivision when requested by a doctor who is performing an independent medical examination or permanent partial impairment evaluation at the request of the organization.

   d. Physical therapy and occupational therapy treatment beyond the first ten treatments or beyond sixty days after first prescribed, whichever occurs first, or physical therapy and occupational therapy treatment after an inpatient surgery, outpatient surgery, or ambulatory surgery beyond the first ten treatments or beyond sixty days after therapy services are originally prescribed, whichever occurs first. Postoperative physical therapy and occupational therapy may not be started beyond ninety days after surgery date. The organization may waive this requirement in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured claimants or providers. Modalities for outpatient physical therapy services and outpatient occupational therapy services are limited to two per visit during the sixty-day or ten-treatment ranges

set out in this subsection. The number of units performed and billed per visit may not exceed four unless otherwise approved.

e. ~~Electrodiagnostic studies may only be performed by electromyographers who are certified or eligible for certification by the American board of electrodiagnostic medicine, American board of physical medicine and rehabilitation, or the American board of neurology and psychiatry's certification in the specialty of clinical neurophysiology. Nerve conduction study reports must include either laboratory reference values or literature-documented normal values in addition to the test values.~~ All nonemergent air ambulance services. When the attending doctor or consulting doctor believes transfer to another treatment facility is needed to treat a compensable injury, the attending doctor or the consulting doctor or the transferring treatment facility, with the approval of the attending doctor, shall give the utilization review department actual notice prior to the proposed transfer to the receiving treatment facility. Notice must give the medical information that substantiates the need for transfer via air ambulance service, the name of the treatment facility where transfer will occur, air service provider and estimated cost. The organization shall review the cost effectiveness and alternatives and provide notice to the requesting doctor or treatment facility within twenty-four hours, or by the end of the next business day.

f. Thermography.

g. Intra-articular injection of hyaluronic acid.

h. Trigger point injections if more than three injections are required in a two-month period. No more than twenty injections may be paid over the life of a claim. If a trigger point injection is administered, the organization may not pay for additional modalities such as cryotherapy and osteopathic manipulations performed in conjunction with the trigger point injection. For purposes of this paragraph, injections billed under CPT code 20552 or 20553 will count as a single injection. Only injections administered on or after May 1, 2002, will be applied toward the maximum number of injections allowed under this subdivision.

i. Facet joint injections.

j. Sacroiliac joint injections.

k. Facet nerve blocks.

l. Epidural steroid injections.

m. Nerve root blocks.

n. Peripheral nerve blocks.

o. Botox injections.

p. Stellate ganglion blocks.

q. Cryoablation.

r. Radio frequency lesioning.

s. Facet rhizotomy.

t. Implantation of stimulators and pumps.

u. ~~Massage therapy. No more than eighteen treatments of thirty-minute duration may be paid for the life of the claim. The organization may waive this requirement in conjunction with programs designed to ensure the ongoing evolution of managed care, to meet the needs of injured workers and providers.~~

~~v.~~ Acupuncture therapy. No more than ~~twelve~~eighteen treatments may be paid for the life of the claim. The organization may waive this requirement in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured workers and providers.

~~w.~~v. Speech therapy ~~if more than thirty visits per year are required~~.

w. The organization shall review all opioid therapies for medical necessity following the conclusion of a chronic opioid therapy. For injured employees whose chronic opioid therapies have been discontinued for noncompliance with North Dakota Century Code section 65-05-39, any subsequent opioid therapies may not exceed ninety days.

6. Chiropractic providers shall request preservice review from the organization's chiropractic managed care vendor for chiropractic treatment beyond the first twelve treatments or beyond ninety days after the first treatment, whichever occurs first. The evaluation to determine a treatment plan is not subject to review. The organization may waive this subsection in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured claimants or providers. Modalities for chiropractic services are limited to two per visit during the ninety-day or twelve-treatment ranges set out in this subsection.

7. The organization may designate those diagnostic and surgical procedures that can be performed in other than a hospital inpatient setting.

8. The organization or managed care vendor must respond to the medical service provider within three business days of receiving the necessary information to complete a review and make a recommendation on the service. Within the time for review, the organization or managed care vendor must recommend approval or denial of the request, request additional information, request the claimant obtain a second opinion, or request an examination by the claimant's doctor. A recommendation to deny medical services must specify the reason for the denial.

9. The organization may conduct retrospective reviews of medical services and subsequently reimburse medical providers only:

   a. If preservice review or prior authorization of a medical service is requested by a provider and a claimant's claim status in the adjudication process is pending or closed; or

   b. If preservice review or prior authorization of a medical service is not requested by a provider and the provider can prove, by a preponderance of the evidence, that the injured employee did not inform the provider, and the provider did not know, that the condition was, or likely would be, covered under workers' compensation.

