

Michigan Register

Issue No. 5 – 2018 (Published April 1, 2018)



**GRAPHIC IMAGES IN THE
MICHIGAN REGISTER**

COVER DRAWING

Michigan State Capitol:

This image, with flags flying to indicate that both chambers of the legislature are in session, may have originated as an etching based on a drawing or a photograph. The artist is unknown. The drawing predates the placement of the statue of Austin T. Blair on the capitol grounds in 1898.

(Michigan State Archives)

PAGE GRAPHICS

Capitol Dome:

The architectural rendering of the Michigan State Capitol's dome is the work of Elijah E. Myers, the building's renowned architect. Myers inked the rendering on linen in late 1871 or early 1872. Myers' fine draftsmanship, the hallmark of his work, is clearly evident.

Because of their size, few architectural renderings of the 19th century have survived. Michigan is fortunate that many of Myers' designs for the Capitol were found in the building's attic in the 1950's. As part of the state's 1987 sesquicentennial celebration, they were conserved and deposited in the Michigan State Archives.

(Michigan State Archives)

East Elevation of the Michigan State Capitol:

When Myers' drawings were discovered in the 1950's, this view of the Capitol – the one most familiar to Michigan citizens – was missing. During the building's recent restoration (1989-1992), this drawing was commissioned to recreate the architect's original rendering of the east (front) elevation.

(Michigan Capitol Committee)

Michigan Register

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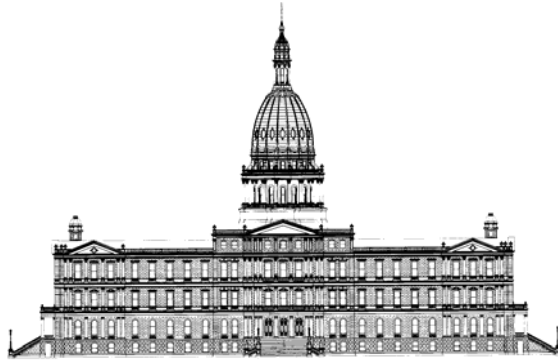
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Rick Snyder, Governor



Brian Calley, Lieutenant Governor

PREFACE

PUBLICATION AND CONTENTS OF THE MICHIGAN REGISTER

The Office of Regulatory Reform publishes the *Michigan Register*.

While several statutory provisions address the publication and contents of the *Michigan Register*, two are of particular importance.

24.208 Michigan register; publication; cumulative index; contents; public subscription; fee; synopsis of proposed rule or guideline; transmitting copies to office of regulatory reform.

Sec. 8.

(1) The office of regulatory reform shall publish the Michigan register at least once each month. The Michigan register shall contain all of the following:

- (a) Executive orders and executive reorganization orders.
- (b) On a cumulative basis, the numbers and subject matter of the enrolled senate and house bills signed into law by the governor during the calendar year and the corresponding public act numbers.
- (c) On a cumulative basis, the numbers and subject matter of the enrolled senate and house bills vetoed by the governor during the calendar year.
- (d) Proposed administrative rules.
- (e) Notices of public hearings on proposed administrative rules.
- (f) Administrative rules filed with the secretary of state.
- (g) Emergency rules filed with the secretary of state.
- (h) Notice of proposed and adopted agency guidelines.
- (i) Other official information considered necessary or appropriate by the office of regulatory reform.
- (j) Attorney general opinions.
- (k) All of the items listed in section 7(m) after final approval by the certificate of need commission under section 22215 of the public health code, 1978 PA 368, MCL 333.22215.

(2) The office of regulatory reform shall publish a cumulative index for the Michigan register.

(3) The Michigan register shall be available for public subscription at a fee reasonably calculated to cover publication and distribution costs.

(4) If publication of an agency's proposed rule or guideline or an item described in subsection (1)(k) would be unreasonably expensive or lengthy, the office of regulatory reform may publish a brief synopsis of the proposed rule or guideline or item described in subsection (1)(k), including information on how to obtain a complete copy of the proposed rule or guideline or item described in subsection (1)(k) from the agency at no cost.

(5) An agency shall electronically transmit a copy of the proposed rules and notice of public hearing to the office of regulatory reform for publication in the Michigan register.

4.1203 Michigan register fund; creation; administration; expenditures; disposition of money received from sale of Michigan register and amounts paid by state agencies; use of fund; price of Michigan register; availability of text on internet; copyright or other proprietary interest; fee prohibited; definition.

Sec. 203.

- (1) The Michigan register fund is created in the state treasury and shall be administered by the office of regulatory reform. The fund shall be expended only as provided in this section.
- (2) The money received from the sale of the Michigan register, along with those amounts paid by state agencies pursuant to section 57 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.257, shall be deposited with the state treasurer and credited to the Michigan register fund.
- (3) The Michigan register fund shall be used to pay the costs of preparing, printing, and distributing the Michigan register.
- (4) The department of management and budget shall sell copies of the Michigan register at a price determined by the office of regulatory reform not to exceed the cost of preparation, printing, and distribution.
- (5) Notwithstanding section 204, beginning January 1, 2001, the office of regulatory reform shall make the text of the Michigan register available to the public on the internet.
- (6) The information described in subsection (5) that is maintained by the office of regulatory reform shall be made available in the shortest feasible time after the information is available. The information described in subsection (5) that is not maintained by the office of regulatory reform shall be made available in the shortest feasible time after it is made available to the office of regulatory reform.
- (7) Subsection (5) does not alter or relinquish any copyright or other proprietary interest or entitlement of this state relating to any of the information made available under subsection (5).
- (8) The office of regulatory reform shall not charge a fee for providing the Michigan register on the internet as provided in subsection (5).
- (9) As used in this section, "Michigan register" means that term as defined in section 5 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.205.

CITATION TO THE MICHIGAN REGISTER

The *Michigan Register* is cited by year and issue number. For example, 2001 MR 1 refers to the year of issue (2001) and the issue number (1).

CLOSING DATES AND PUBLICATION SCHEDULE

The deadlines for submitting documents to the Office of Regulatory Reinvention for publication in the *Michigan Register* are the first and fifteenth days of each calendar month, unless the submission day falls on a Saturday, Sunday, or legal holiday, in which event the deadline is extended to include the next day which is not a Saturday, Sunday, or legal holiday. Documents filed or received after 5:00 p.m. on the closing date of a filing period will appear in the succeeding issue of the *Michigan Register*.

The Office of Regulatory Reinvention is not responsible for the editing and proofreading of documents submitted for publication.

Documents submitted for publication should be delivered or mailed in an electronic format to the following address: MICHIGAN REGISTER, Office of Regulatory Reinvention, Romney Building – Eight Floor, 111 S. Capitol, Lansing, MI 48909

RELATIONSHIP TO THE MICHIGAN ADMINISTRATIVE CODE

The *Michigan Administrative Code* (1979 edition), which contains all permanent administrative rules in effect as of December 1979, was, during the period 1980-83, updated each calendar quarter with the publication of a paperback supplement. An annual supplement contained those permanent rules, which had appeared in the 4 quarterly supplements covering that year.

Quarterly supplements to the Code were discontinued in January 1984, and replaced by the monthly publication of permanent rules and emergency rules in the *Michigan Register*. Annual supplements have included the full text of those permanent rules that appear in the twelve monthly issues of the *Register* during a given calendar year. Emergency rules published in an issue of the *Register* are noted in the annual supplement to the Code.

SUBSCRIPTIONS AND DISTRIBUTION

The *Michigan Register*, a publication of the State of Michigan, is available for public subscription at a cost of \$400.00 per year. Submit subscription requests to: Office of Regulatory Reinvention, Romney Building –Eight Floor, 111 S. Capitol Avenue, Lansing, MI 48909. Checks Payable: State of Michigan. Any questions should be directed to the Office of Regulatory Reinvention (517) 335-8658.

INTERNET ACCESS

The *Michigan Register* can be viewed free of charge on the Internet web site of the Office of Regulatory Reinvention: www.michigan.gov/orr.

Issue 2000-3 and all subsequent editions of the *Michigan Register* can be viewed on the Office of Regulatory Reinvention Internet web site. The electronic version of the *Register* can be navigated using the blue highlighted links found in the Contents section. Clicking on a highlighted title will take the reader to related text, clicking on a highlighted header above the text will return the reader to the Contents section.

Jeff Bankowski, Executive Director,
Office of Performance and Transformation

2018 PUBLICATION SCHEDULE

Issue No.	Closing Date for Filing or Submission Of Documents (5 p.m.)	Publication Date
1	January 15, 2018	February 1, 2018
2	February 1, 2018	February 15, 2018
3	February 15, 2018	March 1, 2018
4	March 1, 2018	March 15, 2018
5	March 15, 2018	April 1, 2018
6	April 1, 2018	April 15, 2018
7	April 15, 2018	May 1, 2018
8	May 1, 2018	May 15, 2018
9	May 15, 2018	June 1, 2018
10	June 1, 2018	June 15, 2018
11	June 15, 2018	July 1, 2018
12	July 1, 2018	July 15, 2018
13	July 15, 2018	August 1, 2018
14	August 1, 2018	August 15, 2018
15	August 15, 2018	September 1, 2018
16	September 1, 2018	September 15, 2018
17	September 15, 2018	October 1, 2018
18	October 1, 2018	October 15, 2018
19	October 15, 2018	November 1, 2018
20	November 1, 2018	November 15, 2018
21	November 15, 2018	December 1, 2018
22	December 1, 2018	December 15, 2018
23	December 15, 2018	January 1, 2019
24	January 1, 2019	January 15, 2019

CONTENTS

ADMINISTRATIVE RULES FILED WITH SECRETARY OF STATE

Department of Licensing and Regulatory Affairs

Public Service Commission (2017-016)

Responsibilities of Providers of Basic Local Exchange Service that
Cease to Provide the Service2-4

Department of Treasury

Bureau of State Lottery (2017-031)

Charitable Gaming Rules5-6

Department of Insurance and FinanceNatural Resources

Insurance Bureau (2017-035)

Certificates of No-Fault Self -Insurance7-12

Department of Treasury

Bureau of State Lottery (2017-036)

Lottery Rules13-15

Department of Licensing and Regulatory Affairs

Bureau of Professional Licensing (2017-037)

Board of Nursing – General Rules16-42

Department of Licensing and Regulatory Affairs

Bureau of Professional Licensing (2017-038)

Public Health Code – General Rules43-43

Department of Licensing and Regulatory Affairs

Workers' Compensation Agency (2017-040)

Workers' Compensation Health Care Services44-57

Department of Health and Human Services

Population Health and Community Services (2017-074)

Crime Victim Services – General Rules58-59

PROPOSED ADMINISTRATIVE RULES, NOTICES OF PUBLIC HEARINGS

Department of Health and Human Services

Population Health and Community Services (2017-046)

EMS Organization Licensure Rules61-61

Public Hearing Notice62-62

**CORRECTION OF OBVIOUS
ERRORS IN PUBLICATION**

Department of Natural Resources

Office of Minerals Management

Metallic Minerals Leased on State Lands.....64-64

Department of Treasury

Bureau of State Lottery (2017-031)

Charitable Gaming Rules.....65-65

**EXECUTIVE ORDERS
AND
EXECUTIVE REORGANIZATION ORDERS**

Executive Order No. 2018 - 3

Michigan Statistical Analysis Center.....67-68

MICHIGAN ADMINISTRATIVE CODE TABLE

Table (2018 Session)70-72

CUMULATIVE INDEX

Cumulative Index (2018).....73-75

BILLS SIGNED INTO LAW OR VETOED

Appendix Table 1 (2018 Session) (Legislative Service Bureau Pages (1-2)).....76-76

ADMINISTRATIVE RULES
FILED WITH THE SECRETARY OF STATE

MCL 24.208 states in part:

“Sec. 8. (1) The Office of Regulatory Reform shall publish the Michigan register at least once each month. The Michigan register shall contain all of the following:

** * **

(f) Administrative rules filed with the secretary of state.”

ADMINISTRATIVE RULES

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

PUBLIC SERVICE COMMISSION

RESPONSIBILITIES OF PROVIDERS OF BASIC LOCAL EXCHANGE SERVICE THAT CEASE
TO PROVIDE THE SERVICE

Filed with the Secretary of State on March 21, 2018

These rules take effect upon filing with the Secretary of State.

(By authority conferred on the public service commission by sections 202 and 213 of 1991 PA 179,
MCL 484.2202 and 484.2213)

R 484.1001, R 484.1002, R 484.1003, R 494.1004, R 484.1005, R 484.1006, R 484.1007, R 484.1008,
and R 484. 1009 are added to the Michigan Administrative Code as follows:

PART 1. GENERAL PROVISIONS

R 484.1001 Applicability.

Rule 1. These rules apply to providers of basic local exchange service that cease to provide service to any segment of end users or geographic area, go out of business, or withdraw from the state, including the transfer of customers to other providers and the reclaiming of unused telephone numbers.

R 484.1002 Definitions.

Rule 2. (1) As used in these rules:

- (a) “Act” means the Michigan telecommunications act, 1991 PA 179, MCL 484.2102 to 484.2601.
 - (b) “Commission” means the Michigan public service commission.
 - (c) “Customer” means the person that is the end subscriber of the retail telecommunications service.
 - (d) “License” means a license to provide basic local exchange service issued pursuant to the act.
 - (e) “Provider” means a person, firm, partnership, corporation, or other entity that provides retail basic local exchange service as defined by section 102(b) of the act.
 - (f) “Reclamation” means the process of removing active and non-active telephone numbers from the inventory of a provider that ceases to provide basic local exchange service.
 - (g) “Wholesale provider” means a person, firm, partnership, corporation, or other entity that provides a resale or local wholesale basic local exchange service product to a provider.
- (2) A term defined in the act that is not defined in this rule has the same meaning when used in these rules.

R 484.1003 Expiration.

Rule 3. These rules expire 3 years from the effective date of the rules. The commission may, prior to the expiration of the rules, promulgate new rules.

PART 2. RESPONSIBILITIES OF PROVIDERS AND WHOLESALE PROVIDERS INVOLVED IN
A DISCONNECTION DISPUTE

R 484.1004 Attempt at resolution.

