CHAPTER 65-05
CLAIMS AND COMPENSATION

65-05-01. Claims for benefits - When and where filed.

All original claims for benefits must be filed by the injured employee, or someone on the injured employee's behalf, within one year after the injury or within two years after the death. The date of injury for purposes of this section is the first date that a reasonable person knew or should have known that the employee suffered a work-related injury and has either lost wages because of a resulting disability or received medical treatment. Notwithstanding a statute of limitations assertion, the claimant bears the burden of proving any entitlement to benefits. If the organization is estopped from applying the statute of limitations in this section because an employer's willful conduct prevented an injured employee from filing a claim in a timely manner, that employer shall reimburse the organization for the full amount of all benefits paid during the first five years of that claim. Benefits may not be allowed under this title to any person, except as provided in section 65-05-04, unless that person, or someone on that person's behalf, files a written claim for benefits within the time specified in this section. A claim must be filed by:

1. Delivering it at the office of the organization or to any person the organization designates by rule; or
2. Depositing it in the mail properly stamped and addressed to the organization or to any person the organization designates by rule.

65-05-01.1. Pneumoconiosis claims - Rules - Agreements.

The organization shall provide such additional coverage, allow such additional time for claims to be filed, and pay such additional compensation and other benefits in excess of the coverage, filing time, and benefits otherwise provided in this title, as may be required by the Federal Coal Mine Health and Safety Act of 1969 and amendments thereto, for any coal miner, coal miner's surviving spouse, or dependents who, due to the disability or death of such coal miner as the result of pneumoconiosis, would be entitled to claim benefits under such federal Act; provided, however, that such claim is first filed with the federal agency designated in the federal Act and adjudicated and found compensable by them; and provided that such pneumoconiosis was contracted or aggravated as the result of employment as a coal miner in the state of North Dakota. The organization shall adopt such reasonable rules and enter into such agreements necessary to comply with section 421 of said federal Act.

65-05-01.2. Notice to employer.

When an employee is involved in an accident while on the job, the employee shall take steps immediately to notify the employer that the accident occurred and what is the general nature of the injury to the employee, if apparent. Notice may be either oral or written. The notice must be given to the employee's immediate supervisor or another supervisor authorized to receive notice. Absent good cause, notice may not be given later than seven days after the accident occurred or the general nature of the employee's injury became apparent.

65-05-01.3. Failure to comply with notice and filing provisions.

If an employee fails to notify the employer of an accident and the general nature of the employee's injury, the organization may consider that failure to notify in determining whether the employee's injury is compensable.

65-05-01.4. Employer to file first report of notice of injury.

The employer shall file a first report of notice of injury with the organization within seven days from the date the employer receives the notice of injury from the employee. Failure of the employer to file a first report of notice of injury is an admission by the employer that the alleged injury may be compensable. The organization may make or reopen a determination made without an employer's first report of notice of injury on its own motion pursuant to section 65-05-04 on the grounds determined by the organization to be sufficient.

65-05-01.5. Organization to notify employee of receipt of employer's first report of notice of injury.

If a claim for compensation has not been received by the organization but the organization has received an employer's first report of notice of injury, the organization shall notify the employee that the employer's first report has been received and shall advise the employee of the claim filing requirements of section 65-05-01.

65-05-02. Form in which claim must be filed.

Every claim must be made on forms to be furnished by the organization and must contain all the information required by it. Each claim must be signed by the person entitled to compensation or by the person acting on that person's behalf and, except in case of death, must be accompanied by a certificate of the employee's doctor stating that the employee was physically examined, stating the nature of the injury and the nature and probable extent of the disability. For any reasonable cause shown, the organization may waive the provisions of this section.

65-05-03. Jurisdiction of organization to hear questions within its jurisdiction - Finality of determination.

The organization shall have full power and authority to hear and determine all questions within its jurisdiction, and its decisions, except as provided in chapter 65-10, are final and are entitled to the same faith and credit as a judgment of a court of record.

65-05-04. Organization has continuing jurisdiction over claims properly filed.

If the original claim for compensation has been made within the time specified in section 65-05-01, the organization at any time, on its own motion or on application, may review the award, and in accordance with the facts found on such review, may end, diminish, or increase the compensation previously awarded, or, if compensation has been refused or discontinued, may award compensation. There is no appeal from an organization decision not to reopen a claim after the organization's order on the claim has become final.

65-05-05. Payments made to insured employees injured in course of employment and to their dependents.

1. The organization shall disburse the fund for the payment of compensation and other benefits as provided in this chapter to employees, or to their dependents in case death has ensued, who:
   a. Are subject to the provisions of this title;
   b. Are employed by employers who are subject to this title; and
   c. Have been injured in the course of their employment.
2. If an employee, or any person seeking benefits because of the death of an employee, applies for benefits from another state for the same injury, the organization will suspend all future benefits pending resolution of the application. If an employee, or any person seeking benefits because of the death of an employee, is determined to be eligible for benefits through some other state act or enters an agreement to resolve a claim through some other state act, no further compensation may be allowed under this title and the employee, or any person seeking benefits because of the death of an employee, must reimburse the organization for the entire amount of benefits paid.

65-05-06. Payment of compensation in lieu of claim for relief against employer.

The payment of compensation or other benefits by the organization to an injured employee, or to the injured employee's dependents in case death has ensued, are in lieu of any and all claims for relief whatsoever against the employer of the injured or deceased employee.

65-05-07. Injured employee given medical and hospital service required - Furnished artificial limbs and appliances for rehabilitation - Fee approval.

The fund shall furnish to an injured employee reasonable and appropriate medical, surgical, and hospital service and supplies necessary to treat a compensable injury. The fund may furnish artificial members and replacements the organization determines necessary to rehabilitate an injured employee.

1. The health care provider or doctor must be acting within the scope of the provider's or doctor's license or fees will be denied.
2. Fees may not be approved for more than one health care provider or doctor in a case where treatment is provided over the same period of time except for the services of a consulting doctor, assistant surgeon, or anesthetist or in an emergency.
3. The organization, in cooperation with professional organizations of doctors and health care providers, shall establish a system of peer review to determine reasonableness of fees and payment denials for unjustified treatments, hospitalization, or visits. The doctor or health care provider may appeal adverse decisions of the organization in accordance with the medical aid rules adopted by the organization.
4. Health care providers and doctors may not bill an injured employee for any services rendered as a result of the compensable work injury.
5. Under this section, the organization may modify real estate and may provide for adaptations and modifications to motor vehicles as follows:
   a. In the case of an injured employee who sustained a catastrophic injury, as defined in chapter 65-05.1, the organization may pay an amount not to exceed seventy-five thousand dollars to provide permanent additions, remodeling, or adaptations to real estate it determines necessary. The dollar limit is for the life of the injured employee, regardless of any subsequent claim. This subdivision does not allow the organization to purchase any real estate.
   b. In the case of an injured employee who sustained a catastrophic injury, as defined in chapter 65-05.1, the organization may pay an amount not to exceed one hundred fifty thousand dollars to provide the most cost-effective, specially equipped motor vehicle or vehicle adaptations the organization determines medically necessary. The organization may establish factors to be used in determining whether a specially equipped motor vehicle or adaptation is necessary. Under this subdivision, the organization may not pay for insurance of or maintenance of the motor vehicle. Within the dollar limit and under this subdivision, the organization may pay for vehicle or adaptation replacement purchases. The dollar limit is for the life of the injured employee, regardless of any subsequent claim.
   c. In the case of an injured employee who has not sustained a catastrophic injury, as defined in chapter 65-05.1, the organization may provide the benefits under subdivisions a and b if the organization determines the benefits would be cost-effective and appropriate because of exceptional circumstances as determined by the organization.
6. If a doctor or health care provider who has treated or provided services to an injured employee fails or refuses without just cause to file with the organization a report required by section 65-05-02, 65-05-08, or 65-05-08.1, within thirty days of examination, treatment, or provision of other services rendered in connection with a compensable work injury, or within thirty days of a request for the report made by the claimant, the claimant's representative, or the organization, the organization shall assess as a penalty a sum of one hundred dollars. Health care providers and doctors may not bill an injured worker for any penalty assessed by the organization under this subsection.
7. The filing of an accident report or the rendering of treatment to an injured worker who comes under the organization's jurisdiction constitutes acceptance of the organization's medical aid rules and compliance with its rules and fees.
8. The organization may not pay for:

a. Personal items that are for the injured employee's personal use or hygiene, including toothbrushes, slippers, shampoo, and soap.
b. Any product or item such as clothing or footwear unless the items are considered orthopedic devices and are prescribed by the treating doctor or health care provider.
c. Any furniture except hospital beds, shower stools, wheelchairs, or whirlpools if prescribed by the treating doctor or health care provider.
d. Vitamins and food supplements except in those cases in which the injury causes severe dietary problems, the injury results in the employee's paraplegia or quadriplegia, or the employee becomes wheelchair-bound due to the injury.
e. Eye examinations unless there is a reasonable potential for injury to the employee's eyes as a result of the injury.
f. Private hospital or nursing home rooms except in cases of extreme medical necessity and only when directed by the attending doctor. If the employee desires better accommodations than those ordered by the attending doctor, the employee will pay the difference in cost.
g. Serological tests, including VDRL and RPR, or other tests for venereal disease or pregnancy, or any other routine tests unless clearly necessitated by the injury.
h. Aids or programs primarily intended to help the employee lose weight or stop smoking unless ordered by the organization.
i. Home gymnasium or exercise equipment unless ordered by the organization.
j. Memberships or monthly dues to health clubs, unless ordered by the organization.
k. Massage, unless ordered by the organization.