   All medical service providers are required to cooperate with the managed care vendor for retrospective review and are required to provide, without additional charge to the organization or the managed care vendor, the medical information requested in relation to the reviewed service.

10. The organization must notify provider associations of the review requirements of this section prior to the effective date of these rules.

11. The organization must respond to the medical service provider within thirty days of receiving a retrospective review request.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; March 1, 2003; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012; April 1, 2014; April 1, 2016; July 1, 2017.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-45.1. Provider responsibilities and billings.

1. A provider may not submit a charge for a service which exceeds the amount the provider charges for the same service in cases unrelated to workers' compensation injuries.

2. All bills must be fully itemized, including ICD codes, and services must be identified by code numbers found in the fee schedules or as provided in these rules. The definitions of commonality in the guidelines found in the current procedural terminology must be used as guides governing the descriptions of services, except as provided in the fee schedules or in these rules. All bills must be submitted to the organization within one year of the date of service or within one year of the date the organization accepts liability for the work injury or condition. Before the date on which centers for medicare and medicaid services implements ICD-10-CM, all bills must be coded with ICD-9-CM codes. On and after the date on which centers for medicare and medicaid services implements ICD-10-CM, all bills must be coded with ICD-10-CM codes.

3. All medical service providers shall submit bills referring to one claim only for medical services on current form UB 04 or form CMS 1500, except for dental billings which must be submitted on American dental association J510 dental claim forms and pharmacy billings which must be submitted electronically to the organization's pharmacy managed care vendor using the current pharmacy transaction standard. Bills and reports must include:

   a. The claimant's full name and address;

   b. The claimant's claim number and social security number;

   c. Date and nature of injury;

   d. Before the date on which centers for medicare and medicaid services implements ICD-10-CM, area of body treated, including ICD-9-CM code identifying right or left, as appropriate. On and after the date on which centers for medicare and medicaid services implements ICD-10-CM, area of body treated, including ICD-10-CM code identifying right or left, as appropriate;

   e. Date of service;

   f. Name and address of facility where the service was rendered;

   g. Name of medical service provider providing the service;

   h. Physician's or supplier's billing name, address, zip code, telephone number; physician's national provider identifier (NPI); physician assistant's North Dakota state license or certification number; physical therapist's North Dakota state license number; or advanced practice registered nurse's NPI or North Dakota state license number;

   i. Referring or ordering physician's NPI;

   j. Type of service;

   k. Appropriate procedure code or hospital revenue code;

   l. Description of service;

m. Charge for each service;

n. Units of service;

o. If dental, tooth numbers;

p. Total bill charge;

q. Name of medical service provider providing service along with the provider's tax identification number, provider's national provider identifier (NPI); and

r. Date of bills.

4. All records submitted by providers, including notes, except those provided by an emergency room physician and those on forms provided by the organization, must be typed to ensure that they are legible and reproducible. Copies of office or progress notes are required for all followup visits. Office notes are not acceptable in lieu of requested narrative reports. Communications may not refer to more than one claim. Addendums and late entries to notes or reports must be signed and must include the date they were created. Addendums or late entries to notes or reports created more than sixty calendar days after the date of service may be accepted at the organization's sole discretion.

5. Providers shall submit with each bill a copy of medical records or reports which substantiate the nature and necessity of a service being billed and its relationship to the work injury, including the level, type, and extent of the service provided to claimants. Documentation required includes:

   a. Laboratory and pathology reports;

   b. X-ray findings;

   c. Operative reports;

   d. Office notes, physical therapy, and occupational therapy progress notes;

   e. Consultation reports;

   f. History, physical examination, and discharge summaries;

   g. Special diagnostic study reports; and

   h. Special or other requested narrative reports.

6. When a provider submits a bill to the organization for medical services, the provider shall submit a copy of the bill to the claimant to whom the services were provided. The copy must be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the claimant.

7. If the provider does not submit records with a bill, and still does not provide those records upon request of the organization, the charges for which records were not supplied may not be paid by the organization, unless the provider submits the records before the decision denying payment of those charges becomes final. The provider may also be liable for the penalty provided in subsection 6 of North Dakota Century Code section 65-05-07.