Rule 4. In the case of a billing dispute between a provider and a wholesale provider, the parties shall make a good faith effort to work with each other to determine what portion, if any, of the bill for resale or the purchase of a local wholesale product provided by the wholesale provider to the provider is disputed and which portion is undisputed. The wholesale provider and the provider shall work together to resolve the billing dispute and arrange for payment of the undisputed charges, pursuant to the agreement between the wholesale provider and the provider.

R 484.1005 Notification of discontinuance.

Rule 5. (1) When the wholesale provider plans to disconnect a service that will make the provider unable to furnish basic local exchange service to its customers due to a dispute concerning resale or the purchase of a local wholesale product, the wholesale provider shall notify the commission and the provider of this disconnection in writing not less than 45 days from the date of the impending disconnect.

(2) Notice required under subrule (1) of this rule must include, to the extent known by the wholesale provider, but not be limited to, all of the following:

- (a) The name, address, and account number or numbers of the provider.
- (b) The number and type of customers to be disconnected.
- (c) An indication whether the wholesale provider is furnishing resale service or a local wholesale product.
- (d) The reason for the disconnection.
- (e) A statement or citation describing where the right to disconnect or deny service is found, such as in an interconnection agreement or other contract.
- (f) If the dispute is related to billing and charges, an estimate of the charges owed and amounts of those charges that are disputed and undisputed and the amount required to be repaid to avoid disruption of services.
- (g) The date and time, or range of dates and times, when the wholesale provider intends to discontinue the service.

(3) The wholesale provider shall notify the commission as soon as reasonably practicable but no less than 1 business day prior to the date of the notice required by the provider under subrule (4) of this rule if the notice to discontinue service to the provider has been modified or withdrawn.

(4) Within 10 business days of receiving notice from the wholesale provider, the provider shall notify all of its affected customers, the governor of the state of Michigan, and the commission of the discontinuance of service pursuant to 47 C.F.R. §63.71 (2016) and any other federal rules applicable to discontinuance of basic local exchange service. Notice to the commission must include both of the following:

- (a) A statement of the company's prospective intent for the disposition of its license and any tariffs on file with the commission.
- (b) A list of customers being served by the provider that may be affected by the discontinuance of service, which shall include billing name, billing address, and service telephone number. For non-published numbers, only the NPA-NXX must be provided. The list must also identify end users of the provider that are public utilities, governmental agencies, schools, or medical facilities.

(5) These rules do not relieve a provider from any obligations it has under section 313 of the act, MCL 484.2313.

(6) The provider shall contact the commission to provide periodic updates of the status of the disconnection and transition of its customers as requested by commission staff.

(7) The provider shall return all deposits to customers and shall apply all appropriate credits to customer accounts associated with the discontinued service within 30 days of the discontinuance.

R 484.1006 Notification of transfer of customer base.

Rule 6. (1) A provider that is acquiring all or part of a customer base from another provider shall comply with the transfer of customer base notice requirements as set forth in 47 C.F.R. 64.1120(e) (2008) and any other state and federal rules applicable to the transfer of all or part of a customer base. The provider shall submit a copy of this notice to the commission at the same time as it files its application with the federal communications commission.

(2) Notice to the commission must include both of the following:

(a) A statement of the prospective intent for the disposition of the license and any tariff of the company that is transferring its customer base.

(b) The number and type of customers affected by the transfer.

(3) If the commission considers it necessary to protect the public interest, it may institute a longer period of time for the transition of a customer base to another provider, but not to exceed 60 days in length.

R 484.1007 Reclamation of telephone numbers.

Rule 7. (1) Inactive telephone numbers of a provider that ceases to provide service are considered abandoned.

(2) The provider ceasing to provide service shall contact the North American numbering plan administrator, the national number pool administrator, and the national portability administration center regarding the NPA-NXX-Xs affected by the discontinuation of service.

(3) The commission staff shall work with the North American numbering plan administrator, the national number pool administrator, and the national portability administration center to assist in the reclamation of numbering resources.

R 484.1008 Resolution of disputes between providers.

Rule 8. If a provider disputes disconnection by another provider, the providers shall follow the appropriate procedures for resolution as set forth in their interconnection agreement and may apply to the commission for resolution as allowable under the act.

PART 3. REMEDIES

R 484.1009 Remedies.

Rule 9. Violation of these rules may result in penalties issued under section 601 of the act, MCL 484.2601, including, but not limited to, revocation of a license to provide basic local exchange service.

ADMINISTRATIVE RULES

DEPARTMENT OF TREASURY

COMMISSIONER OF THE BUREAU OF STATE LOTTERY

CHARITABLE GAMING

Filed with the Secretary of State on March 5, 2018

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, or 45(a)(6) of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

By authority conferred on the commissioner of the Bureau of State Lottery by section 13 of 1972 PA 382, MCL 432.113.

R 432.21514 and R 432.21516 are amended to the Michigan Administrative Code as follows:

PART 5. RAFFLE

R 432.21514 Raffle ticket sellers.

Rule 514. (1) Raffle ticket sellers may be nonmembers of the licensee.

(2) Raffle ticket sellers must be 18 years of age or older.

(3) Raffle ticket sellers in a licensed raffle, other than an in-house raffle, are not be entitled to and shall not receive anything of value for their services except as prescribed by R 432.21517.

(4) Raffle ticket sellers in a licensed in-house raffle are not be entitled to and shall not receive anything of value for their services except as prescribed by R 432.21516 and R 432.21517.

R 432.21516 Worker compensation.

Rule 516. (1) The commissioner shall establish a service compensation schedule for workers.

(2) The commissioner may adjust the established service compensation schedule. If an adjustment is proposed, then the licensees shall be given 30 days to comment before the change is implemented.

(3) A worker shall not be compensated more than the amount established by the commissioner in the service compensation schedule, except as prescribed by R 432.21517.

(4) The amount established by the commissioner that may be paid to a worker is as follows:

(a) The chairperson shall be paid not more than \$50.00 as of the effective date of these rules and the amount may be adjusted by the service compensation schedule not to exceed \$100.00 for his or her services.

(b) All other workers shall be paid not more than \$15.00 as of the effective date of these rules and the amount may be adjusted by the service compensation schedule not to exceed \$50.00 for their services.

(5) Only 1 person may be paid as chairperson for each licensed gaming event.

(6) An individual may only be compensated for being either the chairperson or a worker.

(7) Compensation to workers includes, but is not limited to, any of the following:

(a) Cash or check.

(b) Anything of value.

(c) Credit towards dues, tuition, or any other items of value. Any credit given shall not exceed the limit per licensed gaming event as prescribed by this rule.

(8) In addition to the compensation as provided by subrule (7) of this rule, workers may also receive food and beverages consumed while working that do not exceed \$10.00 in retail value.

(9) All worker compensation, other than credits, shall be paid on the day of the licensed gaming event.

(10) The names of the workers and amounts paid, including any credits as provided by subrule (7)(c) of this rule, shall be recorded on the workers service record for each day of the licensed gaming event or as directed in writing by the bureau.

(11) Any and all forms of worker compensation shall only be paid from the proceeds of the licensed gaming event or the financial account as prescribed by R 432.21519.

(12) All compensation shall be reported on the financial statement for the raffle or associated licensed gaming event.

ADMINISTRATIVE RULES

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

CERTIFICATES OF NO-FAULT SELF-INSURANCE

Filed with the Secretary of State on March 8, 2018

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, or 45(a)(6) of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

(By authority conferred on the director of the Department of Insurance and Financial Services by section 210 of 1956 PA 218, MCL 500.210; 1969 PA 306, MCL 24.201 to 24.328; E.R.O. No. 2011-4, MCL 445.2030; and E.R.O. No. 2013-1, MCL 550.991.)

R 257.531, R 257.532, R 257.533, R 257.534, R 257.535, R 257.536, R 257.537, R 257.538, R 257.539, and R 257.540 of the Michigan Administrative Code are amended as follows:

R 257.531 Definitions.

Rule 1. (1) As used in these rules:

- (a) "Act" means the insurance code of 1956, 1956 PA 218, MCL 500.100 to MCL 500.8302.
- (b) "Applicant" means a motor vehicle registrant who is required to maintain security for the payment of benefits under section 3101 of the no-fault law and who applies for a certificate of self-insurance.
- (c) "Casualty insurance company" means an insurer authorized, as defined in section 108 of the act, MCL 500.108, to transact casualty insurance business in this state, or an eligible unauthorized insurer recognized by the director of insurance pursuant to section 1920 of the act, MCL 500.1920.
- (d) "Financial responsibility law" means Chapter V of the Motor vehicle code, 1949 PA 300, MCL 257.501 to MCL 257.532.
- (e) "Motor vehicle" means a vehicle, including a trailer operated or designed for operation upon a public highway by power other than muscular power that has more than 2 wheels and is required to be registered under the Michigan vehicle code. Motor vehicle does not include a motorcycle or a moped.
- (f) "No-fault law" means sections 3101 to 3179 of the act, MCL 500.3101 to MCL 500.3179.
- (g) "Michigan vehicle code" means the Michigan vehicle code, 1949 PA 300, MCL 257.1 to MCL 257.923.
- (h) "Qualified actuary" means an individual who meets the following:
 - (i) Is a member in good standing of the American academy of actuaries or the casualty actuarial society.
 - (ii) Notwithstanding subdivision (c) of this subrule, has not been found by the director to have done any of the following:
 - (A) Violated any provision of, or any obligation imposed by, the act or other law in the course of his or her dealings as a qualified actuary.
 - (B) Been found guilty of fraudulent or dishonest practices.
 - (C) Demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as a qualified actuary.

(D) Resigned or been removed as an actuary within the past five 5 years as a result of failure to adhere to generally acceptable actuarial standards.

(iii) If an individual has done any of the activities listed in paragraphs (i) to (iv) of this subrule, but has subsequently been reinstated as a qualified actuary following appropriate notice and hearing, the director may, in his or her discretion, deem the individual to be a qualified actuary for purposes of this rule.

(iv) Has notified the director of any action taken by the director of insurance of any other state similar to that described in paragraph (ii) of this subdivision.

(2) A term defined in the act has the same meaning when used in these rules, unless defined otherwise in this rule.

R 257.532 Security equivalent; qualifications for certificate; excess insurance requirement.

Rule 2. (1) A certificate of self-insurance that is issued pursuant to these rules constitutes security equivalent to that afforded by a policy of insurance that provides for the payment of benefits pursuant to the no-fault law.

(2) Pursuant to section 3101d of the no-fault law, the director may issue a certificate of self-insurance to an applicant who possesses all the following qualifications:

(a) Registers in the applicant's name more than 25 motor vehicles, excluding trailers, in this state.

(b) Agrees, in writing, to comply with all of the provisions of the no-fault law, the financial responsibility law contained in chapter V of the Michigan vehicle code, and these rules.

(c) Has not been declared bankrupt or had a financial manager appointed or any substantially equivalent action taken within the 5-year period immediately preceding the date of application.

(d) Possesses a net worth of more than \$15,000,000.00 and complies with the provisions of subrule (3) of this rule.

(e) Possesses a sound financial condition, has sufficient liquid assets, and utilizes financial practices and methods that would not bring into question its ability to pay claims fully and in a timely manner.

(f) Establishes a fully funded loss reserve as described in R 257.536.

(g) Has not had a certificate of self-insurance denied or canceled by this state or any other state within 1 year preceding the date of application, and has maintained insurance coverage on the vehicles described in R 257.533(4)(f) at all times as required by law.

(h) Submits to the director a completed application for a certificate of self-insurance with all required documents attached.

(3) The applicant shall, in addition to meeting the qualifications specified in subrule (2) of this rule, secure and maintain an excess insurance policy, as described in R 257.537, with policy limits and retention amounts commensurate to its risks and exposure that are acceptable to the director.

(4) Except as provided in subrule (6) of this rule, a parent company and its subsidiaries shall make separate applications for the issuance of a certificate of self-insurance pursuant to these rules.

(5) Except for a parent company and its wholly owned subsidiaries making a combined application for the issuance of a certificate of self-insurance pursuant to the provisions of subrule (6) of this rule, a parent company and its subsidiaries shall not combine or commingle net worth, motor vehicle registrations, or loss reserves for the purpose of qualifying or maintaining qualification for a certificate of self-insurance pursuant to these rules.

(6) A parent company and its wholly owned subsidiaries may make a combined application for the issuance of a certificate of self-insurance if either of the following provisions is satisfied:

(a) Both the parent company and each wholly owned subsidiary included in the combined application otherwise meet the qualifications for the issuance of a certificate of self-insurance set forth in this rule.

(b) Both of the following conditions are met:

- (i) Both the parent company and each wholly owned subsidiary included in the combined application enter into a written indemnity agreement jointly and severally binding each entity for any liability under the no-fault law, the financial responsibility law contained in chapter V of the Michigan vehicle code, and these rules. The language and form of the written agreement must be approved by the director.
- (ii) For each wholly owned subsidiary included in the combined application, the parent company guarantees in writing its subsidiary's liability for payment of benefits under the no-fault law, the financial responsibility law contained in chapter V of the Michigan vehicle code, and these rules. The form and substance of the guarantees must be approved by the director.

R 257.533 Application; form; completeness; signature; effective date; accompanying documents.