65-05-07.1. Organization to adopt fee schedule.
Repealed by S.L. 1999, ch. 554, § 4.

65-05-07.2. Payment to organization for certain claims.
The employer shall reimburse the organization for all medical expenses related to a compensable injury to an employee if the expenses are not more than two hundred fifty dollars and shall reimburse the organization for the first two hundred fifty dollars of medical expenses when the expenses are more than two hundred fifty dollars. If a claim for benefits is filed with the organization by midnight central time on the first business day following the workplace injury, the organization shall pay the first two hundred fifty dollars of medical expenses. A claim is filed by submitting a form furnished by the organization or by another method designated by the organization. If a claim for benefits is filed with the organization more than fourteen days from the date the employer received notice of the workplace injury from the employee, the employer shall reimburse the organization for the first three hundred fifty dollars of medical expenses when the expenses are greater than three hundred fifty dollars. If an employee's compensable injury is determined through a civil action to have been sustained through the fault or negligence of a third person, or if a settlement has been entered between the employee and a third person through which the third person agrees to compensate the employee for the injury, the organization, upon receipt of its subrogation interest, shall credit the account of the employer to the extent of the payment made by the employer to the organization under this section. Upon the organization's determination that the claim is compensable, the organization shall pay the medical expenses associated with the claim and notify the employer of payments to be made by the employer under this section. If the employer does not pay the organization within thirty days of notice by the organization, the organization may impose a penalty on that employer. The penalty may not exceed one hundred twenty-five percent of the payment owed by the employer. The organization shall collect the penalty in a civil action against the employer and deposit the money in the fund. An employer may not directly or indirectly charge an injured employee for any payment the employer makes on a claim. Except as otherwise provided, if the cost of an injured employee's medical treatment exceeds two hundred fifty dollars, the organization shall pay all further medical expenses. This section is effective for all compensable injuries that occur

after July 31, 1995. Compensable injuries paid under sections 65-06.2-04 through 65-06.2-08 are not subject to this section.

65-05-08. Disability benefits - Not paid unless period of disability is of five days' duration or more - Application required - Suspended during confinement - Duty to report wages.

No benefits may be paid for disability, the duration of which is less than five consecutive calendar days. An employer may not require an employee to use sick leave or annual leave, or other employer-paid time off work, before applying for benefits under this section, in lieu of receiving benefits under this section, or in conjunction with benefits provided under this section, but may allow an employee to use sick leave or annual leave to make up the difference between the employee's wage-loss benefits and the employee's regular pay. If the period of disability is five consecutive calendar days' duration or longer, benefits must be paid for the period of disability provided that:

1. When disability benefits are discontinued, the organization may not begin payment again unless the injured employee files a reapplication for disability benefits on a form supplied by the organization. In case of reapplication, the award may commence no more than thirty days before the date of reapplication. Disability benefits must be reinstated upon proof by the injured employee that:
   a. The employee has sustained a significant change in the compensable medical condition;
   b. The employee has sustained an actual wage loss caused by the significant change in the compensable medical condition; and
   c. The employee has not retired or voluntarily withdrawn from the job market as defined in section 65-05-09.3.
2. All payments of disability and rehabilitation benefits of any employee who is eligible for, or receiving, benefits under this title must be suspended when the employee is confined in a penitentiary, jail, youth correctional facility, or any other penal institution for a period of between seventy-two consecutive hours and one hundred eighty consecutive days. All payments of disability and rehabilitation benefits of any employee who is eligible for, or receiving, benefits under this title must be discontinued when the employee is confined in a penitentiary, jail, youth correctional facility, or any other penal institution for a period in excess of one hundred eighty consecutive days.
3. Any employee who is eligible for, or receiving disability or rehabilitation benefits under this title shall report any wages earned, from part-time or full-time work from any source. If an employee fails to report wages earned, the employee shall refund to the organization any disability or vocational rehabilitation benefits overpaid by the organization for that time period. To facilitate recovery of those benefits, the organization may offset future benefits payable, under section 65-05-29. If the employee willfully fails to report wages earned, the employee is subject to the penalties in section 65-05-33. An employee shall report whether the employee has performed work or received wages. The organization periodically shall provide a form to all injured employees receiving disability or rehabilitation benefits which the injured employee must complete to retain eligibility for further disability or rehabilitation benefits, regardless of the date of injury or claim filing. The form will advise the injured employee of the possible penalties for failure to report any work or activities as required by this section. An injured employee who is receiving disability or vocational rehabilitation benefits must report any work activities to the organization whether or not the injured employee receives any wages. An injured employee who is receiving disability or vocational rehabilitation benefits also must report any other activity if the injured employee receives any money, including prize winnings, from undertaking that activity, regardless of expenses or whether there is a net profit. For purposes of this subsection, "work" does not include routine daily activities of self-care or family care, or routine maintenance of the home and yard, and "activities" does not include recreational gaming or passive investment endeavors.

4. An employee shall request disability benefits on a claim form furnished by the organization. Disability benefits may not commence more than one year prior to the date of filing of the initial claim for disability benefits.
5. The provisions of this section apply to any disability claim asserted against the fund on or after July 1, 1991, irrespective of injury date.
6. It is the burden of the employee to show that the inability to obtain employment or to earn as much as the employee earned at the time of injury is due to physical limitation related to the injury, and that any wage loss claimed is the result of the compensable injury.
7. If the employee voluntarily limits income or refuses to accept employment suitable to the employee's capacity, offered to or procured for the employee, the employee is not entitled to any disability or vocational rehabilitation benefits during the limitation of income or refusal to accept employment unless the organization determines the limitation or refusal is justified.
8. The organization may not pay disability benefits unless the loss of earning capacity exceeds ten percent. The injured employee may earn up to ten percent of the employee's preinjury average gross weekly earnings with no reduction in total disability benefits. The employee must report any earnings to the organization for a determination of whether the employee is within the limit set in this subsection.
9. Upon securing suitable employment, the injured employee shall notify the organization of the name and address of the employer, the date the employment began, and the amount of wages being received. If the injured employee is receiving disability benefits, the injured employee shall notify the organization whenever there is a change in work status or wages received.
10. The organization shall pay to an employee receiving disability benefits a dependency allowance for each child of the employee at the rate of fifteen dollars per week per child.
11. Dependency allowance for the children may be made directly to either parent or guardian at the discretion of the organization.

65-05-08.1. Verification of disability.

1. An injured employee's doctor shall certify the period of disability and the extent of the injured worker's abilities and restrictions.
2. A doctor certifying disability shall include in the report filed with the organization:
   a. The medical basis established by medical evidence supported by objective medical findings for the certification of disability;
   b. Whether the employee is totally disabled, or, if the employee is not totally disabled, whether the employee is able to return to any employment, and a statement of the employee's restrictions and physical limitations; and
   c. A professional opinion as to the expected length of, and reason for, the disability.
   d. A doctor may not certify or verify past disability commencing more than sixty days before the doctor's examination of the employee.
3. The report must be filed on a form furnished by the organization, or on any other form acceptable to the organization.
4. The injured employee shall ensure that the required reports for any period of disability are filed.
5. Prior to the expiration of a period of disability certified by a doctor, if a report certifying an additional period of disability has not been filed, or upon receipt of a report or other evidence indicating an injured employee who is receiving disability benefits has been or will be released to return to work, the organization shall send a notice to that employee of the organization's intention to discontinue benefits, including an explanation of the reason for discontinuing benefits, an explanation of the employee's right to respond, and the procedure for filing the required report or challenging the proposed action. A copy of the notice must be mailed to the employee's doctor. Thereafter, if the required certification is not filed, the organization shall discontinue disability benefits, effective twenty-one days after the date the notice of intention to

discontinue benefits is mailed or the date on which the employee actually returned to work, whichever occurs first.