8. Disputes arising out of reduced or denied reimbursement are handled in accordance with section 92-01-02-46. In all cases of accepted compensable injury or illness under the jurisdiction of the workers' compensation law, a provider may not pursue payment from a claimant for treatment, equipment, or products unless a claimant desires to receive them and

has accepted responsibility for payment, or unless the payment for the treatment was denied because:

a. The claimant sought treatment from that provider for conditions not related to the compensable injury or illness.

b. The claimant sought treatment from that provider which was not prescribed by the claimant's attending doctor. This includes ongoing treatment by the provider who is a nonattending doctor.

c. The claimant sought palliative care from that provider not compensable under section 92-01-02-40 after the claimant was provided notice that the palliative care service is not compensable.

d. The claimant sought treatment from that provider after being notified that the treatment sought from that provider has been determined to be unscientific, unproven, outmoded, investigative, or experimental.

e. The claimant did not follow the requirements of subsection 1 of North Dakota Century Code section 65-05-28 regarding change of doctors before seeking treatment of the work injury from the provider requesting payment for that treatment.

f. The claimant is subject to North Dakota Century Code section 65-05-28.2, and the provider requesting payment is not a preferred provider and has not been approved as an alternative provider under subsection 2, 3, or 4 of North Dakota Century Code section 65-05-28.2.

9. A medical service provider may not bill for services not provided to a claimant and may not bill multiple charges for the same service. Rebilling must indicate that the charges have been previously billed.

10. Pursuant to North Dakota Century Code section 65-05-33, a medical service provider may not submit false or fraudulent billings.

11. Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

12. When a claimant is seen initially in an emergency department and is admitted subsequently to the hospital for inpatient treatment, the services provided immediately prior to the admission are part of the inpatient treatment.

13. Hot and cold pack as a modality will be considered as a bundled charge and will not be separately reimbursed.

14. When a medical service provider is asked to review records or reports prepared by another medical service provider, the provider shall bill review of the records using CPT code 99080 with a descriptor of "record review". The billing must include the actual time spent reviewing the records or reports and must list the medical service provider's normal hourly rate for the review.

15. When there is a dispute over the amount of a bill or the necessity of services rendered, the organization shall pay the undisputed portion of the bill and provide specific reasons for nonpayment or reduction of each medical service code.

16. If medical documentation outlines that a non-work-related condition is being treated concurrently with the compensable injury and that condition has no effect on the compensable

injury, the organization may reduce the charges submitted for treatment. In addition, the attending doctor must notify the organization immediately and submit:

a. A description or diagnosis of the non-work-related condition.

b. A description of the treatment being rendered.

c. The effect, if any, of the non-work-related condition on the compensable injury.

The attending doctor shall include a thorough explanation of how the non-work-related condition affects the compensable injury when the doctor requests authorization to treat the non-work-related condition. Temporary treatment of a non-work-related condition may be allowed, upon prior approval by the organization, provided the condition directly delays recovery of the compensable injury. The organization may not approve or pay for treatment for a known preexisting non-work-related condition for which the claimant was receiving treatment prior to the occurrence of the compensable injury, which is not delaying recovery of the compensable injury. The organization may not pay for treatment of a non-work-related condition when it no longer exerts any influence upon the compensable injury. When treatment of a non-work-related condition is being rendered, the attending doctor shall submit reports monthly outlining the effect of treatment on both the non-work-related condition and the compensable injury.

17. In cases of questionable liability when the organization has not rendered a decision on compensability, the provider has billed the claimant or other insurance, and the claim is subsequently allowed, the provider shall refund the claimant or other insurer in full and bill the organization for services rendered.

18. The organization may not pay for the cost of duplicating records when covering the treatment received by the claimant. If the organization requests records in addition to those listed in subsection 5 or records prior to the date of injury, the organization shall pay ~~a minimum charge of five dollars for five or fewer pages and the minimum charge of five dollars for the first five pages plus thirty-five cents per page for every page after the first five pages~~a charge of no more than twenty dollars for the first twenty-five pages and seventy-five cents per page after twenty-five pages. In an electronic, digital, or other computerized format, the organization shall pay a charge of thirty dollars for the first twenty-five pages and twenty-five cents per page after twenty-five pages. This charge includes any administration fee, retrieval fee, and postage expense.

19. The provider shall assign the correct approved billing code for the service rendered using the appropriate provider group designation. Bills received without codes will be returned to the provider.

20. Billing codes must be found in the most recent edition of the physician's current procedural terminology; health care financing administration common procedure coding system; code on dental procedures and nomenclature maintained by the American dental association; or any other code listed in the fee schedules.

21. A provider shall comply within thirty calendar days with the organization's request for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the organization's determination of compensability, medical necessity, or excessiveness or the organization may refuse payment for services provided by that provider.

22. A provider may not bill a claimant a fee for the difference between the maximum allowable fee set forth in the organization's fee schedule and usual and customary charges, or bill the

claimant any other fee in addition to the fee paid, or to be paid, by the organization for individual treatments, equipment, and products.

History: Effective January 1, 1994; amended effective April 1, 1996; October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2008; July 1, 2010; April 1. 2012; April 1, 2014; April 1, 2016; July 1, 2017.
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