- Rule 3. (1) A person who seeks to qualify as a self-insurer or renew his or her certificate of self-insurance shall submit an application for a certificate of self-insurance to the director on a form prescribed by the director and available on the department of insurance and financial services website.
- (2) The application for a certificate of self-insurance must contain complete answers to all questions and must be signed by the person who makes the application or by the applicant's duly authorized representative.
- (3) An application must be submitted to the director not less than 45 days before the desired effective date of the certificate.
- (4) An application must be accompanied by all of the following documents:
- (a) A statement of financial condition that has been prepared in accordance with generally accepted accounting practices and principles, that has been certified by a certified public accountant, and that covers at least a 1-year period ending not more than 12 months before the date of application. The director may request more recent unaudited financial statements be filed with the application.
 - (b) A copy of the declaration sheet of any policy of excess insurance.
 - (c) Either of the following:
 - (i) A written estimate of loss reserve that is prepared by a qualified actuary.
 - (ii) A written estimate of loss reserve that is prepared by a qualified employee of a casualty insurance company.
 - (d) A copy of a written authorization that designates a specified employee of the applicant, or another authorized person, to receive and process claims that are submitted to the applicant.
 - (e) A copy of a claim form that is used by a person who submits a claim to the applicant for benefits due to suffering accidental bodily injury or property damage arising out of the ownership, operation, maintenance, or use of a motor vehicle that is registered or owned by the applicant.
 - (f) A list of all motor vehicles that are registered in this state in the name of the applicant at the time of application or that are to be self-insured under a certificate of self-insurance issued to the applicant as determined at the time of application. The vehicles must be identified by all of the following:
 - (i) Make.
 - (ii) Model.
 - (iii) Year.
 - (iv) Vehicle identification number (VIN).
 - (v) Registration number.
 - (g) A written policy and procedure or detailed description on how claims will be processed and paid in a timely manner.
- (5) A claim form that accompanies an application must include all of the following information:
- (a) A statement of a claimant's right to personal protection insurance benefits, property protection insurance benefits, and residual liability insurance benefits under the no-fault law.
 - (b) A statement of a self-insurer's responsibility to pay claims in a timely manner.

(c) An instruction that directs claimants to contact the director concerning a self-insurer's failure to fulfill its responsibilities under the no-fault law.

R 257.534 Application; review; hearing; certificate duration; renewals.

Rule 4. (1) Upon receipt of a complete application for an original certificate of self-insurance, the director shall promptly review the application and all supporting documents. Within 45 days after receipt, the director shall notify the applicant that the application has been approved or denied.

(2) If an application has been denied, the applicant may request an administrative hearing to review the denial. This hearing must be conducted in accordance with the procedures set forth in R 257.539. The director shall affirm or reverse the denial based upon the record made at the hearing.

(3) If an applicant meets the qualifications for receipt of a certificate of self-insurance, the director shall issue the applicant a formal certificate that indicates that status as a self-insurer is conferred. An original certificate of self-insurance will expire 1 year after the effective date of the certificate.

(4) A self-insurer may apply for a renewal certificate of self-insurance by submitting a complete renewal application 45 days before the expiration of the previously issued certificate. The renewal application must be accompanied by the documents required pursuant to the provisions of R 257.533(4). The director shall promptly review the renewal application and all supporting documents. Within 30 days after receipt, the director shall notify the applicant that the renewal application has been approved or denied.

(5) If a renewal application has been denied, the applicant may request an administrative hearing to review the denial. This hearing must be conducted in accordance with the procedures set forth in R 257.539. The director shall affirm or reverse the denial based upon the record made at the hearing.

(6) If a renewal application is submitted and approved, the existing certificate of self-insurance will be extended for 1 year from the date of expiration. A renewal application that is submitted after the expiration of the previously issued certificate is considered an application for an original certificate of self-insurance.

R 257.535 Additional reports.

Rule 5. The director may require a self-insurer or applicant to submit additional reports, including an accident and claim activity report or a statement of claims and losses, and any relevant additional information that is necessary to determine the continuing ability of the self-insurer or applicant to pay present and future claims. Any additional report, statement, or information that is required must be made upon a form that is prescribed by the director and is due not later than 30 days after being requested by the director. If the director does not receive the additional report, statement, or information within the 30-day period, the self-insurer's certificate of self-insurance may be canceled or the applicant's application for a certificate of self-insurance may be denied.

R 257.536 Loss reserve; use; amount; funding; expenditures; commingling; trust or escrow account.

Rule 6. (1) A loss reserve must be utilized to pay claims that are anticipated during the certification year and that are submitted for payment during that year and to pay claims that have been incurred and submitted before the certification year, but have not yet been paid by the applicant or self-insurer.

(2) Except as provided in subrule (7) of this rule, a fully funded loss reserve consists of an amount of money or investment grade securities that can be liquidated for face value, as determined by a qualified actuary, or as determined by a qualified employee of a casualty insurance company, that is sufficient to compensate claimants for all benefits that are due for claims that are to be paid or that are anticipated to

be paid during the certification year and all benefits that are due for claims incurred before the certification year, but are to be paid or are anticipated to be paid during the certification year, including all benefits that may be due during the certification year for claims that can be anticipated or are incurred but not reported, exclusive of that portion of any claim that is covered by excess insurance.

(3) Before the beginning of a certification year, an applicant or self-insurer shall fully fund its loss reserve account.

(4) Loss reserve funds must only be expended to pay claims that are incurred and submitted under the no-fault law, the financial responsibility law contained in chapter V of the Michigan vehicle code, and these rules.

(5) Loss reserve funds must be kept in a segregated account and must not be commingled with other funds of the applicant or self-insurer. The funds must be physically located in this state unless otherwise approved by the director and may be maintained in a financial institution, in an escrow account, under a trust agreement, or by the applicant or self-insurer individually. With prior approval of the director, the loss reserve may be commingled for applicants with net worth of more than \$50,000,000.00 and sufficient liquidity.

(6) For a governmental unit that has the authority to tax, a fully funded loss reserve consists of an amount of money that is included in the budget or reserve accounts of the governmental unit for the fiscal year, which includes its certification year, as determined by a qualified actuary, or as determined by a qualified employee of a casualty insurance company, and that is sufficient to compensate claimants for all benefits that are due for claims that are to be paid or that are anticipated to be paid during the certification year and all benefits that are due for claims that are incurred before the certification year, but are to be paid or are anticipated to be paid during the certification year, including all benefits that may be due during the certification year for claims that can be anticipated or are incurred but not reported, exclusive of that portion of any claim that is covered by excess insurance.

R 257.537 Excess insurance; conditions for compliance.

Rule 7. The director shall not recognize a contract or policy of excess insurance in considering the ability of an applicant to fulfill its financial obligations under the no-fault law or the financial responsibility law contained in chapter V of the Michigan vehicle code, unless the contract or policy is in compliance with all of the following requirements:

(a) Is issued by a casualty insurance company.

(b) Is not cancelable or nonrenewable, unless the party that desires to cancel or not renew the policy gives written notice, by registered or certified mail, to the other party to the policy and to the director not less than 30 days before termination of the policy.

(c) Does not contain policy coverage exceptions or exclusions, or any other policy provisions, that are not in compliance with the no-fault law, the Michigan vehicle code, and these rules.

(d) Does not contain a commutation clause, unless the clause provides that a commutation does not relieve an underwriter of further liability either in respect to claims and expenses unknown at the time of the commutation or in respect to any claim that is apparently closed at the time of initial commutation and that is subsequently reopened by, or through, a competent authority. The clause must, in addition, provide for both of the following:

(i) If the underwriter proposes to settle its liability for future claims with respect to accidents that occur during the term of the policy by the payment of a lump sum to the self-insurer, to be fixed as provided in the commutation clause of the policy, then not less than 30 days' prior notice of the commutation must be given to the director by the underwriter or its agent by certified mail.

(ii) If any commutation is effected, then the director may direct that the sum be placed in trust for the benefit of all claimants who are entitled to future payments of compensation.

(e) Contains a clause that provides that if a self-insurer becomes insolvent and is unable to pay claims, the excess insurer shall make, directly to claimants or their authorized representatives, such payments as would have been made by the excess carrier to the self-insurer after it has been determined that the retention level has been reached on the excess insurance contract.

R 257.538 Denial or cancellation of certificate; certificates issued before effective date of rules.

Rule 8. (1) The director may disapprove an application for a certificate of self-insurance if the applicant fails to possess a qualification for the issuance of a certificate of self-insurance as set forth in R 257.532.

(2) The director may cancel a certificate of self-insurance if any of the following provisions applies to a self-insurer:

(a) Fails to pay a judgment that is rendered against the self-insurer upon a cause of action arising out of the ownership, operation, maintenance, or use of any motor vehicle, as defined in the Michigan vehicle code or the no-fault law, within 30 days after the judgment becomes final.

(b) Fails to pay an assessment bill that is issued pursuant to the provisions of section 3171 of the no-fault law within 30 days after billing.

(c) Fails to pay personal protection insurance benefits to which a claimant is entitled under the no-fault law within 30 days after the receipt of reasonable proof of the loss and the amount of loss.

(d) Files a petition in bankruptcy or is declared bankrupt by a federal court.

(e) Is placed in receivership, declared insolvent, or ordered dissolved or liquidated by a state court or has a financial manager appointed by the governor or any substantially equivalent action taken.

(f) Commits an act that would jeopardize the self-insurer's ability to pay claims that are filed with, or judgments that are obtained against, the self-insurer.

(g) Fails to continuously possess any qualification for a certificate of self-insurance as described in R 257.532 or fails to comply with any other provision of these rules.

(h) The director has reasonable grounds to believe that any information that is submitted by an applicant or self-insurer and that is contained in any application, renewal, document, statement, or report that is required pursuant to these rules is false.

R 257.539 Administrative hearing.

Rule 9. (1) An administrative hearing that is conducted with regard to the denial of an application for a certificate of self-insurance, or before the cancellation of a certificate of self-insurance pursuant to the provisions of section 3101d of the no-fault law must be conducted pursuant to these rules, the procedures set forth in chapter 4 of 1969 administrative procedures act of 1969, 1969 PA 306, MCL 24.271 to MCL 24.287, and R 500.2101 to R 500.2142.

(2) Before the commencement of any proceeding with regard to the denial of a renewal application or the cancellation of a certificate of self-insurance, the director shall afford an applicant or self-insurer an opportunity to demonstrate compliance pursuant to section 92 of 1969 PA 306, MCL 24.292.

R 257.540 Proof of insurance.

Rule 10. A person whose certificate of self-insurance has been canceled or whose renewal application has been denied shall immediately obtain a policy of insurance that affords security for the payment of benefits as required by the no-fault law for each motor vehicle that is required to be registered by the person in this state and shall provide proof of insurance to the director and the secretary of state.

ADMINISTRATIVE RULES

DEPARTMENT OF TREASURY

COMMISSIONER OF THE BUREAU OF STATE LOTTERY

LOTTERY

Filed with the Secretary of State on March 5, 2018

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, 45a(6), or 48 of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

(By authority conferred on the commissioner of Bureau of State Lottery by section 11 of 1972 PA 239, MCL 432.11)

R 432.2, R 432.5, R 432.6, R 432.16, and R 432.17 of the Michigan Administrative Code are amended as follows:

R 432.2 Employees and contractors.

Rule 2. (1) None of the individuals referred to in section 31 of the act may have any interest, direct or indirect, in dealing in the lottery or in the ownership or leasing of any property or premises used by or for the lottery.

(2) An individual or organization or employees of an organization under contract with the bureau is not eligible to win any prize in any lottery operated by the bureau during the period of the contract if the individual, organization, or employee has access to any of the following that is not open to the general public:

- (a) Bureau data.
- (b) Books and records.
- (c) Electronic data processing programs.
- (d) Systems designs.
- (e) Other information.

R 432.5 License fee.

Rule 5. (1) The commissioner shall determine the fee for a license as a retailer. The fee is payable at the time of license application.

(2) The bureau may charge a license renewal fee annually in an amount determined by the commissioner.

(3) The fees in subrules (1) and (2) of this rule shall not exceed the actual cost to the bureau.

R 432.6 Conditions of licensing.

Rule 6. (1) Upon issuance of a license, the agent shall agree that he or she will do all of the following:

- (a) Be bound by and comply with the act, these rules, and instructions and directives of the commissioner or bureau.
 - (b) Make tickets available for sale to the public during normal business hours.
 - (c) Not purchase any winning ticket from its original purchaser or from subsequent purchasers.
 - (d) Maintain authorized displays, notions, drop boxes, and other material used in conjunction with sales in accordance with instructions issued by the bureau.
 - (e) Act in a fiduciary capacity with respect to all tickets accepted from the bureau or its authorized distributors until payment has been made.
 - (f) Maintain current and accurate records of all operations in conjunction with sales in conformity with rules, instructions, and directives of the bureau. The agent shall make the records available to representatives of the bureau upon request for inspection and audit.
 - (g) Ensure that a person under 18 years of age does not sell tickets or pay winning tickets.
 - (h) Ensure that tickets will not be sold at any price greater than the price stated on the ticket.
 - (i) Hold the bureau and the state harmless from any liability arising in connection with sales.
 - (j) Remit funds due for lottery sales and other amounts owing to the bureau at the time and in the manner specified by the bureau.
 - (k) Validate all winning tickets through the bureau gaming system and pay customers the full prize value of validated winning tickets up to the retailer's cashing limit as determined by the commissioner.
- (2) Subrule (1)(b) of this rule does not apply to retailers who are considered "exempt from taxation" under Section 501(c) of the Internal Revenue Code, 26 U.S.C. §1 et seq., but only to the extent such retailers are restricted from making lottery sales to the general public as a condition of maintaining their status as "exempt from taxation."

R 432.16 Claiming of prizes.

Rule 16. (1) The commissioner shall designate claim centers for the lottery program and advertise their locations.

(2) The processing of winning tickets must be in accordance with directives and instructions issued by the commissioner. If a special drawoff is required to determine the exact amount won, then the bureau shall notify the claimant when and where to appear for the drawoff and where to present his or her winning ticket for validation.

(3) Mutilated tickets shall be validated only if adequate portions of the ticket remain reasonably intact to ensure the authenticity of the ticket.

(4) A claimant shall fill out a claim form, present the form with the winning ticket, and receive a copy of the claim form as his or her receipt.

(5) A winning ticket may only be claimed by a natural person. Annuitized prize payments may be assigned to a person or entity in accordance with section 25 of the act.

(6) Upon validation of a winning ticket, payment of the amount due shall be forwarded to the claimant in accordance with bureau procedures. If a claim is not validated as proper, then the bureau shall deny the claim and promptly notify the claimant.

R 432.17 Ownership of lottery tickets.