65-05-08.2. Preacceptance disability benefits.

If, after receiving a claim for benefits, the organization determines that more information is needed to process the claim, but that the information in the file indicates the injured employee is more likely than not entitled to disability benefits, the organization may pay preacceptance disability benefits equal to the weekly disability benefit allowed under section 65-05-09. The organization may continue to pay preacceptance disability benefits to the employee during the period the claim is pending, unless the injured employee is not cooperating with requests from the organization for additional information needed to process the claim. The organization may not pay more than sixty days of preacceptance benefits. The organization may only recover a payment made to an injured employee under this section if that recovery is allowed under section 65-05-33. There is no appeal from an organization decision not to pay preacceptance disability benefits.

65-05-08.3. Treating doctor's opinion.

1. A presumption may not be established in favor of any doctor's opinion. The organization shall resolve conflicting medical opinions and in doing so the organization shall consider the following factors:
   a. The length of the treatment relationship and the frequency of examinations;
   b. The nature and extent of the treatment relationship;
   c. The amount of relevant evidence in support of the opinion;
   d. How consistent the opinion is with the record as a whole;
   e. Appearance of bias;
   f. Whether the doctor specializes in the medical issues related to the opinion; and
   g. Other relevant factors.
2. This section does not apply to managed care programs under section 65-02-20. For purposes of this section, the organization shall determine whether a doctor is an injured employee's treating doctor.

65-05-09. Temporary total or permanent total disability - Weekly and aggregate benefit.

If an injury causes temporary total or permanent total disability, the fund shall pay to the disabled employee during that disability a weekly benefit equal to sixty-six and two-thirds percent of the gross weekly wage of the employee, subject to a minimum of sixty percent and a maximum of one hundred twenty-five percent of the average weekly wage in the state. If an employee is disabled due to an injury, that employee's benefits will be based upon the employee's wage and the organization benefit rates in effect on the date of first disability.

1. If an employee suffers disability but is able to return to employment for a period of three consecutive calendar months or more, that employee's benefits will be based upon the wage in effect at the time of the recurrence of the disability or upon the wage that employee received prior to the injury, whichever is higher. The organization benefit rates are those in effect at the time of that recurrence.
2. The disability benefit or the combined disability benefit and dependency award may not exceed the weekly wage of the employee after deductions for social security and federal income tax.
3. When an employee is permanently and totally disabled, must be maintained in a nursing home or similar facility, and has no dependent parent, spouse, or children, as much of that employee's weekly benefit as is necessary may be used by the organization to help defray the cost of the nursing home care.

65-05-09.1. Social security offset.

When an injured employee, or spouse or dependent of an injured employee, is eligible for and is receiving permanent total or temporary total disability benefits under section 65-05-09,

and is also eligible for, is receiving, or will receive, benefits under title II of the Social Security Act [42 U.S.C. 423], the aggregate benefits payable under section 65-05-09 must be reduced, but not below zero, by an amount equal as nearly as practicable to one-half of such federal benefit. The federal benefit, or primary insurance amount, must be determined by the social security administration. The amount to be offset must equal the primary insurance amount rounded to the next lowest dollar less credit for either the entire amount of attorney's fees and costs, or the fees and costs paid to an authorized representative of the employee as allowed by the social security administration, withheld from past-due social security benefits or paid directly by the claimant for representation before the social security administration. The amount of the offset computed by the organization initially must remain the same throughout the period of eligibility and may not be affected by any increase or decrease in federal benefits.

Any injured employee, or dependent of an injured employee, receiving permanent total or temporary total disability benefits under section 65-05-09 and whose benefits are offset as provided herein, is not eligible for any escalation of benefits which would adversely affect the organization's right to offset workforce safety and insurance benefits against social security benefits, as provided for in this chapter. This offset will become effective on January 1, 1980, provided that it meets the criteria necessary to allow states to offset federal benefits under title II of the Social Security Act [42 U.S.C. 424a]. Providing further that:

1. If the receipt of social security benefits results in an overpayment of temporary or permanent total disability benefits by the organization, a refund of any overpayment must be made by the injured worker or that overpayment must be taken from future temporary total or permanent total disability benefits or permanent partial impairment awards, on the current claim or any future claim filed, at a recovery rate to be determined by the organization.
2. If a claim has been accepted on an aggravation basis and the injured worker is eligible for social security benefits, the organization's offset must be proportionally calculated.
3. If any person described in this section refuses to authorize the release of information concerning the amount of benefits payable under the Social Security Act, the organization's estimate of the amount is deemed to be correct until the actual amount is established and no adjustment may be made for any period of time covered by the refusal.

65-05-09.2. Retirement offset.

If an employee is entitled to permanent total disability benefits and social security retirement benefits under 42 U.S.C. sections 402 and 405, the aggregate wage-loss benefits payable under this title must be determined in accordance with this section. The employee's social security retirement offset must equal forty percent of the calculated ratio of the employee's average weekly wages, as calculated on the commencement of the first, or recurrent, disability under section 65-05-09, to the current state's average weekly wage. Any offset calculated cannot exceed forty percent of the employee's weekly social security retirement benefit. If a claim has been accepted on an aggravation basis and the employee is eligible for social security benefits, the organization's offset must be proportionally calculated. An overpayment must be recouped in the same manner as set forth in section 65-05-09.1. This section applies to an employee who becomes entitled to and receives social security retirement benefits after June 30, 1989, or who receives social security retirement benefits that have been converted from social security disability benefits by the social security administration after June 30, 1989. A conversion by the organization from offsetting an employee's social security disability benefits to offsetting an employee's social security retirement benefits under this section may not result in a decrease in the aggregate amount of benefits the employee receives from both sources.

65-05-09.3. Retirement presumption - Termination of benefits upon retirement.

1. An employee who has retired or voluntarily withdrawn from the labor force and who, at that time, was not eligible to receive temporary total disability, temporary partial disability, or permanent total disability benefits or to receive a rehabilitation allowance from the organization is presumed retired from the labor market. The presumption may be rebutted by a preponderance of the evidence; however, the subjective statement of

an employee that the employee is not retired is not sufficient in itself to rebut objective evidence of retirement.

2. An injured employee who begins receiving social security retirement benefits or other retirement benefits in lieu of social security retirement benefits or who attains retirement age for social security retirement benefits, unless the employee proves the employee is not eligible to receive social security retirement benefits or other benefits in lieu of social security retirement benefits, is considered retired. The organization may not pay any disability benefits, rehabilitation benefits, or supplementary benefits to an employee who is considered retired; however, the employee remains eligible for medical benefits, permanent partial impairment benefits, and the additional benefit payable under section 65-05-09.4.
3. The organization retains liability for disability benefits, rehabilitation benefits, permanent partial impairment benefits, and medical benefits for an injured employee who is receiving social security retirement benefits or other retirement benefits in lieu of social security retirement benefits or who attains retirement age for social security retirement benefits, unless the employee is not eligible to receive social security retirement benefits or other benefits in lieu of social security retirement benefits, and who is gainfully employed and who suffers an injury arising out of and in the course of that employment. The organization may not pay disability or rehabilitation benefits under this subsection for more than three years, subject to section 65-05-09.2, for injuries occurring after August 1, 1997.
4. If an employee is injured within the two years preceding the employee's presumed retirement date, the organization shall pay disability benefits, rehabilitation benefits, or a combination of both benefits for no more than two years. If the duration of disability benefits, rehabilitation benefits, or a combination of both benefits extends beyond the presumed retirement date, the organization shall convert the benefit to an additional benefit payable at the date the disability ends or when two years of benefits have been paid, whichever occurs first.
5. This section applies to an individual who begins receiving social security retirement benefits or other retirement benefits in lieu of social security retirement benefits or who attains retirement age for social security retirement benefits unless the employee proves the employee is not eligible to receive social security retirement benefits or other benefits in lieu of social security retirement benefits, after July 31, 1995.

65-05-09.4. Additional benefit payable.