Rule 17. (1) A valid lottery ticket that has been sold by a licensed retailer is presumed to be owned by the person whose name is entered on the claim form, notwithstanding that the name of another person may appear on the ticket face or reverse side. Except as provided in subrule (2) of this rule, the bureau shall pay a prize to the person whose name is entered on the claim form or present the prize to a third

party who is authorized, in writing, as the claimant's representative. All liability of the bureau, the state, their employees and agents terminates upon payment.

(2) Upon receipt of information supported by proper evidence that another person is entitled to payment, or upon assertion that the ticket was not legally issued initially, the commissioner may withhold payment pending an investigation. If the ownership of a winning lottery ticket is disputed and the results of the commissioner's investigation are inconclusive, then the commissioner may initiate an appropriate judicial proceeding to determine ownership.

(3) The claimant of a lottery prize shall not assign or sell his or her right to any prize except as provided for by law. The commissioner shall develop policies, procedures, and fee schedules for the disposition of a claimant's rights to future payments.

(4) The prize for a winning ticket must be claimed by the expiration date printed, or as defined, on the ticket.

ADMINISTRATIVE RULES

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

DIRECTOR'S OFFICE

BOARD OF NURSING - GENERAL RULES

Filed with the Secretary of State on March 8, 2018

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, or 45(a)(6) of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

(By authority conferred on the director of the department of licensing and regulatory affairs by section 16145(3) and 17201 of 1978 PA 368, MCL 333.16145(3) and 333.17201 and Executive Reorganization Order Nos. 1996-1, 1996-2, 2003-1, and 2011-4, MCL 330.3101, 445.2001, 445.2011, and 445.2030)

R 338.10204, R 338.10207, R 338.10208, R 338.10209, R 338.10210, R 338.10212, R 338.10213, R 338.10301, R 338.10303, R 338.10303a, R 338.10303b, R 338.10303c, R 338.10305, R 338.10305a, R 338.10305b, R 338.10305c, R 338.10306, R 338.10307, R 338.10308, R 338.10309, R 338.10310, R 338.10401, R 338.10403, R 338.10601, R 338.10602, R 338.10702, R 338.10703, R 338.10704 of the Michigan Administrative Code are amended, and R 338.10303d, R 338.10404c, and R 338.10405c are added to the Code to read as follows:

PART 2. LICENSURE

R 338.10204 Examinations; registered professional nurse; eligibility; reexaminations.

Rule 204. (1) To determine eligibility for the examination, an applicant shall submit a completed application on forms provided by the department, together with the requisite fee.

(2) To be eligible to take the NCLEX-RN examination, an applicant shall establish that he or she has successfully completed a registered nurse education program that satisfies 1 of the following:

(a) The applicant has successfully completed a registered professional nurse education program that is located in this state and is approved by the board.

(b) The applicant has successfully completed a registered professional nurse education program that is located in another state of the United States, as required by section 16186(1) of the code, MCL 333.16186(1), and that program is substantially equivalent to the program requirements of article 15 of the code, MCL 333.16101 to 333.18838, and the rules promulgated by the board.

(c) The applicant is a graduate of a registered professional nurse education program or an equivalent education program that is outside the United States and has been certified pursuant to R 338.10208 by the Commission on Graduates of Foreign Nursing Schools (CGFNS) or its successor agency, to have substantially similar education credentials as a program approved by the board.

(3) An applicant for licensure as a registered professional nurse shall comply with all of the following:

(a) Take the NCLEX-RN examination within 2 years of graduation from a registered nurse education program or after obtaining certification from the certification program of the CGFNS.

(b) Successfully pass the NCLEX-RN examination within 12 months of the first examination attempt in this state or another state. An applicant who has not successfully passed this examination shall comply with the following provisions:

(i) An applicant who did not pass the NCLEX-RN examination on any attempt shall wait 45 days before taking the examination again.

(ii) An applicant who did not pass the NCLEX-RN examination by the third attempt is not eligible to repeat the examination until he or she has completed an approved NCLEX-RN review course with content pertaining specifically to the registered nurse scope of practice.

(iii) An applicant shall submit to the department, prior to retesting, documentation of having completed an approved NCLEX-RN review course.

(iv) An applicant who has completed the NCLEX-RN review course may sit for the NCLEX-RN examination a maximum of 3 times after completion of the review course.

(c) An applicant who has not passed the NCLEX-RN examination after attempting the examination 6 times within 2 years of the first attempt shall repeat an entire registered professional nurse education program that has been approved by the board pursuant to R 338.10303a and is in compliance with R 338.10303b.

(4) “Approved NCLEX-RN review course” means 1 of the following:

(a) A review course sponsored by a nursing education program that is approved by the board pursuant to R 338.10303a and is in compliance with R 338.10303b.

(b) A review course sponsored by 1 of the following providers:

(i) Assessment Technologies Institute Nursing Education.

(ii) Elsevier/Health Education System Incorporated.

(iii) Hurst Review Services.

(iv) Kaplan.

(v) National Council of State Boards of Nursing.

(c) A college or university provided NCLEX-RN review course that is approved by another state board of nursing.

(d) A review course approved by the board.

R 338.10207 Lapsed registered professional nurse license; relicensure requirements.

Rule 207. An applicant for relicensure whose Michigan registered professional nurse license has lapsed, under the provisions of section 16201(3) or (4) of the code, MCL 333.16201(3) or (4), as applicable, may be relicensed by complying with the following requirements as noted by (√):

(1) For a registered professional nurse who has let his or her Michigan license lapse and who is not currently licensed in another state:	Lapsed 0-3 Years	Lapsed more than 3 years, but less than 7 years	Lapsed 7 or more years
(a) Application and fee: Submit a completed application on a form provided by the department, together with the requisite fee.	√	√	√
(b) Establish that he or she is of good moral character as defined under section 7 of 1974 PA 381, MCL 338.41 to 338.47.	√	√	√
(c) Submit fingerprints as required under section 16174(3) of the code, MCL 333.16174(3).		√	√

<p>(d) Continuing education: Submit proof of having completed 25 hours of continuing education in courses and programs approved by the board, including at least 2 hours in pain and symptom management, all of which were earned within the 2-year period immediately preceding the application for relicensure.</p>	<p>√</p>		
<p>(e) Continuing education: Submit proof of having completed 25 hours of continuing education in courses and programs approved by the board, including at least 2 hours in pain and symptom management, with a minimum of 3 hours in each of the following areas, all of which were earned within the 2-year period immediately preceding the application for relicensure:</p> <ul style="list-style-type: none"> (i) Safe documentation for nurses. (ii) Critical thinking skills for nurses. (iii) Pharmacology. (iv) Preventing medication errors. (v) Professional and legal accountability for nurses. (vi) Delegation. 		<p>√</p>	<p>√</p>
<p>(f) Certification of skill competency: Within 3 years of the period immediately preceding the application for relicensure, receive written certification of skill competency from a nurse education program approved pursuant to R 338.10303a. Certification of competency must cover the following skills:</p> <ul style="list-style-type: none"> (i) Head-to-toe physical assessment, including vital signs. (ii) Medication administration. (iii) Documentation. (iv) Surgical asepsis and infection control. (v) Safety, including fall prevention, body mechanics, and transfers. 		<p>√</p>	<p>√</p>
<p>(g) NCLEX-RN Examination: Within 3 years of the period immediately following approval of the application for relicensure, retake and pass the NCLEX-RN examination.</p>			<p>√</p>
<p>(h) Proof of license verification from another state: An applicant's license shall be verified by the licensing agency of all other states of the United States in which the applicant ever held a license as a registered professional nurse. Verification shall include the record of any disciplinary action taken or pending against the applicant.</p>	<p>√</p>	<p>√</p>	<p>√</p>

(2) For a registered professional nurse who has let his or her Michigan license lapse, but who holds a current and valid registered professional nurse license in another state:	Michigan license Lapsed 0-3 Years	Michigan license Lapsed more than 3 years, but less than 7 years	Michigan license Lapsed 7 or more years
(a) Application and fee: Submit a completed application on a form provided by the department, together with the requisite fee.	√	√	√
(b) Establish that he or she is of good moral character as defined under sections 1 to 7 of 1974 PA 381, MCL 338.41 to 338.47.	√	√	√
(c) Submit fingerprints as required under section 16174(3) of the code, MCL 333.16174(3).		√	√
(d) Continuing education: Submit proof of completion of 25 hours of continuing education, including at least 2 hours in pain and symptom management, earned within the 2-year period immediately preceding the application for relicensure.		√	√
(e) Proof of license verification from another state: An applicant's license shall be verified by the licensing agency of all other states of the United States in which the applicant holds a current license or ever held a license as a registered professional nurse. Verification shall include the record of any disciplinary action taken or pending against the applicant.	√	√	√

R 338.10208 Graduate from non-accredited program; graduate from non-board approved program; registered professional nurse program; requirements.

Rule 208. (1) Except as provided in subrules (3) and (4) of this rule, if the applicant is a graduate of a registered professional nurse education program that is located outside of the United States, the applicant shall have his or her nursing education reviewed and certified by the Certification Program of the CGFNS or its successor agency. Certification from CGFNS is required before receiving authorization from the department to take the NCLEX-RN examination under R 338.10204. Information about the certification program can be obtained from the CGFNS website at www.cgfns.org.

(2) If an applicant's educational program was taught in a language other than English, an applicant shall demonstrate a working knowledge of the English language by obtaining a score of not less than 83 on the Test of English as a Foreign Language Internet-Based Test (TOEFL IBT) administered by the Educational Testing Service.

(3) If the applicant is a graduate of a registered professional nurse education program that is located outside of the United States, has passed the NCLEX-RN examination, and has maintained an active

license with no disciplinary sanctions in the United States for at least 5 years immediately preceding the application for a Michigan license, then the applicant shall be exempt from completing the nursing education review and certification process through the Certification Program of the CGFNS.

(4) If the applicant is a graduate of a Canadian registered nurse education program that is approved by a province in Canada, then the applicant shall be exempt from completing the nursing education review and certification process through the certification program of the CGFNS if all of the following are met:

- (a) The registered nurse education program was taught in English.
- (b) The applicant has a current active license to practice nursing in Canada.
- (c) The applicant has not been sanctioned by the applicable Canadian nursing authority.

R 338.10209 Licensure by examination; licensed practical nurse; requirements.

Rule 209. (1) An applicant for licensure by examination shall submit a completed application on a form provided by the department, together with the requisite fee. In addition to meeting the other requirements of the code and the administrative rules promulgated pursuant to the code, an applicant shall satisfy the requirements of this rule.

(2) An applicant for a licensed practical nurse license shall establish that he or she meets the eligibility requirements to sit for the NCLEX-PN examination set forth in R 338.10210 and shall pass the NCLEX-PN examination.

(3) An applicant for licensure shall comply with section 16174(3) of the code, MCL 333.16174(3), and submit his or her fingerprints to the department of state police to have a criminal history check conducted by the state police and the federal bureau of investigation.

R 338.10210 Examinations; licensed practical nurse; eligibility; reexaminations.

Rule 210. (1) To determine eligibility for the examination, an applicant shall submit a completed application on forms provided by the department, together with the requisite fee.

(2) To be eligible to take the NCLEX-PN examination, an applicant shall establish that he or she has successfully completed a licensed practical nurse education program that satisfies 1 of the following:

(a) The applicant has successfully completed a practical nurse education program that is located in this state and is approved by the board.

(b) The applicant has successfully completed a practical nurse education program that is located in another state of the United States, as required by section 16186(1) of the code, MCL 333.16186(1), and that program is substantially equivalent to the program requirements of article 15 of the code, MCL 333.16101 to 333.18838, and the rules promulgated by the board.

(c) The applicant is a graduate of a practical nurse education program or an equivalent program that is located outside the United States and has been certified by either the CGFNS, the National Association of Credential Evaluation Services (NACES), or their successor agencies, to have substantially similar education credentials as a program approved by the board.

(d) The applicant has successfully completed a registered nurse education program that meets the requirements of R 338.10204(2). The applicant shall be certified to take the NCLEX-PN examination by a practical nurse program that is approved by the board pursuant to subdivision (a) of this subrule.

(3) An applicant for licensure as a licensed practical nurse shall comply with all of the following:

(a) Take the NCLEX-PN examination within 2 years of graduation from a practical nurse education program.

(b) Successfully pass the NCLEX-PN examination within 12 months of the first examination attempt in this state or another state. An applicant who has not successfully passed this examination shall comply with the following provisions:

(i) An applicant who did not pass the NCLEX-PN examination on any attempt shall wait 45 days before taking the examination again.

(ii) An applicant who did not pass the NCLEX-PN examination by the third attempt is not eligible to repeat the examination until he or she has completed an approved NCLEX-PN review course with content pertaining specifically to the licensed practical nurse scope of practice

(iii) An applicant shall submit to the department, prior to retesting, documentation of having completed an approved NCLEX-PN review course.

(iv) An applicant who has completed the NCLEX-PN review course may sit for the NCLEX-PN examination a maximum of 3 times after completion of the review course.

(c) An applicant who has not passed the NCLEX-PN examination after attempting the examination 6 times within 2 years of the first attempt shall repeat an entire practical nurse education program that has been approved by the board pursuant to R 338.10303a and is in compliance with R 338.10303b.

(4) “Approved NCLEX-PN review course” means 1 of the following:

(a) A review course sponsored by a nursing education program that is approved by the board pursuant to R 338.10303a and is in compliance with R 338.10303b.

(b) A review course sponsored by 1 of the following providers:

(i) Assessment Technologies Institute Nursing Education.

(ii) Elsevier/Health Education system Incorporated.

(iii) Hurst Review Services.

(iv) Kaplan.

(v) National Council of State Boards of Nursing.

(c) A college or university provided NCLEX-PN review course that is approved by another state board of nursing.

(d) A review course approved by the board.

R 338.10212 Graduate of non-accredited program; licensed practical nurse; requirements.

Rule 212. (1) Except as provided in subrule (2) of this rule, if the applicant is a graduate of a licensed practical nurse education program that is located outside of the United States, the applicant shall have his or her nursing education reviewed and certified by either a credentialing agency that is accredited by the National Association of Credential Evaluation Services (NACES) or through the Credential Evaluation Service (CES) of the Commission on Graduates of Foreign Nursing Schools (CGFNS) or their successor agencies. Certification from these agencies is required before receiving authorization from the department to take the NCLEX-PN examination under R 338.10209. The list of NACES approved credentialing agencies can be found on its website at www.naces.org. Information about CES can be obtained from the CGFNS website at www.cgfns.org.

(2) If the applicant is a graduate of a licensed practical nurse education program that is located outside of the United States, has passed the NCLEX-PN examination, and has maintained an active license with no disciplinary sanctions in this country for at least 5 years immediately preceding the application for a Michigan license, then the applicant shall be exempt from completing the nursing education review and certification process through either a credentialing agency that is accredited by NACES or through the Credentials Evaluation Service (CES) of the CGFNS.

(3) If an applicant's licensed practical nurse educational program was taught in a language other than English, an applicant shall demonstrate a working knowledge of the English language by obtaining a score of not less than 83 on the Test of English as a Foreign Language Internet-Based Test (TOEFL IBT) administered by the Educational Testing Service.

(4) If an applicant is a graduate of a Canadian registered nurse education program that is approved by a province in Canada, the applicant shall be exempt from completing the nursing education review and certification process through either a credentialing agency that is accredited by NACES or through the CES of the CGFNS provided that all of the following are met:

(i) The registered nurse education program was taught in English.

- (ii) The applicant has a current active license to practice nursing in Canada.
- (iii) The applicant has not been sanctioned by the applicable Canadian nursing authority.

R 338.10213 Lapsed licensed practical nurse license; relicensure requirements.

Rule 213. An applicant for relicensure whose Michigan licensed practical nurse license has lapsed under the provisions of section 16201(3) or (4) of the code, MCL 333.16201(3) or (4), may be relicensed by complying with the following requirements as noted by (√):

(1) For a licensed practical nurse who has let his or her Michigan licensed practical nurse license lapse and who is not currently licensed in another state:	Lapsed 0-3 Years	Lapsed more than 3 years, but less than 7 years	Lapsed 7 or more years
(a) Application and fee: Submit a completed application on a form provided by the department, together with the requisite fee.	√	√	√
(b) Establish that he or she is of good moral character as defined under sections 1 to 7 of 1974 PA 381, MCL 338.41 to 338.47.	√	√	√
(c) Submit fingerprints as set forth in section 16174(3) of the code, MCL 333.16174(3).		√	√
(d) Continuing education: Submit proof of having completed 25 hours of continuing education in courses and programs approved by the board, including at least 2 hours in pain and symptom management, all of which were earned within the 2-year period immediately preceding the application for relicensure.	√		
(e) Continuing education: Submit proof of having completed 25 hours of continuing education in courses and programs approved by the board, including at least 2 hours in pain and symptom management, with a minimum of 3 hours in each of the following areas, all of which were earned within the 2-year period immediately preceding the application for relicensure: (i) Safe documentation for nurses. (ii) Critical thinking skills for nurses. (iii) Pharmacology. (iv) Preventing medication errors. (v) Professional and legal accountability for nurses.		√	√
(f) Certification of skill competency: Within 3 years of the period immediately preceding the application for relicensure, receive written certification of skill competency from a nurse education program approved pursuant to R 338.10303a. Certification of competency must		√	√

<p>cover the following skills:</p> <p>(i) Head-to-toe physical assessment, including vital signs.</p> <p>(ii) Medication administration.</p> <p>(iii) Documentation.</p> <p>(iv) Surgical asepsis and infection control.</p> <p>(v) Safety, including fall prevention, body mechanics, and transfers.</p>			
<p>(g) NCLEX-PN Examination: Within 3 years of the period immediately following approval of the application for relicensure, retake and pass the NCLEX-PN examination.</p>			√
<p>(h) Proof of license verification from another state: An applicant's license shall be verified by the licensing agency of all other states of the United States in which the applicant ever held a licensed as a licensed practical nurse. If applicable, verification shall include the record of any disciplinary action taken or pending against the applicant.</p>	√	√	√

(2) For a licensed practical nurse who has let his or her Michigan license lapse, but who holds a current and valid licensed practical nurse license in another state:	Michigan license lapsed 0-3 Years	Michigan license lapsed more than 3 years, but less than 7 years	Michigan license lapsed 7 or more years
(a) Application and fee: Submit a completed application on a form provided by the department, together with the requisite fee.	√	√	√
(b) Establish that he or she is of good moral character as defined under sections 1 to 7 of 1974 PA 381, MCL 338.41 to 338.47.	√	√	√
(c) Submit fingerprints as set forth in section 16174(3) of the code, MCL 333.16174(3).		√	√
(d) Continuing education: Submit proof of completion of 25 hours of continuing education, including at least 2 hours in pain and symptom management, all of which was earned within the 2-year period immediately preceding the application for relicensure.		√	√
(e) Proof of license verification from another state: An applicant's license shall be verified by the licensing agency of all other states of the United States in which the applicant holds a current license or ever held a licensed as a licensed practical nurse. If applicable, verification shall include the record of	√	√	√

any disciplinary action taken or pending against the applicant.			
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PART 3. NURSING EDUCATION PROGRAMS

R 338.10301 Definitions.

Rule 301. As used in this part:

- (a) "Clinical experience" means direct nursing care experiences with patients or clients that offer students the opportunity to integrate, apply, and refine specific skills and abilities that are based on theoretical concepts and scientific principles. Clinical experience may include simulated nursing experiences.
- (b) "Clinical laboratory hours" means those hours of the curriculum which are assigned to laboratory practice, basic skills training, and observational experiences which offer the student the opportunity to meet educational outcomes.
- (c) "Cohort" means a group of students admitted in the same academic semester or term with the intention of completing the nursing program at the same graduation date. This includes students who transfer into the program at the same academic level.
- (d) "Conceptual framework" means the distinct, systematic organization of concepts and planned student outcomes of the program that are consistent with relevant professional nursing standards and the mission, goals, philosophy, and purposes of the sponsoring institution, and which gives direction to the curriculum.
- (e) "Cooperating agency" means an individual, organization, or institution which, by written agreement or letter of intent, accepts students and faculty for nursing educational experiences.
- (f) "Core curriculum for licensed practical nurse applicants" means courses in didactic instruction and planned clinical experience, which encompass the LPN scope of practice, in each of the following areas of nursing:
 - (i) Adult health nursing, which consists of the study of nursing care throughout the adult lifespan; providing care for the acute or chronic phases of a medical illness; providing care before, during, and after a surgical procedure; health promotion; and disease prevention.
 - (ii) Maternal and reproductive nursing must consist of the study of nursing care for women and their families in the gynecological, antepartum, labor and delivery, and postpartum phases of pregnancy, and includes the care of the newborn infant.
 - (iii) Children's nursing must consist of the study of nursing care for children whose ages range from birth through adolescence and who are receiving nursing care for both medical and surgical reasons.
 - (iv) Surgical nursing, which consists of the study of nursing care throughout the adult lifespan, providing care before, during, and after a surgical procedure, health promotion, and disease prevention.
- (g) "Core curriculum for registered professional nurse applicants" means courses in didactic instruction and planned clinical experience, which encompass the RN scope of practice, in each of the following areas of nursing:
 - (i) Adult health nursing, which consists of the study of nursing care throughout the adult lifespan; providing care for the acute or chronic phases of a medical illness; providing care before, during, and after a surgical procedure; health promotion; and disease prevention.
 - (ii) Maternal and reproductive nursing must consist of the study of nursing care for women and their families in the gynecological, antepartum, labor and delivery, and postpartum phases of pregnancy, and includes the care of the newborn infant.

(iii) Children’s nursing must consist of the study of nursing care for children whose ages range from birth through adolescence and who are receiving nursing care for both medical and surgical reasons.

(iv) Mental health nursing, which consists of the nursing care of patients who are receiving nursing care for an acute or chronic psychiatric disorder or physical disorder and shall not be limited only to areas of physical disorders that cause impaired mental function or neurological diseases.

(v) Surgical nursing, which consists of the study of nursing care throughout an adult lifespan, providing care before, during, and after a surgical procedure, health promotion, and disease prevention.

(h) “Course student learning outcomes” means statements of educational expectations written in measurable terms for the knowledge, skills, or behaviors students should demonstrate by the end of the course. The statements should reflect contemporary evidence-based nursing practice and enhance achievement of end of program student learning outcomes.

(i) “Curriculum” means implementation of the philosophy, purposes, program outcomes, and conceptual framework of the nursing program through the systematic arrangement of courses, including outcomes stated in measurable terms and accomplished through appropriate learning experiences planned for a clearly defined group of students and extending over a period of time. Systematic and ongoing evaluation within the context of measurable outcomes is inherent in the curriculum.

(j) “End of program student learning outcomes” means statements of educational expectations written in measurable terms for the knowledge, skills, or behaviors students should demonstrate by the end of the program. The statements should reflect professional standards, guidelines, contemporary nursing practice, guide the curriculum, and increase in complexity as students progress through the curriculum.

(k) “Final approval report” means a self-study done after the graduation of the second cohort and before the graduation of the fourth cohort that is submitted to the board when the program is seeking full program approval.

(l) “Full program approval” means approval of a program granted after satisfactory demonstration to the board of compliance with these rules.

(m) “Initial approval” means approval that is granted by the board to inaugurate a program of nursing education.

(n) “Instruction” means educational methodology for achieving curriculum outcomes.

(o) “Learning experiences” means planned learning situations, which may include clinical experiences, clinical laboratory hours, or classroom instruction.

(p) “Major program change” means any of the following:

(i) Revision of the program’s philosophy, conceptual framework, curriculum, program outcomes, student learning outcomes, or changes that increase the use of simulation more than 10% of the total clinical hours in a program.

(ii) Change in primary instruction delivery methods.

(iii) Elimination of separate course content for an integrated approach.

(iv) A permanent expansion in the number of students served.

(v) Increase or decrease in overall program credits.

(q) “Minor program change” means a change that does not permanently affect the program’s philosophy, conceptual framework, program outcomes, student learning outcomes, approved enrollment numbers, increase simulation experiences by more than 10%, change the primary instruction delivery methods, eliminate a separate course content for an integrated approach, permanently expand the number of students served, or increase or decrease the overall program credits.

(r) “Nurse education consultant” means a nurse with expertise in curriculum development and nursing program administration or education that independently examines a nursing program under disciplinary review.

(s) “National accreditation” means a self-regulatory process that meets or exceeds educational quality standards and criteria set forth by a national nursing accreditation agency.

(t) “Nursing education program report” means a report completed and submitted at the halfway point between the self-study submissions. This report may also be required in the years between the self-study submissions during the program approval phase to provide the board with information as to the program’s admissions, attrition courses, clinical experience, faculty program evaluation, and outcomes.

(u) “Nurse site reviewer” means a nurse with expertise in curriculum development and nursing program administration or education that independently examines a nursing program applying for program approval.

(v) “Nursing process” means the ongoing assessment, analysis, nursing diagnosis, planning, implementation, and evaluation of nursing care.

(w) “Observational experience” means a planned learning situation that is not direct patient care, does not require intervention by the student, meets preplanned stated outcomes, and provides for student evaluation.

(x) “Philosophy” means the stated beliefs of faculty about nursing education and practice that determine the design of the curriculum and the evaluation of the program and that are consistent with the educational philosophy of the sponsoring agency.

(y) “Practical nurse program” means a nursing program to prepare students for practical nurse licensure.

(z) “Preceptor” means an experienced nurse, paired in a 1-to-1 relationship with a nursing student, who actively participates in the education, mentoring, and evaluation of the nursing student in a clinical setting.

(aa) “Probationary status” means the period when a program is under disciplinary action by the board.

(bb) “Program director” means a nurse who is delegated the authority and accountability for the nursing program by the sponsoring agency.

(cc) “Program of nursing education” means a plan or design indicating the relationship of the components necessary to achieve the goal of preparing persons for licensure as registered or practical nurses under the code.

(dd) “Program outcomes” means documented and measurable indicators that reflect the program’s overall effectiveness.

(ee) “Registered professional nurse program” means a nursing program to prepare students for initial registered nurse licensure.

(ff) “Self-study report” means an in-depth written review of all aspects of a nursing education program that contains evidence of the program’s compliance with all the requirements of these rules.

(gg) “Simulation laboratory” means activities that replicate patient care scenarios and are designed to foster clinical decision-making and critical thinking. Scenarios may include the use of medium- or high-fidelity mannequins, standardized patients, role playing, skills stations, and computer-based critical thinking simulations.

(hh) “Site visit” means a physical inspection of an institution and all the components of its program of nursing education for the purpose of determining compliance with the requirements of this part.

(ii) “Sponsoring agency” means the organization or institution of which the nursing program is a component.

R 338.10303 Initial program approval; procedure.

Rule 303. The following requirements are established for initial approval of a program of nursing education:

(a) The sponsoring agency shall submit all of the following to the board:

(i) A letter of intent to initiate a program of nursing education.