If an injured employee's benefits cease under subsection 2 of section 65-05-09.3, the organization shall pay to that employee every twenty-eight days a benefit based on the length of time the injured employee received disability benefits during the term of that claim. The organization shall pay the injured employee's additional benefits until the employee's death or for a period of time not to exceed the total length of time the employee received disability benefits under sections 65-05-08, 65-05-08.1, 65-05-09, and 65-05-10, and a vocational rehabilitation allowance under chapter 65-05.1, for that claim, whichever occurs first. The benefit is based on the injured employee's compensation rate before any applicable social security offset. The percentage of that final payment payable as the additional benefit is:

At least 1 year and less than 3 years of disability	5 percent of weekly benefit.
At least 3 years and less than 5 years of disability	10 percent of weekly benefit.
At least 5 years and less than 7 years of disability	15 percent of weekly benefit.
At least 7 years and less than 9 years of disability	20 percent of weekly benefit.
At least 9 years and less than 11 years of disability	25 percent of weekly benefit.
At least 11 years and less than 13 years of disability	30 percent of weekly benefit.
At least 13 years and less than 15 years of disability	35 percent of weekly benefit.
At least 15 years and less than 17 years of disability	40 percent of weekly benefit.
At least 17 years and less than 20 years of disability	45 percent of weekly benefit.
Twenty or more years of disability	50 percent of weekly benefit.

However, the organization shall pay to an injured employee who has been determined to be catastrophically injured as defined by subdivision c of subsection 2 of section 65-05.1-06.1 an

additional benefit, until the death of the employee, equal to one hundred percent of the final payment of the disability benefit that was discontinued under subsection 2 or 3 of section 65-05-09.3.

65-05-09.5. Additional benefit payable - Alternative calculation.

1. This section applies to an injured employee who has a claim for which:
   a. A compensable injury was incurred before August 1, 1995;
   b. The date of first disability or the date of successful reapplication under subsection 1 of section 65-05-08 was after July 31, 1995; and
   c. The injured employee received a determination of permanent and total disability before August 1, 2007.
2. An injured employee who meets the requirements of subsection 1 is entitled to an alternative calculation of additional benefits payable instead of the calculation provided for under section 65-05-09.4. For the limited purpose of this alternative calculation, the organization shall use the calculation established under section 65-05-09.4 and shall consider that the injured employee's pre-August 1, 1995, date of injury is also the injured employee's date of first disability.

65-05-10. Partial disability - Weekly benefit.

If the injury causes temporary partial disability resulting in decrease of earning capacity, the disability benefit is sixty-six and two-thirds percent of the difference between the injured employee's average weekly wages before the injury and the employee's wage-earning capacity after the injury in the same or another employment. Partial disability benefits are subject to a maximum of one hundred twenty-five percent of the average weekly wage in the state. The combined partial disability benefits, dependency allowance, and postinjury wage-earning capacity may not exceed ninety percent of the preinjury weekly wage of the employee after deductions for social security and federal income tax.

1. The benefits provided by this section are available to any otherwise eligible worker, providing the loss of earning capacity occurs after July 1, 1989. Partial loss of earning capacity occurring prior to July 1, 1989, must be paid at a rate to be fixed by the organization.
2. Benefits must be paid during the continuance of partial disability, not to exceed a period of five years. The organization may waive the five-year limit on the duration of partial disability benefits in cases of catastrophic injury as defined in section 65-05.1-06.1 or when the injured worker is working and has long-term restrictions verified by clear and convincing objective medical and vocational evidence that limits the injured worker to working less than twenty-eight hours per week because of the compensable work injury. This subsection is effective for partial loss of earnings capacity occurring after June 30, 1991.
3. The employee's earnings capacity may be established by expert vocational evidence of a capacity to earn in the statewide job pool where the worker lives. Actual postinjury earnings are presumptive evidence of earnings capacity if the job employs the employee to full work capacity in terms of hours worked per week, and if the job is in a field related to the employee's transferable skills. The presumption may be rebutted by competent evidence from a vocational expert that the employee's actual earnings do not fairly reflect the employee's earnings capacity in the statewide job pool, considering the employee's capabilities, education, experience, and skills.

65-05-10.1. Long-term temporary partial disability inflation adjustment.

This benefit only applies to claims with a date of first disability or date of successful reapplication occurring after June 30, 1991. For these claims, beginning on the first day of July immediately following the fifth full year of partial disability and every year thereafter, an injured employee who has received a waiver of the five-year cap on partial disability benefits under section 65-05-10 is eligible for a lump sum inflation adjustment. The organization shall calculate the lump sum inflation adjustment under this section on July first of each year by multiplying the

previous year's percent increase in the state's average weekly wage, if any, by the total amount of partial disability payments paid to the injured employee in the preceding twelve months, including the preceding year's inflationary adjustment award.

65-05-11. Maximum and minimum compensation allowances - Total and partial disability.

Repealed by S.L. 1969, ch. 558, § 6.

65-05-12. Permanent impairment - Compensation - Time paid.

Repealed by S.L. 1995, ch. 624, § 2.

65-05-12.1. Permanent impairment.

Repealed by S.L. 1995, ch. 624, § 2.

65-05-12.2. Permanent impairment - Compensation - Time paid.

A permanent impairment is not intended to be a periodic payment and is not intended to reimburse the employee for specific expenses related to the injury or wage loss. If a compensable injury causes permanent impairment, the organization shall determine a permanent impairment award on the following terms:

1. The organization shall calculate the amount of the award by multiplying thirty-five percent of the average weekly wage in this state on the date of the impairment evaluation, rounded to the next highest dollar, by the permanent impairment multiplier specified in subsection 10.
2. The organization shall notify the employee by certified mail, to the last-known address of the employee, when that employee becomes potentially eligible for a permanent impairment award. After the organization has notified the employee, the employee shall file, within one hundred eighty days from the date the employee was notified, a written request for an evaluation for permanent impairment. Failure to file the written request within the one hundred eighty-day period precludes an award under this section.
3. An injured employee is entitled to compensation for permanent impairment under this section only for those findings of impairment that are permanent and which were caused by the compensable injury. The organization may not issue an impairment award for impairment findings due to unrelated, noncompensable, or pre-existing conditions, even if these conditions were made symptomatic by the compensable work injury, and regardless of whether section 65-05-15 applies to the claim.
4. An injured employee is eligible for an evaluation of permanent impairment only when all conditions caused by the compensable injury have reached maximum medical improvement. The injured employee's doctor shall report to the organization the date an employee has reached maximum medical improvement and any evidence of impairment of function the injured employee has after that date. If the report states that the employee is potentially eligible for a permanent impairment award, the organization shall conduct a review and provide notice to the employee as provided by subsection 2. If the injured employee files a timely written request under subsection 2, the organization shall schedule an impairment evaluation by a doctor qualified to evaluate the impairment.
5. A doctor evaluating permanent impairment shall include a clinical report in sufficient detail to support the percentage ratings assigned. The organization shall adopt administrative rules governing the evaluation of permanent impairment. These rules must incorporate principles and practices of the sixth edition of the American medical association's "Guides to the Evaluation of Permanent Impairment" modified to be consistent with North Dakota law, to resolve issues of practice and interpretation, and to address areas not sufficiently covered by the guides. Subject to rules adopted under this subsection, impairments must be evaluated under the sixth edition of the guides.