(ii) A feasibility study that clearly demonstrates all of the following, with supporting documentation relative to the proposed program location:

- (A) Need for the program.
 - (B) Need for graduates of the proposed program.
 - (C) Availability of students.
 - (D) Impact on all existing nursing education programs in a 50-mile radius of the proposed program.
 - (E) Ability of proposed clinical education sites to provide students with clinical experiences that meet course outcomes, provide students the opportunity to practice skills with individuals or groups across the life span and meet the requirements of R 338.10307(5), (6), (7), and (8). Evidence shall also include documentation of the effect on other schools utilizing the proposed clinical facilities and letters of intent from the proposed clinical education sites, signed by the chief nursing officer, or an equivalent position, outlining the plan to accommodate all of the sponsoring agency's students.
- (iii) Evidence that the mission of the sponsoring agency is consistent with the philosophy and purpose of a program to prepare students for the practice of nursing as defined in section 17201(1)(a) of the code, MCL 333.17201(1)(a).
 - (iv) Evidence that the sponsoring agency will provide funding and other support for the nursing education program that meets all of the following requirements:
 - (A) A 5-year budget in which the first 2 years of the budget do not include tuition and the remaining 3 years of the budget includes tuition.
 - (B) A financial statement prepared by an independent certified public accountant or auditor, a bank line of credit, or a surety bond that equals the total tuition for all students who have been enrolled for 2 years.
 - (C) Submission of evidence that the sponsoring agency will provide appropriate physical facilities and other support services for the nursing education program, in conjunction with other departments in the sponsoring agency, including faculty, administration, and student participation in governance of the sponsoring agency, a grievance or complaint process, counseling, academic advising, career placement, financial aid, and learning resource centers or library.
 - (v) Evidence of approval to provide financial aid for students, under Title IV of the Higher Education Act of 1965, 20 U.S.C. 1070 § 400 et seq.
 - (vi) A sponsoring agency that is an institution requiring approval from the department's proprietary schools unit, or its successor agency, to conduct a nursing education program or to confer a particular degree or certificate upon the graduates of the program shall submit to the board a copy of the approval. A proprietary school shall possess a state-issued license, be in operation for 2 years, offer health-related courses, and demonstrate student success by certifying that exam results meet or exceed state or national averages.
 - (vii) Proposed number of students to be enrolled in the program annually, the number of times that enrollment periods will be held per year, and the dates when enrollment periods will be held annually.
 - (viii) Proposed first date of admission of students to the nursing sequence of the program.
 - (ix) Plans to recruit and employ a program director and other faculty members sufficiently in advance of admitting students to the nursing sequence to ensure consistency in the planning and implementation of the curriculum. If already appointed, the names and qualifications of the director of the program and other faculty members shall be provided.
 - (x) The sponsoring agency shall provide evidence of a tuition policy in which students pay as they proceed through the program either by semesters, terms, units, or other time frame as specified by the sponsoring agency. The sponsoring agency shall also provide evidence of a refund policy that adheres to the refund policies of applicable state, federal, and accrediting agencies.
 - (xi) Evidence that students possess the necessary prerequisite education before admissions to the program. The program shall not be the provider of the prerequisite education, unless it is a state-approved higher educational institution or has the approval of the state to offer prerequisite courses.

(xii) A student contract or enrollment application that outlines the nursing education program's admission requirements, a tuition refund policy that complies with subdivision (a)(x) of this subrule, a withdrawal and failure policy, and academic progression and program completion requirements.

(b) Following initial approval from the board and before admitting the first cohort, the program director shall submit a self-study report to be approved by the board. The report shall set forth evidence of plans for compliance with the following:

- (i) History of sponsoring agency.
- (ii) Philosophy.
- (iii) Conceptual framework.
- (iv) Curriculum to include end of program student learning outcomes and course student learning outcomes.
- (v) Course descriptions and outlines.
- (vi) Signed clinical contracts or letters of commitment for clinical placements.
- (vii) Evaluation methods and tools.
- (viii) Program outcomes.
- (ix) Director and faculty credentials.
- (x) Student policies and support services.

(c) The board may require a site visit to the program by a board-approved nurse site reviewer. A report of the site visit shall be prepared by the nurse site reviewer and provided to the board and the sponsoring agency.

(d) After the first cohort has been admitted and during the initial approval period, the program director shall submit an annual nursing education program report to the board. The nursing education program report shall include information about each of the following:

- (i) Admission, progression, and retention of students.
- (ii) Student achievement on the required licensure examination.
- (iii) Systematic program evaluation results, including, but not limited to, student evaluations, faculty reviews, NCLEX evaluation results, and attrition rates.
- (iv) Program changes.
- (v) Faculty qualifications, assignments, and any faculty exceptions.

R 338.10303a Full program approval; procedure.

Rule 303a. (1) The sponsoring agency may apply to the board for full approval of the program after graduation of the second cohort, but shall apply no later than graduation of the fourth cohort. The sponsoring agency shall comply with the following requirements for full approval of a nursing education program:

- (a) The sponsoring agency shall make application to the board in the form of a letter.
- (b) The sponsoring agency shall submit an updated self-study report to the board. The self-study report shall review the program's progress since initial approval was granted and shall include a review and evaluation of program implementation.
- (c) The board may require a subsequent site visit to the program by a board-approved nurse site reviewer before considering full approval. If conducted, a report of the site visit shall be prepared by the nurse site reviewer and provided to the board and the sponsoring agency.

(2) When granted full approval for the program of nursing education, the sponsoring agency shall continue to meet all of the requirements of this part.

R 338.10303b Continued program approval; requirements.

Rule 303b. (1) A program shall submit a comprehensive self-study report and a nursing education program report at designated intervals. The self-study report shall be submitted every 8 years for a non-accredited program or at the midpoint of the accreditation cycle for nationally accredited programs.

(2) A program may submit a self-study report prepared for accreditation or re-accreditation by a nationally recognized accrediting agency of nursing education programs instead of the self-study report prepared for the board. The schedule for submission of a self-study report for accredited programs shall follow the schedule of the nationally recognized accrediting agency. The self-study report shall include documentation of decisions and recommendations from the accrediting agency and be submitted to the board within 1 month following receipt of the nationally recognized accrediting agency's decision on accreditation of the nursing education program. Programs that have accreditation date changes shall notify the board of nursing to determine a submission date.

(3) Starting at the expiration of the first year after a program has been granted full approval, the sponsoring agency shall submit a nurse education program report to the board every 4 years for a non-accredited program or at the midpoint of the accreditation cycle for nationally accredited programs that contain the following information:

- (a) Admission, progression, and retention of students.
- (b) Student achievement on the required licensure examination.
- (c) Systematic program evaluation results and action plan, including but not limited to, student evaluations, faculty reviews, NCLEX evaluation results, and attrition rates.
- (d) Program changes.
- (e) Faculty qualifications, assignments, and any faculty exceptions.

(4) The sponsoring agency of a program that is accredited by a nationally recognized nursing education accrediting organization may submit a self-study report approved by the nationally recognized nursing education accrediting organization instead of submitting a nursing education program report referenced in subrule (1) of this rule.

(5) The board shall notify the program director of the date by which a nursing education program report must be submitted.

R 338.10303c Program changes; requirements.

Rule 303c. (1) A nursing education program shall submit major program changes to the board in writing and shall be approved by the board before implementation. All of the following information shall be submitted when requesting approval of a major program change:

- (a) A comparative description of the current and proposed program or portion of the program which is proposed for change.
- (b) Rationale for the change.
- (c) Plans to evaluate the effect of the change.
- (d) Any supporting documents.

(2) A nursing education program shall submit minor program changes to the department in writing as notification to the board of nursing before implementation. Minor program changes include, but are not limited to, all of the following:

- (a) Changing prerequisites, co-requisites, or both.
- (b) A temporary expansion of students. After 1 year, a major program change must be submitted if the temporary expansion of students is desired.
- (c) Separation of 1 course into 2 courses.
- (d) Moving a course from 1 semester to another.
- (e) Combining 2 courses.
- (f) Changing the sequence in which courses are offered.

(3) The type of program approval, initial or full, under which a program is conducted, shall not be altered when program changes are approved.

R 338.10303d Accreditation.

Rule 303d. (1) A nursing education program approved by the board shall be accredited pursuant to 1 of the following:

(a) A nursing education program that has received full board approval pursuant to R 338.10303a, before the promulgation of this rule, shall receive nursing accreditation by a board-recognized nursing accreditation agency no later than January 1, 2025.

(b) A nursing education program that has initial approval of the board shall receive nursing accreditation by a board-recognized nursing accreditation agency within 6 years of receiving full program approval pursuant to R 338.10303a.

(c) A nursing education program that fails to achieve nursing accreditation by a board-recognized nursing accreditation agency as set forth by this rule shall be removed from the list of approved programs pursuant to section 17242 of the code, MCL 333.17242.

(2) The board recognizes the following nursing education accrediting agencies or their successor organizations:

(a) Accreditation Commission for Education in Nursing (ACEN).

(b) Commission for Nursing Education Accreditation (CNEA).

(c) Commission on Collegiate Nursing Education (CCNE).

(3) Failure to maintain accreditation from an approved national nursing accrediting agency shall result in withdrawal of school approval pursuant to section 17242 of the code, MCL 333.17242 and R 338.10311.

R 338.10305 Registered professional nurse and licensed practical nurse programs; program requirements; generally.

Rule 305. Programs of registered professional nursing education and licensed practical nursing education shall meet all of the following requirements:

(a) Comply with the curriculum requirements established by the board and with other requirements set forth in this part.

(b) Contribute to the safe practice of nursing by including the standards of practice, nursing behaviors, and other skills and knowledge in the curriculum to prepare persons for the practice of nursing as defined in section 17201(1)(a) of the code, MCL 333.17201(1)(a).

(c) Prepare students to meet the requirements for eligibility to take the required licensure examination.

(d) Establish requirements for admission, progression, and graduation which shall be made known and available in written form to prospective and current students.

(e) Establish a system for the permanent maintenance of course descriptions and student and graduate transcripts.

R 338.10305a Registered professional nursing education program; program requirements; faculty requirements.

Rule 305a. (1) The program director and all nurse faculty members shall hold a current unrestricted license to practice as a registered professional nurse in this state.

(2) If clinical experiences are offered by the nursing education program at sites that are not located in this state, then any nurse faculty members at those sites shall hold a current unrestricted license to practice as a registered nurse in the state or Canadian province where the clinical experience is located.

(3) The program director shall hold a minimum of a graduate degree with a major in nursing.

(4) A member of the nursing faculty who provides didactic/theory instruction shall hold a minimum of a graduate degree. The majority of the didactic/theory faculty shall hold a graduate degree with a major in nursing, unless an exception is granted under subrule (7) of this rule. If the graduate degree is not in nursing, the faculty member shall hold a minimum of a baccalaureate degree in nursing or an equivalent standing in a nationally nursing accredited Associate's Degree in Nursing to Master's of Science in Nursing (ADN to MSN) nursing education program with attestation of baccalaureate level competency from that educational program. Courses that are non-nursing in content but are health-related are exempt from the requirements of this subrule and may be taught by non-nurse faculty.

(5) A member of the nursing faculty who provides instruction in either the clinical or simulation laboratory shall hold a minimum of a baccalaureate degree in nursing or an equivalent standing in a nationally nursing accredited ADN to MSN nursing education program with attestation of baccalaureate level competency from that educational program.

(6) Notwithstanding section 16148(6) of the code, MCL 333.16148(6), all nursing faculty shall meet the requirements of subrules (4) and (5) of this rule by January 6, 2022. (7) An exception may be made to the requirements of subrule (4) of this rule for full-time or part-time nursing faculty and shall be based on the faculty member's progress toward meeting the requirements of these rules during each year for which the exception is requested. Board approval for faculty exception requests must be received before the faculty member begins course instruction. A maximum of 5 yearly exceptions shall be granted to any full-time or part-time faculty member.

(8) Nursing faculty shall be sufficient in number to prepare students to achieve the outcomes of the program. The maximum ratio of students to faculty in clinical areas involving direct care of patients shall be not more than 8 students to 1 faculty member. The maximum ratio of students to faculty in clinical areas involving non-direct patient care shall be not more than 10 students to 1 faculty member. The required ratio of 8 students to 1 faculty member may be reduced in specialty units, subject to a sponsoring clinical hospital or agency determination, to ensure safe and competent direct patient care.

R 338.10305b Licensed practical nursing education program; program requirements; faculty requirements.

Rule 10305b. (1) The program director and all nurse faculty members shall hold a current unrestricted license to practice as a registered professional nurse in this state.

(2) If clinical experiences are offered by the nursing education program at sites that are not located in this state, then any nurse faculty members at those sites shall hold a current unrestricted license to practice as a registered professional nurse in the state or Canadian province where the clinical experience is located.

(3) The program director shall hold a minimum of a graduate degree in nursing.

(4) Every member of the nursing faculty shall hold a minimum of a baccalaureate degree in nursing, unless an exception is granted under subrule (6) of this rule.

(5) Notwithstanding section 16148(7) of the code, MCL 333.16148(7), all nursing faculty shall comply with the requirements of subrule (4) of this rule within 5 years after the effective date of these rules.

(6) An exception may be made to the requirements of subrule (4) of this rule for full-time or part-time nursing faculty and shall be based on the faculty member's progress toward meeting the requirements of these rules during each year for which the exception is requested. Board approval for faculty exception requests must be received before the faculty member begins course instruction. A maximum of 5 yearly exceptions shall be granted to any full-time or part-time faculty member.

(7) Nursing faculty shall be sufficient in number to prepare students to achieve the outcomes of the program. The maximum ratio of students to faculty in clinical areas involving direct care of patients shall be not more than 8 students to 1 faculty member. The maximum ratio of students to faculty in

clinical areas involving non-direct patient care shall be not more than 10 students to 1 faculty member. The required ratio of 8 students to 1 faculty member may be reduced in specialty units, subject to a sponsoring clinical hospital or agency determination, to ensure safe and competent direct patient care.

R 338.10305c Registered professional nursing and licensed practical nursing education programs; preceptor requirements.

Rule 10305c. (1) A program of nursing education that uses the personnel of a clinical facility as preceptors to facilitate the faculty-directed clinical experience of students shall meet all of the following requirements:

- (a) Each preceptor shall be approved by the faculty of the program of nursing education.
- (b) Each preceptor shall meet either of the following education and experience requirements:
 - (i) Be educated at the same or higher level as the academic program in which the student is enrolled, have demonstrated competencies that are appropriate for the student's learning experience, and have a minimum 1 year of clinical nursing experience and supervisor recommendation.
 - (ii) Have a minimum of an associate's degree or diploma in nursing, demonstrated competencies that are appropriate for the student's learning experience, and a minimum of 1 year of clinical nursing experience and supervisor recommendation.
- (c) Each preceptor shall hold an unencumbered license in the state where the clinical experience occurs.
- (d) The faculty of the program of nursing education shall ensure that each preceptor is provided education including the roles and responsibilities of students, faculty members, and preceptors. The program shall maintain documentation of preceptor education.
- (e) Before the preceptor begins instruction of the students, the faculty of the program of nursing shall develop written learning outcomes and provide a copy of those outcomes to each preceptor.
- (f) The faculty member shall retain authority and responsibility for the student's learning experiences and shall confer routinely and periodically with the preceptor and student to monitor and evaluate the learning experiences.
- (g) The maximum ratio of precepted students to a supervising faculty member shall be not more than 10 students to 1 faculty member.
- (h) If the faculty member is not physically present in the area in which students are practicing, he or she shall be immediately available by telephone or other means of telecommunication when students are engaged in clinical activities with a preceptor.
- (i) Preceptors shall not be used to replace clinical faculty in prelicensure certificate, associate, or baccalaureate degree nursing programs.
- (j) A preceptor shall supervise not more than 1 student during any 1 scheduled work time or shift.
- (2) This rule does not apply to staff nurses used by faculty intermittently during non-precepted clinical experiences.

R 338.10306 Registered nursing and practical nursing education programs; curriculum requirements; generally.

Rule 306. The sponsoring agency's curriculum shall include all of the following:

- (a) A statement of philosophy shall be established that is consistent with the philosophy of the sponsoring agency and that is implemented in the program of nursing education.
- (b) End of program student learning outcomes and course student learning outcomes shall be established to serve as a guide in the development, implementation, and evaluation of the curriculum. The outcomes shall be leveled in a manner that shows progression throughout the program, and shall be reviewed periodically and revised as necessary.

(c) Learning experiences and methods of instruction shall be selected to fulfill the stated outcomes of each nursing course.

(d) Related clinical experiences and clinical laboratory and simulation laboratory hours shall be provided concurrently with, or immediately after, the theoretical presentation of the course content. Simulation laboratory hours shall be limited to no more than 50% of each clinical experience. In practical nursing education programs, simulation laboratory hours for obstetrics and pediatrics courses are unlimited and may equal 100% of the clinical experience hours.

(e) Evaluation methods and tools to be used for measuring student achievement shall be determined by the faculty in keeping with the assessment methods of the sponsoring agency. These methods and tools shall be known to the students in the program.

(f) The director and faculty shall evaluate all aspects of the curriculum on a systematic basis. Records of the results of the evaluation shall be maintained for board review, if requested.

R 338.10307 Registered professional nursing and licensed practical nursing education programs; curriculum; organization, development, implementation, control, and evaluation.

Rule 307. (1) The program director and faculty shall organize, develop, implement, control, and evaluate the curriculum on a regularly scheduled basis within the framework of the philosophy, purposes, and outcomes of the sponsoring agency and those approved by the board.

(2) The curriculum outcomes shall identify the behavioral expectations of the graduate of the program and shall be used for all of the following purposes:

(a) Developing, organizing, implementing, and evaluating the curriculum.

(b) Identifying outcomes for levels of progression and course and program completion.

(c) Providing to the student an organized pattern to follow in which the sequence of learning is from the simple to the complex and from the known to the unknown, with each learning experience built on previously learned information of nursing and related scientific knowledge.

(d) Organizing the courses to approximate, as closely as possible, the schedules of the sponsoring agency in terms, quarters, semesters, or trimesters.

(e) Distributing the courses throughout the curriculum so that an unreasonable overload does not exist in any segment of the sequence.

(3) The philosophy and conceptual framework or rationale for the program shall be the basis for the organization of the nursing content of the curriculum.

(4) The course content and other learning experiences shall promote student growth in all of the following areas:

(a) The understanding of the roles and responsibilities of the members of the nursing profession.

(b) The application of the principles of nursing and the sciences which are basic to nursing practice in the development of plans of care for the patient or client.

(c) The provision of direct and indirect nursing care.

(d) The understanding of effective human relations and demonstrating the ability to use these principles in nursing situations.

(e) The recognition of physical, psychosocial, and spiritual needs of diverse patient/client populations in the provision of nursing care.

(f) The understanding of health, including the manifestations of disease and the initiation, organization, and application of the principles underlying the nursing care provided.

(g) Developing skills and abilities in the administration of all aspects of nursing care, including all of the following:

(i) Communications.

(ii) Critical thinking, clinical reasoning, and problem solving.

(iii) Understanding legal and professional responsibilities.

- (iv) Inter-professional relationships with other health care providers.
- (v) Evidence-based practice.
- (vi) Quality and safety.
- (h) Understanding and protecting the rights of patients or clients.
- (5) All cooperating agencies selected for clinical laboratory and simulation laboratory experiences shall have standards of nursing care that demonstrate concern for the patient or client and evidence the skillful application of all measures of quality and safe, evidence-based nursing practice.
- (6) All cooperating agencies shall have a current license, if required, for their operation and adhere to the local zoning ordinances governing their operation.
- (7) When a nurse site reviewer visits a site, he or she may survey cooperating agencies as a part of the review process to determine the contribution each makes to the course and program outcomes. Selection shall be made by the nurse site reviewer.
- (8) Each resource selected to provide clinical experience shall indicate a willingness to cooperate in the curriculum by providing a letter of intent, a written agreement, or a formal contract. Each cooperating agency shall provide experiences of a quality and quantity that will enable all students to meet the outcomes established for the clinical experience pursuant to R 338.10303.

R 338.10308 Registered professional nursing education program; curriculum; implementation.

Rule 308. (1) The director and faculty of a program of nursing education leading to licensure as a registered professional nurse shall comply with all of the following provisions:

(a) Select courses and ensure teaching concepts for basic content in the biological, physical, behavioral, and other courses supportive of the nursing major which shall assist the student to succeed in the nursing sequence.

(b) Provide courses and clinical and simulation laboratory experiences in the care of individuals across diverse age groups, genders, races and cultures, in medical, surgical, pediatric, geriatric, obstetrical, and psychiatric nursing. Opportunities for learning experiences in community aspects of nursing shall be made available. The elements of the nursing process shall be emphasized in all nursing courses. Clinical laboratory, simulation laboratory, and clinical experience hours shall be sufficient in number to meet the course and program outcomes.

(c) Ensure that courses include content relating to all of the following:

- (i) The legal scope of practice of a registered nurse.
- (ii) The standards of practice and performance and code of ethics for the nursing profession.
- (iii) Historical perspectives of nursing and current legal-ethical issues.
- (iv) Licensure requirements.

(d) Select cooperating agencies that meet the requirements of R 338.10307(5), (6), and (8).

(2) A registered professional nurse program may substitute up to 50% of clinical hours in any single course with simulation laboratory experiences. For simulation laboratory experiences, the board adopts by reference the standards of the International Nursing Association for Clinical Simulation and Learning, as specified in the publication entitled, "Standards of Best Practice: Simulation" 2016. The standards are available from the International Nursing Association for Clinical Simulation and Learning's website at <http://www.inacsl.org> at no cost. Copies of the standards are available for inspection and distribution at cost from the Board of Nursing, Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, 611 W. Ottawa Street, P.O. Box 30670, Lansing, Michigan 48909.

R 338.10309 Licensed practical nursing education program; curriculum; implementation.

Rule 309. (1) The director and faculty of a program of nursing education leading to licensure as a licensed practical nurse shall comply with all of the following provisions:

(a) Select courses and ensure teaching concepts on which the theory and practice of practical nursing are based. The basic principles of the natural and applied sciences that are fundamental to the theory and practice of practical nursing and that are applied in the planning and implementation of nursing care shall be included.

(b) Provide courses and clinical and simulation laboratory experiences in the care of individuals across diverse age groups, genders, races and cultures, in medical, surgical, pediatric, obstetrical, and geriatric nursing and provide supervised practice in the administration of medications. Clinical laboratory, simulation laboratory, and clinical experience hours shall be sufficient to meet the outcomes of the curriculum.

(c) Ensure that courses include content relating to all of the following:

(i) The legal scope of practice of a licensed practical nurse.

(ii) The standards of conduct for members of the nursing profession and, in particular, a licensed practical nurse.

(iii) Historical perspectives of nursing and current legal-ethical issues.

(iv) Licensure requirements.

(d) Select cooperating agencies that meet the requirements of R 338.10307(5), (6), and (8).

(2) A licensed practical nursing education program may substitute up to 50% of clinical hours in any single course with simulation laboratory experiences, except for pediatric and obstetric clinical hours. A licensed practical nursing education program may substitute up to 100% of pediatric and obstetric clinical hours with simulation laboratory. For simulation laboratory experiences, the board adopts by reference the standards of the International Nursing Association for Clinical Simulation and Learning, as specified in the publication entitled, “Standards of Best Practice: Simulation” 2016. The standards are available from the International Nursing Association for Clinical Simulation and Learning’s website at <http://www.inacsl.org> at no cost. Copies of the standards are available for inspection and distribution at cost from the Board of Nursing, Bureau of Health Care Services, Department of Licensing and Regulatory Affairs, 611 W. Ottawa Street, P.O. Box 30670, Lansing, Michigan 48909.

R 338.10310 Board evaluation of a nursing education program.

Rule 310. The board may evaluate a program of nursing education when any of the following occurs:

(a) A request for initiating a program of nursing education is submitted.

(b) A request for full approval of a program is submitted.

(c) A request for approval of a major program change is submitted.

(d) The failure rate for first-time test takers on the required licensure examination reaches or exceeds 25% for any 1 year of compiled statistics or reaches or exceeds 15% for any 2 of 3 consecutive years of compiled annual statistics.

(e) Complaints regarding the conduct of the program are received and it is necessary to validate the complaints, pursuant to section 17242 of the code, MCL 333.17242.

(f) Failure of a nursing education program to submit a report or self-study pursuant to the time frames set forth in R 338.10303b.

(g) Failure of a nursing education program to submit faculty exception requests before the start date of the semester under R 338.10305a and R 338.10305b.

PART 4. NURSE SPECIALTY CERTIFICATION

R 338.10401 Definitions.

Rule 401. As used in this part:

(a) “Clinical nurse specialist” means an individual who is licensed under part 172 of the code, MCL 333.17201 to 333.17242, as a registered nurse, who is certified by the board to use the title clinical nurse specialist, and who focuses on continuous improvement of patient outcomes and nursing care with broad focus across the areas of direct patient care, patient education, nursing education, nursing practice, and organizational systems. A clinical nurse specialist is responsible and accountable for diagnosis and treatment of health/illness states, including the prescription and use of pharmacological and nonpharmacological interventions that are within the clinical nurse specialist’s specialty role and scope of practice; disease management, health promotion; and prevention of illness and risk behaviors among individuals, families, groups, and communities. Nursing care provided by a clinical nurse specialist also includes the evaluation of patient outcomes; the translation of evidence into practice; and the development, planning, coordination and direction of programs of care for acute and chronically ill patients and their families.

(b) “Nurse anesthetist” means an individual who is licensed under part 172 of the code, MCL 333.17201 to 333.17242, as a registered nurse, who is certified by the board to use the title nurse anesthetist, and who is prepared to provide the full spectrum of anesthesia care and anesthesia-related care that is within the nurse anesthetist’s specialty role and scope of practice for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury.

(c) “Nurse midwife” means an individual who is licensed under part 172 of the code, MCL 333.17201 to 333.17242, as a registered nurse, who is certified by the board to use the title nurse midwife, and who focuses on primary care services for women throughout their lifespan, including comprehensive maternity care that includes prenatal care, childbirth in diverse settings, postpartum care, and newborn care; gynecological, reproductive, and contraceptive care; physical exams; diagnosis and treatment of common health problems with consultation or referral as indicated; prescribing pharmacological and nonpharmacological interventions and treatments that are within the nurse midwife’s specialty role and scope of practice; and treatment of male partners for sexually transmitted infection and reproductive health.

(d) “Nurse practitioner” means an individual who is licensed under part 172 of the code, MCL 333.17201 to 333.17242, as a registered nurse, who is certified by the board to use the title nurse practitioner, and who focuses on the performance of comprehensive assessments; providing physical examinations and other health assessments and screening activities; and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. Nursing care provided by a nurse practitioner includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing pharmacological and nonpharmacological interventions and treatments that are within the nurse practitioner’s specialty role and scope of practice; health promotion; disease prevention; health education; and counseling of patients and families with potential, acute, and chronic health disorders.

R 338.10403 Advertisement of services.

Rule 403. Only nurses certified in a nursing specialty field may hold themselves out to the public as nurse specialists using the title clinical nurse specialist, nurse anesthetist, nurse midwife, or nurse practitioner. Conduct contrary to this rule is considered a violation of section 16221(d) of the code, MCL 333.16221(d).

R 338.10404c Specialty certification qualifications; clinical nurse specialist.

Rule 404c. (1) A specialty certification for a clinical nurse specialist shall be granted to a registered professional nurse who satisfies all of the following requirements:

- (a) Holds a current and valid license to practice nursing in this state.

(b) Submits an application for certification as a clinical nurse specialist, on a form provided by the department with the required fee.

(c) Possesses either of the following:

(i) An advanced practice certification from either of the following certification organizations, or successor organizations:

(A) The American Nurses Credentialing Center.

(B) The American Association of Critical Care Nurses Certification Corporation.

(ii) If an applicant is unable to take a national certification exam due to graduation from an accredited clinical nurse specialist master's or doctoral nursing program before the development of clinical nurse specialist core competencies and the requirement of 500 clinical practice hours, he or she may be granted a specialty certification as a clinical nurse specialist based upon submission of a portfolio of evidence that demonstrates knowledge and skill competence in the clinical nurse specialist role and population focus. The portfolio must include all of the following:

(A) Transcripts from an accredited master's or doctoral level educational program in clinical nursing with preparation as a clinical nurse specialist.

(B) Curriculum vitae demonstrating work history in a clinical nurse specialist position before April 9, 2017.