6. The organization shall deduct, on a permanent impairment multiplier basis, from an award for impairment under this section, any previous impairment award under the workers' compensation laws of any jurisdiction.
7. An injured employee is not entitled to a permanent impairment award due solely to pain.
8. Other than an award identified in subsection 11, an award may not be issued unless specifically identified and quantified within the sixth edition of the American medical association's "Guides to the Evaluation of Permanent Impairment".
9. If an employee dies, the right to any compensation payable pursuant to an impairment evaluation previously requested by the employee under subsection 2, which remains unpaid on the date of the employee's death, survives and passes to the employee's dependent spouse, minor children, parents, or estate, in that order. If the employee dies, only those findings of impairment which are objectively verifiable such as values for surgical procedures and amputations may be considered in a rating for impairment. Impairment findings not supported by objectively verifiable evidence may not be included in a rating for impairment. The deceased employee's dependents or representatives shall request an impairment award under this subsection within one year from the date of death of the employee.
10. If the injury causes permanent impairment, the award must be determined based on the percentage of whole body impairment in accordance with the following schedule:

Impairment:	Permanent impairment multiplier of:
1 to 13 percent	0
14 percent	10
15 percent	10
16 percent	15
17 percent	15
18 percent	20
19 percent	20
20 percent	25
21 percent	25
22 percent	30
23 percent	30
24 percent	30
25 percent	35
26 percent	35
27 percent	35
28 percent	40
29 percent	45
30 percent	50
31 percent	60
32 percent	70
33 percent	80
34 percent	90
35 percent	100
36 percent	110
37 percent	120
38 percent	130
39 percent	140
40 percent	150
41 percent	160
42 percent	170
43 percent	180
44 percent	190
45 percent	200
46 percent	210

47 percent	220
48 percent	230
49 percent	240
50 percent	260
51 percent	280
52 percent	300
53 percent	320
54 percent	340
55 percent	360
56 percent	380
57 percent	400
58 percent	420
59 percent	440
60 percent	465
61 percent	490
62 percent	515
63 percent	540
64 percent	565
65 percent	590
66 percent	615
67 percent	640
68 percent	665
69 percent	690
70 percent	715
71 percent	740
72 percent	765
73 percent	790
74 percent	815
75 percent	840
76 percent	865
77 percent	890
78 percent	915
79 percent	940
80 percent	965
81 percent	990
82 percent	1015
83 percent	1040
84 percent	1065
85 percent	1090
86 percent	1115
87 percent	1140
88 percent	1165
89 percent	1190
90 percent	1215
91 percent	1240
92 percent	1265
93 percent	1290
94 percent	1320
95 percent	1350
96 percent	1380
97 percent	1410
98 percent	1440
99 percent	1470
100 percent	1500

11. An amputation of a finger or toe at the level of the distal interphalangeal joint or proximal to that joint, or the thumb or the great toe at the interphalangeal joint or

proximal to that joint, which is determined to result in a whole body impairment of less than fourteen percent and which is not identified in the following schedule, is payable as a fourteen percent impairment. If an evaluation for the loss of an eye or for an amputation results in an award that is less than the permanent impairment multiplier identified in the following schedule, the organization shall pay an award equal to the permanent impairment multiplier set out in the following schedule:

For amputation of:	Permanent impairment multiplier of:
A thumb	65
The second or distal phalanx of the thumb	28
The first finger	40
The middle or second phalanx of the first finger	28
The third or distal phalanx of the first finger	22
The second finger	30
The middle or second phalanx of the second finger	22
The third or distal phalanx of the second finger	14
The third finger	20
The middle or second phalanx of the third finger	16
The fourth finger	16
The middle or second phalanx of the fourth finger	12
The leg at the hip	234
The leg at or above the knee	195
The leg at or above the ankle	150
A great toe	30
The second or distal phalanx of the great toe	18
Any other toe	12

For loss of:	Permanent impairment multiplier of:
An eye	150
Vision of an eye which equals or exceeds 20/200 corrected	100

The award for the amputation of more than one finger of one hand may not exceed an award for the amputation of a hand. The award for the amputation of more than one toe of one foot may not exceed an award for the amputation of a foot. If any of the amputations or losses set out in this subsection combine with other impairments for the same work-related injury or condition, the organization shall issue an impairment award based on the greater of the permanent impairment multiplier allowed for the combined rating established under the sixth edition of the American medical association's "Guides to the Evaluation of Permanent Impairment" or the permanent impairment multiplier set forth in this subsection.

12. If there is a medical dispute regarding the percentage of an injured employee's permanent impairment, all relevant medical evidence must be submitted to an independent doctor who has not treated the employee and who has not been consulted by the organization in relation to the injury upon which the impairment is based. The organization shall establish a list of doctors who have the training and experience necessary to conduct an evaluation of permanent impairment and to apply the sixth edition of the American medical association's "Guides to the Evaluation of Permanent Impairment". The organization shall define, by rule, the process by which the organization shall choose an independent doctor or doctors to review a disputed permanent impairment evaluation or rating. The decision of the independent doctor or doctors chosen under this process is presumptive evidence of the degree of permanent impairment of the employee which can only be rebutted by clear and convincing evidence. This subsection does not impose liability on the organization for an impairment award for a rating of impairment for a body part or condition the organization has not determined to be compensable as a result of the injury. The employee bears the expense of witness fees of the independent doctor or doctors if the employee disputes the findings of the independent doctor or doctors.

13. An attorney's fees are not payable unless there is a bona fide dispute as to the percentage of the employee's permanent impairment or unless there is a dispute as to the employee's eligibility for an award for permanent partial impairment. An attorney's fees payable in connection with a permanent impairment dispute may not exceed twenty percent of the additional amount awarded upon final resolution of the dispute, subject to the maximum fees established pursuant to section 65-02-08.
14. An attorney may not seek or obtain from an employee through a contingent fee arrangement, or on a percentage basis, costs or fees payable in connection with the award or denial of compensation for permanent impairment. A permanent impairment award is exempt from the claims of creditors, including an employee's attorney, except as provided by section 65-05-29.
15. If an injured employee qualifies for an additional award and the prior award was based upon the number of weeks, the impairment multiplier must be used to compare against the prior award of weeks in determining any additional award.

65-05-13. Scheduled injuries - Permanent loss of member - Compensation - Time compensation payable.

Repealed by S.L. 1995, ch. 624, § 2.

65-05-14. Scheduled injuries - Partial loss of use of member - Weekly compensation time - Compensation payable.

Repealed by S.L. 1995, ch. 624, § 2.

65-05-15. Aggravation awards.

When a compensable injury combines with a noncompensable injury, disease, or other condition, the organization shall award benefits on an aggravation basis, on the following terms:

1. In cases of a prior injury, disease, or other condition, known in advance of the work injury, which has caused previous work restriction or interference with physical function the progression of which is substantially accelerated by, or the severity of which is substantially worsened by, a compensable injury, the organization shall pay benefits during the period of acute care in full. The period of acute care is presumed to be sixty days immediately following the compensable injury, absent clear and convincing evidence to the contrary. Following the period of acute care, the organization shall pay benefits on an aggravation basis.
2. If the progression of a prior compensable injury is substantially accelerated by, or the severity of the compensable injury is substantially worsened by a noncompensable injury, disease, or other condition, the organization shall pay benefits on an aggravation basis.
3. The organization shall pay benefits on an aggravation basis as a percentage of the benefits to which the injured worker would otherwise be entitled, equal to the percentage of cause of the resulting condition that is attributable to the compensable injury. Benefits payable on an aggravation basis are presumed to be payable on a fifty percent basis. The party asserting a percentage other than the presumed fifty percent may rebut the presumption with clear and convincing evidence to the contrary.
4. When an injured worker is entitled to benefits on an aggravation basis, the organization shall still pay costs of vocational rehabilitation, burial expenses under section 65-05-26, travel, other personal reimbursement for seeking and obtaining medical care under section 65-05-28, and dependency allowance on a one hundred percent basis.

65-05-16. Death benefits payable.

1. The organization may pay benefits under this chapter in the case of the death of an injured employee as the direct result of an injury sustained in the course of the injured employee's employment when:

a. If there has been no disability preceding death, the death occurs within one year after the date of the injury;
b. If there has been disability preceding death, the death occurs within one year after the cessation of disability resulting from the injury;
c. If there has been disability that has continued to the time of death, the death occurs within six years after the date of injury; or
d. If there has been disability that has continued to the time of death, the death occurs more than six years after the date of injury, and the injured employee has been designated catastrophically injured as defined under section 65-05.1-06.1.

2. The organization may not pay death benefits unless a claim is submitted within two years of the death and:
   a. The death is a direct result of an accepted compensable injury; or
   b. If a claim was not submitted by the deceased, the claim for death benefits is submitted within two years of the injury.

65-05-17. Weekly compensation allowances for death claims.

If death results from an injury under the conditions specified in section 65-05-16, the fund shall pay to the following persons, for the periods specified:

1. To the decedent's spouse or to the guardian of the children of the decedent, an amount equal to the benefit rate for total disability under section 65-05-09. All recipients of benefits under this subsection are eligible for benefits at the rate provided in this section, regardless of the date of death of the deceased employee. These benefits continue until the death of the decedent's spouse; or, if the surviving children of the decedent are under the care of a guardian, until those children no longer meet the definition of child in this title. If there is more than one guardian for the children who survive the decedent, the organization shall divide the death benefits equally among the children and shall pay benefits to the children's guardians. Total death benefits, including supplementary benefits, paid on any one claim may not exceed three hundred thousand dollars.
2. To each child of the deceased employee, the amount of fifteen dollars per week. This rate must be paid to each eligible child regardless of the date of death. The organization may pay the benefit directly to the child of the deceased employee or to the surviving parent or guardian of the child. Dependency allowance may not be reduced by the percentage of aggravation.
3. In addition to the payments provided under subsections 1 and 2, a payment in the sum of two thousand five hundred dollars to the decedent's spouse or the guardian of the children of the decedent and eight hundred dollars for each dependent child. If there is more than one guardian of the decedent's surviving children, the two thousand five hundred dollars must be divided equally among the children and paid to the children's guardians.

65-05-18. Provisions of section 65-05-17 retroactive.

Repealed by omission from this code.

65-05-19. Providing nondependency payments in certain cases.

If the death of an employee with no surviving spouse or dependent children results from an injury within the time specified in section 65-05-16, the organization shall pay a lump sum equal to five percent of the maximum total death benefits specified in subsection 1 of section 65-05-17 to the surviving nondependent child, or in equal shares to the surviving nondependent children. In the event that no nondependent child is living, the sum provided under this section must be paid in equal shares to the surviving parents of the deceased, and if there are none, then to the deceased employee's living brothers and sisters. If there are no living brothers or sisters, the sum under this section must be paid in equal shares to the surviving grandparents, if any, of the deceased employee.

65-05-20. Dependents have option of accepting amount of nondependency payments in lieu of dependency compensation.

Repealed by S.L. 1969, ch. 565, § 2.

65-05-20.1. Scholarship fund - Rules.

1. The organization may establish a scholarship fund. Scholarships may be awarded to:
   a. The spouse and child of a worker who dies as a result of a compensable work-related injury, if the spouse and child have received benefits under section 65-05-17;
   b. The spouse and child of a worker who is deemed to be catastrophically injured as defined in subdivision c of subsection 2 of section 65-05.1-06.1; and
   c. Injured workers for whom the organization determines a scholarship would be beneficial and appropriate because of exceptional circumstances, or upon successful completion of a rehabilitation program contemplated under subdivision g of subsection 4 of section 65-05.1-01, as determined by the organization.
2. For purposes of this section, child includes a legitimate child, a step child, adopted child, posthumous child, foster child, and acknowledged illegitimate child between twenty-three and twenty-six years of age who is enrolled as a full-time student in any accredited educational institution and is dependent upon the employee for support.
3. Scholarships are payable to an accredited institution of higher education or an institution of technical education on behalf of a student attending that institution.
4. The total amount awarded annually in scholarships may not exceed five hundred thousand dollars. The maximum amount payable on behalf of an applicant is ten thousand dollars per year for no more than five years, except that the combined retraining and scholarship periods for applicants successfully completing a rehabilitation program under subdivision g of subsection 4 of section 65-05.1-01 may not exceed five years.
5. Scholarships must be awarded by a panel chosen by the organization. The organization shall adopt rules establishing selection criteria and obligations associated with the program and identifying information an applicant is required to submit to determine an appropriate scholarship award. Scholarships may be awarded at the sole discretion of the organization. There is no right to reconsideration, rehearing, or appeal from any decision regarding the award, denial, or amount of a scholarship.

65-05-21. Marriage settlement to spouse.

If a spouse who receives compensation under the provisions of subsection 1 of section 65-05-17 remarries, there shall be paid to such spouse a lump sum equal to one hundred four weeks' compensation. If, prior to such marriage, such spouse has received a partial lump sum settlement which covers all or any portion of the said one hundred four weeks following such spouse's marriage, the amount of such partial lump sum settlement which covers all or any part of the said one hundred four weeks following such spouse's marriage shall be deducted from such marriage settlement, and the spouse shall receive only the remainder, if any, over and above such deduction. Any judgment annulling such marriage shall not reinstate the right of such spouse to compensation if the action for annulment is instituted more than six months after the marriage. The provisions of this section apply only to remarriages that occur before August 1, 2003, regardless of the date of injury or date of death of the decedent.

65-05-22. Adjustment on cessation of compensation for death to one beneficiary.

Upon the cessation of compensation payable to a beneficiary under the provisions of this chapter, the compensation of the remaining persons entitled to compensation for the unexpired part of the period during which their compensation is payable, shall be that which such persons would have received if they had been the only persons entitled to compensation at the time of the decedent's death.

65-05-23. Organization may modify apportionment of benefits in certain cases.
Repealed by S.L. 1997, ch. 545, § 6.

65-05-24. Accepting compensation after marriage - Penalty.
Repealed by S.L. 2003, ch. 562, § 13.

65-05-25. Lump sum settlements - Granted in discretion of organization - How computed.

1. If an employee is determined to be permanently and totally disabled, the organization may pay the employee a lump sum equal to the present value of all future payments of compensation. The probability of the employee's death before the expiration of the period during which the employee is entitled to compensation must be determined by generally accepted mortality studies. The organization may not pay the employee a lump sum unless it has first determined that there is clear and convincing evidence that the lump sum payment is in the best interest of the employee. Best interest of the employee may not be deemed to exist because the employee can invest the lump sum in another manner to realize a better yield. The employee must show a specific plan of rehabilitation which will enable the employee to return as a productive member of society.
2. The organization and an employee may compromise to resolve a disputed claim. The contract of settlement made is enforceable by the parties. The contract may provide that the employee shall utilize the funds to engage in certain rehabilitation programs. If the employee breaches the contract, the organization may require the employee to repay the benefits received under the agreement. In cases in which the extent of disability is disputed and resolved by agreement, the concept of reopening a disability claim due to significant change in medical condition is inapplicable.
3. If death results from an injury under the conditions specified in section 65-05-16, the organization may pay the decedent's spouse or the guardian of the decedent's children a lump sum equal to the present value of all future payments of compensation.
4. Notwithstanding any other provision of law, structured settlements may be used to resolve a dispute or to provide for payment of ongoing future benefits. The organization may contract with a third-party vendor to provide structured settlement payments.

65-05-26. Burial expenses.
If death benefits are payable under section 65-05-16, the fund shall pay to the facility handling the funeral arrangements of the deceased employee burial expenses not to exceed ten thousand dollars.

65-05-27. Organization without probate proceedings may pay spouse of deceased claimant sum due deceased - Maximum payment.
If a compensation claimant dies, the organization, without probate proceedings, may pay to the spouse of such claimant, if living, or in the event of the claimant's spouse's death or incompetency, to any adult person who has assumed or paid the expenses of the last illness or funeral expense of the said claimant, the amount actually due claimant's estate, not to exceed the sum of one thousand dollars.

65-05-28. Examination of injured employee - Paid expenses - No compensation paid if claimant refuses to reasonably participate.
Every employee who sustains an injury may select a doctor of that employee's choice to render initial treatment. Upon a determination that the employee's injury is compensable, the organization may require the employee to begin treating with another doctor to better direct the medical aspects of the injured employee's claim. The organization shall provide a list of three doctors who specialize in the treatment of the type of injury the employee sustained. At the

organization's request, the employee shall select a doctor from the list. An injured employee shall follow the directives of the doctor or health care provider who is treating the employee as chosen by the employee at the request of the organization and comply with all reasonable requests during the time the employee is under medical care. Providing further that:

1. No employee may change from one doctor to another while under treatment or after being released, without the prior written authorization of the organization. Failure to obtain approval of the organization renders the employee liable for the cost of treatment and the new doctor will not be considered the attending doctor for purposes of certifying temporary disability.
    a. Any employee requesting a change of doctor shall file a written request with the organization stating all reasons for the change. Upon receipt of the request, the organization will review the employee's case and approve or deny the change of doctor, notifying the employee and the requested doctor.
    b. Emergency care or treatment or referral by the attending doctor does not constitute a change of doctor and does not require prior approval of the organization.
2. Travel and other personal reimbursement for seeking and obtaining medical care is paid only upon request of the injured employee. 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 or reimbursement must be denied. Reimbursement must be made at the organization reimbursement rates in effect on the date of incurred travel or expense. The calculation for reimbursement for travel by motor vehicle must be calculated using miles actually and necessarily traveled. Providing further that:
    a. Payment for mileage or other travel expenses may not be made when the distance traveled is less than fifty miles [80.47 kilometers] one way, unless the total mileage equals or exceeds two hundred miles [321.87 kilometers] in a calendar month;
    b. All travel reimbursements are payable at the rates at which state employees are paid per diem and mileage, except that the organization may pay no more than actual cost of lodging, if actual cost is less;
    c. Reimbursement may not be paid for travel other than that necessary to obtain the closest available medical or hospital care needed for the injury. If the injured employee chooses to seek medical treatment outside a local area where care is available, travel reimbursement may be denied;
    d. Reimbursement may not be paid for the travel and associated expenses incurred by the injured employee's spouse, children, or other persons unless the employee's injury prevents travel alone and the inability is medically substantiated; and
    e. Other expenses, including telephone calls and car rentals are not reimbursable expenses.
3. The organization may at any time require an injured employee to submit to an independent medical examination or independent medical review by one or more duly qualified doctors designated or approved by the organization. The organization shall make a reasonable effort to designate a duly qualified doctor licensed in the state in which the employee resides to conduct the examination before designating a duly qualified doctor licensed in another state or shall make a reasonable effort to designate a duly qualified doctor licensed in a state other than the employee's state of residence if the examination is conducted at a site within two hundred seventy-five miles [442.57 kilometers] from the employee's residence. An independent medical examination and independent medical review must be for the purpose of review of the diagnosis, prognosis, treatment, or fees. An independent medical examination contemplates an actual examination of an injured employee, either in person or remotely if appropriate. An independent medical review contemplates a file review of an injured employee's records, including treatments and testing. The injured employee may have a duly qualified doctor designated by that employee present at the

examination or later review the written report of the doctor performing the independent medical examination, if procured and paid for by that employee. Providing further that:

a. In case of any disagreement between doctors making an examination on the part of the organization and the injured employee's doctor, the organization shall appoint an impartial doctor duly qualified who shall make an examination and shall report to the organization.
b. The injured employee, in the discretion of the organization, may be paid reasonable travel and other per diem expenses under the guidelines of subsection 2. If the injured employee is working and loses gross wages from the injured employee's employer for attending the examination, the gross wages must be reimbursed as a miscellaneous expense upon receipt of a signed statement from the employer verifying the gross wage loss.

4. If an employee, or the employee's representative, refuses to submit to, or in any way intentionally obstructs, any examination or treatment, or refuses to reasonably participate in medical or other treatments or examinations, the employee's right to claim compensation under this title is suspended until the refusal or obstruction ceases. No compensation is payable while the refusal or obstruction continues, and the period of the refusal or obstruction must be deducted from the period for which compensation is payable to the employee.
5. If an employee undertakes activities, whether or not in the course of employment, which exceed the treatment recommendations of the employee's doctor regarding the work injury, and the doctor determines that the employee's injury or condition has been aggravated or has worsened as a result of the employee's activities, the organization may not pay benefits relative to the aggravation or worsening, unless the activities were undertaken at the demand of an employer. An employer's account may not be charged with the expenses of an aggravation or worsening of a work-related injury or condition unless the employer knowingly required the employee to perform activities that exceed the treatment recommendations of the employee's doctor.

65-05-28.1. Employer to select preferred provider.

Notwithstanding section 65-05-28, any employer subject to this title may select a preferred provider to render medical treatment to employees who sustain compensable injuries. "Preferred provider" means a designated provider or group of providers of medical services, including consultations or referral by the provider or providers.

65-05-28.2. Preferred provider - Use required - Exceptions - Notice.

1. During the first thirty days after a work injury, an employee of an employer that has selected a preferred provider under this section may seek medical treatment only from the preferred provider for the injury. Treatment by a provider other than the preferred provider is not compensable and the organization may not pay for treatment by a provider who is not a preferred provider, unless a referral was made by the preferred provider. A provider who is not a preferred provider may not certify disability or render an opinion about any matter pertaining to the injury, including causation, compensability, impairment, or disability. This section does not apply to emergency care nor to any care the employee reasonably did not know was related to a work injury.
2. An employee of an employer that has selected a preferred provider may elect to be treated by a different provider provided the employee makes the election and notifies the employer in writing before the occurrence of an injury.
3. After thirty days have passed following the injury, the employee may make a written request to the organization to change providers. The employee shall make the request and serve it on the employer and the organization at least thirty days before treatment by the provider. The employee shall state the reasons for the request and the employee's choice of provider.
4. If the employer objects to the provider selected by the employee under subsection 2 or 3, the employer may file an objection to the change of provider. The employer shall

detail in the objection the grounds for the objection and shall serve the objection on the employee and the organization within five days of service of the request. The employee may serve, within five days of service of the employer's objection, a written response on the employer and the organization in support of the request for change of provider. Within fifteen days after receipt of the response or of the expiration of the time for filing the response, the organization shall rule on the request. Failure of the organization to rule constitutes approval of the request. Treatment by the employee's chosen provider is not compensable until the organization approves the request. The preferred provider remains the treating provider until the organization approves the employee's request to change providers.

5. An employer that selects a preferred provider shall give notice and post notice as required under this subsection.
   a. An employer shall give written notice of the identity and the terms of the preferred provider program:
      (1) To the employer's employees when the employer makes an initial selection of a preferred provider.
      (2) To the employer's employees when the employer changes the selection of the preferred provider.
      (3) To an employee at the time of hire.
      (4) To the employer's employees at least annually after the initial notice.
   b. An employer that has selected a preferred provider shall display notice of the identity of the preferred provider and the terms of the preferred provider program in a conspicuous manner at fixed worksites, and wherever feasible at mobile worksites, and in a sufficient number of places to reasonably inform employees of the identity of the preferred provider and of the terms of the preferred provider program.
   c. Failure to give written notice, to properly post notice, or to reasonably inform employees of the terms of the preferred provider program as required under this subsection invalidates the selection for the employee's claim.

65-05-29. Assignment of claims void - Claims exempt.

1. Any assignment of a claim for compensation under this title is void. All compensation and claims therefor are exempt from claims of creditors except any of the following:
   a. A child support obligation ordered by a court of competent jurisdiction.
   b. A claim by job service North Dakota for reimbursement of unemployment benefits, for the amount that was paid by job service North Dakota during the period for which the claimant is found eligible for temporary total or permanent total disability benefits, not to exceed the disability award actually made by the organization.
   c. A claim by the organization for any payments made due to:
      (1) Clerical error, mistake of identity, innocent misrepresentation by or on behalf of the recipient, or any other circumstance of a similar nature, all not induced by fraud, in which cases the recipient shall repay it or recoupment of any unpaid amount may be made from any future payments due to the recipient on any claim with the organization;
      (2) An adjudication by the organization or by order of any court, if the final decision is that the payment was made under an erroneous adjudication, in which cases the recipient shall repay it or recoupment of any unpaid amount may be made from any future payments due to the recipient on any claim with the organization;
      (3) Fraud, in which case the recipient shall repay the payment or the unpaid amount of the sum may be recouped from any future payments due to the recipient on any claim with the organization;
      (4) Overpayment due to application of section 65-05-09.1; or
      (5) A claim by the organization for premiums, penalties, and interest under chapter 65-04.

2. a. Notwithstanding paragraph 2 of subdivision c of subsection 1, during the sixty days immediately following the date of injury, if the organization accrues a medical expense or makes a payment for a medical expense and the organization later determines the medical expense is for the care and treatment of a noncompensable injury, disease, or other condition, the injured employee is not liable for the medical expense accrued or paid by the organization before the earlier of:
   (1) The third day following the date the organization makes a determination the medical expense is for a noncompensable injury, disease, or condition; or
   (2) The third day following the date the injured employee or medical provider reasonably should have known the medical expense is for a noncompensable injury, disease, or condition.
   b. Medical expenses incurred under this subsection may not be charged against an employer's account for purposes of experience rating.

65-05-30. Filing of claim constitutes consent to use of information received by doctor.

1. The filing of a claim with the organization constitutes a consent to the use by the organization, in any proceeding by the organization or to which the organization is a party in any court, of any information, including prior and subsequent prognosis reports, medical records, medical bills, and other information concerning any health care or health care services which was received by any health care provider, hospital, or clinic in the course of any examination or treatment of the claimant.
2. The filing of a claim with the organization authorizes a health care provider, hospital, or clinic to disclose to the organization, or authorized representative of the organization, information or render an opinion regarding the injured employee's claim with the organization. As used in this subsection, an opinion may include a statement regarding liability, causation, or a pre-existing condition or other information the organization deems necessary for the administration of this title. The filing of a claim with the organization authorizes a health care provider, hospital, or clinic to disclose any information to the organization deemed necessary for the administration of this title to the organization's representative, or the employer, except any information directly disclosed to the employer must be relevant to the employee's work injury or to return-to-work issues.
3. If a health care provider furnishes information or an opinion under this section:
   a. That health care provider does not incur any liability as a result of furnishing that information or opinion.
   b. The act of furnishing that information or opinion may not be the sole basis for a disciplinary or other proceeding affecting professional licensure. However, the act of furnishing that information or opinion may be considered in conjunction with another action that may subject the health care provider to a disciplinary or other proceeding affecting professional licensure.

65-05-31. False statement - Penalty.

Repealed by S.L. 1975, ch. 106, § 673.

65-05-32. Privacy of records and hearings - Penalty.

Information contained in the claim files and records of injured employees is confidential and is not open to public inspection, other than to organization employees or agents in the performance of their official duties. Providing further that:

1. Representatives of a claimant, whether an individual or an organization, may review a claim file or receive specific information from the file upon the presentation of the signed authorization of the claimant. However, reserve information may not be made available to the claimant or the claimant's representatives. Availability of this information to employers is subject to the sole discretion of the organization.

2. Employers or their duly authorized representatives who are required to have access to an injured employee's claim file for the performance of their duties may review and have access to any files of their own injured employees. An employer or an employer's duly authorized representative who willfully communicates information contained in an employee's claim file to any person who does not need the information in the performance of that person's duties is guilty of a class B misdemeanor.
3. Physicians or health care providers treating or examining employees claiming benefits under this title, or physicians giving medical advice to the organization regarding any claim may, at the discretion of the organization, inspect the claim files and records of injured employees.
4. Other persons may have access to and make inspections of the files, if such persons are rendering assistance to the organization at any stage of the proceedings on any matter pertaining to the administration of this title.
5. The claimant's name; date of birth; injury date; employer name; type of injury; whether the claim is accepted, denied, or pending; and whether the claim is in active or inactive pay status will be available to the public. This information may not be released in aggregate form, except to those persons contracting with the organization for exchange of information pertaining to the administration of this title or except upon written authorization by the claimant for a specified purpose.
6. At the request of a claimant, the organization may close the medical portion of a hearing to the public.
7. The organization may release the social security number of an individual claiming entitlement to benefits under this title to health care providers or health care facilities for the purpose of adjudicating a claim for benefits.
8. The organization may provide an injured employee's insurer information regarding the injured employee's claim.
9. The organization may provide any state or federal agency any information obtained pursuant to the administration of this title. Any information so provided must be used for the purpose of administering the duties of that state or federal agency.

65-05-33. Filing false claim or false statement - Penalty.

1. A person who claims benefits or payment for services under this title or the employer of a person who claims benefits or payments for services is guilty of a class A misdemeanor if the person or employer does any one or more of the following:
   a. Willfully files a false claim or makes a false statement in an attempt to secure payment of benefits or payment for services.
   b. Willfully misrepresents that person's physical condition, including deceptive conduct which misrepresents that person's physical ability.
   c. Has a claim for disability benefits that has been accepted by the organization and willfully fails to notify the organization of:
      (1) Work or other activities as required under subsection 3 of section 65-05-08;
      (2) The receipt of income from work; or
      (3) An increase in income from work.
2. If any of the acts in subsection 1 are committed to obtain, or pursuant to a scheme to obtain, more than five hundred dollars in benefits or payment for services, the offense is a class C felony.
3. In addition to any other penalties provided by law, the person claiming benefits or payment for services in violation of this section shall reimburse the organization for any benefits paid based upon the false claim or false statement and, if applicable, under section 65-05-29 and shall forfeit any additional benefits relative to that injury.
4. For purposes of this section, "statement" includes any testimony, claim form, notice, proof of injury, proof of return-to-work status, bill for services, diagnosis, prescription, hospital or doctor records, x-ray, test results, or other evidence of loss, injury, or expense.

65-05-34. False statement on employment application.

A false statement in an employment application made by an employee bars all benefits under this title if:

1. The employee knowingly and willfully made a false representation as to the employee's physical condition;
2. The employer relied upon the false representation and this reliance was a substantial factor in the hiring; and
3. There was a causal connection between the false representation and the injury.

65-05-35. Closed claim - Presumption.

1. A claim for benefits under this title is presumed closed if the organization has not paid any benefit or received a demand for payment of any benefit for a period of four years.
2. A claim that is presumed closed may not be reopened for payment of any further benefits unless the presumption is rebutted by clear and convincing evidence that the work injury is the primary cause of the current symptoms.
3. With respect to a claim that has been presumed closed, the employee shall provide the organization written notice of reapplication for benefits under that claim. In case of award of lost-time benefits, the award may commence no more than thirty days before the date of reapplication. In case of award of medical benefits, the award may be for medical services incurred no more than thirty days before the date of reapplication.
4. This section applies to all claims for injury, irrespective of injury date.

65-05-36. Preferred worker program - Continuing appropriation.

For purposes of this section, "preferred worker" means a worker who has incurred a compensable injury that resulted in a disability that poses a substantial obstacle to employment. The organization may provide assistance as determined appropriate to preferred workers or employers who employ a preferred worker. In addition, employers who apply for and are approved as a preferred worker employer may not be assessed premiums on a preferred worker's salary for three years from the date of hiring. The organization may not charge claims costs incurred as a result of an injury sustained by a preferred worker against the preferred worker's employer's account during the first three years after the worker is hired. The organization shall charge those claims costs to the general fund. The organization may adopt rules to regulate and manage the preferred worker program authorized by this section. An employer or preferred worker may not appeal an organization decision not to provide assistance to that employer or preferred worker under this section. Money in the workforce safety and insurance fund is appropriated on a continuing basis to provide the assistance authorized under this section.

65-05-37. Retaliation by employer prohibited - Action for damages - Penalty.

An employer who willfully discharges or willfully threatens to discharge an employee for seeking or making known the intention to seek workforce safety and insurance benefits is liable in a civil action for damages incurred by the employee, including reasonable attorney's fees. Damages awarded under this section may not be offset by any workforce safety and insurance benefits to which the employee is entitled. A willful violation of this section is a class A misdemeanor.

65-05-38. Death of permanently and totally disabled employee - Surviving spouse.

In the case of the death of an injured employee who is receiving permanent total disability benefits, or additional benefits payable, if the injured employee was permanently and totally disabled for at least ten years and was married to the surviving spouse for at least ten years, the decedent's surviving spouse is eligible to receive no more than six months of the decedent's permanent total disability benefits, supplementary benefits, and additional benefits payable in the same manner as the deceased spouse would have been entitled to receive the benefits. A surviving spouse is eligible for benefits under this section if the organization approved the decedent for home health care services and reimbursed the surviving spouse for providing the

home health care services. The surviving spouse is not eligible for benefits under this section if the surviving spouse is eligible for benefits under section 65-05-16. The eligibility of the surviving spouse to receive benefits under this section terminates upon the remarriage of the surviving spouse.

65-05-39. Chronic opioid therapy coverage and monitoring.

1. As used in this section, "chronic opioid therapy" is opioid treatment extending beyond ninety days from initiation which is for the treatment of pain resulting from a nonmalignant, compensable condition or therapies for another nonterminal compensable condition.
2. In order to qualify for payment for chronic opioid therapy:
   a. Chronic opioid therapy must result in an increase in function, enable an injured employee to resume working, or improve pain control without debilitating side effects;
   b. Chronic opioid therapy must treat an injured employee:
      (1) Who has been nonresponsive to non-opioid treatment;
      (2) Who is not using illegal substances or abusing alcohol; and
      (3) Who is compliant with the treatment protocol; and
   c. The prescriber of chronic opioid therapy shall provide to the organization:
      (1) At least every ninety days, documentation of the effectiveness of the chronic opioid therapy, including documentation of improvements in function or improvements in pain control without debilitating side effects; and
      (2) A treatment agreement between the injured employee and the prescriber which restricts treatment access and limits prescriptions to one identified single prescriber. This paragraph does not preclude temporary coverage within a single clinic by an identified prescriber when the prescriber of record is unavailable and does not preclude a referral to a pain specialist.
3. At the prescriber's or organization's request, an injured employee on chronic opioid therapy is subject to random drug testing for the presence of prescribed and illicit substances. Failure of the test or of timely compliance with the request may result in termination of chronic opioid therapy coverage.
4. Failure to comply with any of the conditions under this section may result in the termination of coverage for chronic opioid therapy.