(C) Three letters of recommendation, including 1 from a clinical nurse specialist with national board certification and 2 letters from nursing administrators, nursing supervisors, or advanced practice nurses attesting that the applicant has at least 3,000 hours of practice as a clinical nurse specialist before April 9, 2017. These letters must provide evidence that the applicant engaged in practice consistent with the standards for a clinical nurse specialist as described by the National Association of Clinical Nurse Specialists (NACNS) in the publication entitled "Clinical Nurse Specialist and Core Competencies" 2010. A copy of the standards and requirements is available at no cost from the association's website at www.nacns.org. A copy of the standards and requirements also is available for inspection and distribution at no cost from the Board of Nursing, Michigan Department of Licensing and Regulatory Affairs, 611 West Ottawa, Lansing, MI 48909

(2) Application for certification as a clinical nurse specialist granted under the criteria set forth in subrule (1)(c)(ii) of this rule shall be permitted for not more than 2 years after the effective date of this rule set.

R 338.10405c Clinical nurse specialist specialty certification renewal; schedule; requirements; maintenance of evidence of compliance.

Rule 405c. (1) Specialty certification renewal shall correspond with the same schedule as the license renewal.

(2) An applicant for renewal of a certification shall meet the following requirements appropriate to his or her current source of certification:

(a) An applicant who holds national certification as a clinical nurse specialist shall have obtained recertification or maintained certification within the 2-year period immediately preceding the application from either of the following organizations or successor organizations:

(i) American Nurses Credentialing Center.

(ii) American Association of Critical Care Nurses Certification Corporation.

(b) An applicant who does not possess national certification as a clinical nurse specialist shall have met the continuing education requirements for his or her role and population focus consistent with the recertification standards as established by the American Nurses Credentialing Center or the American Association of Critical Care Nurses Certification Corporation for the 2-year period immediately preceding the certification renewal.

(3) An applicant or licensee shall maintain evidence of his or her compliance with the requirements of this rule for a period of 4 years after the date of application, during which time the board may require the licensee to submit this evidence for audit.

PART 6. CONTINUING EDUCATION

R 338.10601 License renewals; requirements; applicability.

Rule 601. (1) Pursuant to section 16201 of the code, MCL 333.16201, an applicant for license renewal who has been licensed for the 2-year period immediately preceding the expiration date of the license, shall accumulate at least 25 hours of continuing education that are approved by the board pursuant to these rules during the 2 years preceding an application for renewal. This part applies to an application for renewal that is filed for the renewal cycle 1 year or more after the effective date of these rules.

(2) An applicant for license renewal shall complete at least 2 hours of continuing education in pain and pain symptom management in each renewal period pursuant to section 16204(2) of the code, MCL 333.16204(2). Continuing education in pain and pain symptom management may include, but is not limited to, courses in behavior management, psychology of pain, pharmacology, behavior modification, stress management, clinical applications, and drug interventions as they relate to professional practice.

(3) Submission of an application for renewal shall constitute the applicant’s certification of compliance with the requirements of this rule. A nurse shall retain documentation of meeting the requirements of this rule for a period of 4 years from the date of applying for license renewal. The board may require an applicant to submit evidence to demonstrate compliance with this rule. Failure to comply with this rule is a violation of section 16221(h) of the code, MCL 333.16221(h).

(4) A request for a waiver under section 16205 of the code, MCL 333.16205, must be received by the department before the expiration date of the license.

(5) The requirements of this part do not apply to an applicant during an initial licensure cycle.

R 338.10602 Acceptable continuing education; requirements; limitations.

Rule 602. (1) The 25 hours of continuing education required pursuant to R 338.10601(1) for the renewal of a license shall comply with the following, as applicable:

(a) No more than 12 credit hours shall be earned during a 24-hour period for online or electronic media, such as videos, internet web-based seminars, video conferences, online continuing education programs, and online journal articles.

(b) An applicant may not earn credit for a continuing education program or activity that is identical to a program or activity the applicant has already earned credit for during that renewal period.

(2) The board shall consider the following as acceptable continuing education:

ACCEPTABLE CONTINUING EDUCATION ACTIVITIES		
(a)	Completion of an approved continuing education program or activity related to the practice of nursing or any non-clinical subject relevant to the practice of nursing. A continuing education program or activity is approved, regardless of the format in which it is offered, if it is approved or offered for continuing education credit by any of the following: <ul style="list-style-type: none"> • The American Association of Nurse Anesthetists (AANA). 	The number of hours approved by the sponsor or the approving organization. If the activity was not approved for a set number of hours, then 1 credit hour for each 60 minutes of participation may be earned. A minimum of 25 hours shall be earned in each renewal period.

	<ul style="list-style-type: none"> • The American Association of Nurse Practitioners (AANP). • The Accreditation Council for Continuing Medical Education (ACCME). • The American College of Nurse-Midwives (ACNM). • The American Nurses Credentialing Center (ANCC). • The American Osteopathic Association (AOA). • The National Association of Clinical Nurse Specialists. • The National Association for Practical Nurse Education and Service, Inc. (NAPNES). • The National League for Nursing (NLN). • Another state or provincial board of nursing. • A continuing nursing education program offered by a nursing education program that is approved by the board under R 338.10303a. <p>If audited, an applicant shall submit a copy of a letter or certificate of completion showing the applicant’s name, number of hours earned, sponsor name or the name of the organization that approved the program or activity for continuing education credit, and the date on which the program was held or activity completed.</p>	
(b)	<p>Completion of academic courses related to nursing practice offered in a nursing education program approved by the board.</p> <p>If audited, an applicant shall submit an official transcript that reflects completion of the academic course and number of semester or quarter credit hours earned.</p>	<p>Five hours of continuing education may be earned for each semester credit hour earned.</p> <p>Three hours of continuing education may be earned for each quarter credit hour earned.</p>
(c)	<p>Obtaining specialty certification or maintaining certification as 1 of the following:</p> <ul style="list-style-type: none"> • Clinical nurse specialist. • Nurse anesthetist. 	<p>Twenty-five hours may be credited for obtaining or maintaining specialty certification during the renewal period.</p>

	<ul style="list-style-type: none"> • Nurse midwife. • Nurse practitioner. <p>If audited, an applicant shall submit proof of certification or recertification.</p>	
(d)	<p>Successful completion of a national nursing specialty examination.</p> <p>If audited, an applicant shall submit proof of a passing score on the examination.</p>	<p>Ten hours may be earned in the year in which the applicant achieves a passing score.</p> <p>A maximum of 20 hours may be earned in each renewal period. Credit will not be given for repeating the same examination in a renewal period.</p>
(e)	<p>Initial publication of a chapter or an article related to the practice of nursing or allied health in either of the following:</p> <ul style="list-style-type: none"> • A nursing or health care textbook. • A peer-reviewed textbook. • A nursing or health care peer-reviewed journal. <p>If audited, an applicant shall submit a copy of the publication that identifies the applicant as the author or a publication acceptance letter.</p>	<p>Ten hours per publication.</p> <p>A maximum of 10 hours may be earned in each renewal period.</p>
(f)	<p>Independent reading of articles or viewing or listening to media related to nursing practice that do not include a self-assessment component.</p> <p>If audited, an applicant shall submit an affidavit attesting to the number of hours the applicant spent participating in these activities and that includes a description of the activity.</p>	<p>One hour for each 50 to 60 minutes of participation.</p> <p>A maximum of 4 hours may be earned in each renewal period.</p>
(g)	<p>Participation on a health care organization committee dealing with quality patient care or utilization review.</p> <p>If audited, an applicant shall submit a letter from an organization official verifying the applicant's participation and the number of hours the applicant spent participating on the committee.</p>	<p>One hour for each 60 minutes of participation.</p> <p>A maximum of 4 hours may be earned in each renewal period.</p>
(h)	<p>Presentation of an academic or continuing education program that is not a part of the applicant's regular job description.</p> <p>If audited, an applicant shall submit a copy of</p>	<p>Three hours may be earned for each 60 minutes of presentation.</p> <p>A maximum of 6 hours may be earned in each renewal period.</p>

	the curriculum and a letter from the program sponsor verifying the length and date of the presentation.	
(i)	<p>Participation as a preceptor for at least 1 nursing student or new employee undergoing orientation.</p> <p>A preceptorship shall be for a minimum of 120 hours and have a 1 student/employee to 1 preceptor ratio. This may involve more than 1 student or employee.</p> <p>If audited, an applicant shall submit written documentation from the educational institution or preceptor's supervisor verifying the dates and hours of the preceptorship.</p>	<p>A maximum of 5 hours of continuing education may be earned in each renewal period.</p>

PART 7. NURSING PROFESSIONAL FUND SCHOLARSHIP PROGRAM

R 338.10702 Board determination of categories and areas of need for designating awards; department required to communicate board's determination of need to nursing programs; applications.

Rule 702. (1) The board shall annually determine categories and areas of need for designating scholarship awards to eligible programs of nursing. The board may consider any of the following in establishing categories and areas of need:

- (a) Data generated from Michigan licensure renewal information and nursing surveys.
- (b) National and state trends that have identified nursing shortages.
- (c) Data identifying medically underserved areas (MUA), medically underserved populations (MUP), or health professional shortage areas (HPSA).
- (d) Health status and nursing care needs of the state's residents.

(2) The department shall communicate the board's determination as to categories and areas of need to approved nursing education programs in this state.

(3) The department shall provide applications to approved programs of nursing that meet the established eligibility criteria in R 338.10703.

R 338.10703. Eligibility of and allocation to nursing education programs.

Rule 703. (1) To be eligible for a scholarship award, a school shall meet 1 of the following criteria:

- (a) Provide a prelicensure nursing program that complies with all of the following:
 - (i) Is approved by the Michigan board of nursing.
 - (ii) Has a primary campus located in this state.
 - (iii) Offers a program of nursing that meets the predetermined category and area of need as established by the board under R 338.10702.
 - (iv) File an application approved by the department declaring a notice of intent to participate in the scholarship.
- (b) Provide a post-licensure nursing program that complies with all of the following:
 - (i) Is accredited by a national nursing education accrediting entity.
 - (ii) Has a primary campus located in this state.

(iii) File an application approved by the department declaring a notice of intent to participate in the scholarship.

(2) A school may submit an application for participation for only those programs that are included in the annual list of scholarship program categories and areas of need as determined by the board pursuant to R 338.10702.

(3) The department shall annually determine the allocation for each eligible education program.

R 338.10704 Nursing education program awards to eligible students; requirements, procedures.

Rule 704. (1) An eligible nursing education program, upon receiving an allocation, shall award a scholarship to a student who meets all of the following criteria:

(a) Is a permanent resident of this state.

(b) If licensed as a nurse, holds an unencumbered Michigan license to practice nursing.

(c) Is not in receipt of a full scholarship from another source.

(d) Maintains satisfactory progress as determined by the eligible nursing education program.

(2) A nursing education program shall apply a scholarship award first to the cost of tuition, books, and fees associated with the program. A nursing program shall then provide the remainder of the award, if any, to the student in the form of a stipend.

(3) The nursing education program shall notify the department, in writing, of its intent to award a scholarship. The notice shall contain all of the following information:

(a) The name of the recipient.

(b) Course of study or program in which the recipient is enrolled.

(c) Validation that all criteria have been met.

(4) A student may receive a scholarship award only once for each level of nursing education.

(5) If a recipient withdraws from the nursing education program, then within 30 days of withdrawal, the nursing education program shall notify the department, in writing, of its intent to award the remaining scholarship monies in accordance with subrule (3) of this rule or return the unused funds to the department.

(6) The nursing education program shall account for all of the funds disbursed by the department no later than February 15 of the academic year in which the funds were distributed. Both of the following apply:

(a) The department shall supply the accounting form to each program that is participating in the nurse professional fund scholarship program.

(b) Failure of a program to submit an accounting statement to the department in accordance with subrule (6) of this rule will result in the department withholding future scholarship funds from the program until all past due accounting statements have been submitted and approved.

ADMINISTRATIVE RULES

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

BUREAU OF PROFESSIONAL LICENSING

GENERAL RULES – PUBLIC HEALTH CODE

Filed with the Secretary of State on March 5, 2018

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, or 45a(6) of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

(By authority conferred on the director of the department of licensing and regulatory affairs by sections 16145, 16194, 16201, and 16221(e)(iv)(B) of 1978 PA 368, MCL 333.16145, 333.16194, 333.16201, and 333.16221(e)(iv)(B) and Executive Reorganization Order Nos. 1996-1, 1996-2, 2003-1, 2008-4, and 2011-4, MCL 330.3101, 445.2001, 445.2011, 445.2015, 445.2025, and 445.2030)

R 338.7001a of the Michigan Administrative Code is amended as follows:

R 338.7001a Biennial renewal; authorized boards; license renewal content.

Rule 1a. (1) The license or registration renewals issued for the following professions are valid for a period of 2 years commencing on the following dates and must be renewed every 2 years upon receipt of payment and compliance with renewal requirements, if appropriate:

Acupuncture	10/1
Audiology	1/1
Chiropractic	12/1
Marriage and family therapy	2/1
Nursing	Issue date
Nursing home administrators	11/1
Occupational therapy	6/1
Optometry	7/1
Pharmacy	7/1
Physical therapy	8/1
Physician's assistants	9/1
Psychology	9/1
Respiratory care	1/1
Sanitarians	12/1
Speech-language pathology	10/1

(2) A license or registration having a limitation may be renewed for a term less than the biennial cycle.

ADMINISTRATIVE RULES

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

WORKERS' COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

Filed with the Secretary of State on March 8, 2018

These rules take effect 7 days after filing with the Secretary of State.

(By authority conferred on the workers' compensation agency by sections 205 and 315 of 1969 PA 317, section 33 of 1969 PA 306, Executive Reorganization Order Nos. 1982-2, 1986-3, 1990-1, 1996-2, 2003-1, and 2011-4, MCL 418.205, 418.315, 24.233, 18.24, 418.1, 418.2, 445.2001, 445.2011, and 445.2030)

R 418.10106, R 418.10107, R 418.10207, R 418.10208, R 418.10212, R 418.10214, R 418.10404, R 418.10416, R 418.10904, R 418.10905, R 418.10909, R 418.10912, R 418.10920, R 418.10923b, R 418.101002, R 418.101003, R 418.101003a, R 418.101008a, R 418.101501, R 418.101503 of the Michigan Administrative Code are amended, and R 418.10926 and R 418.101010 are added.

PART 1. GENERAL PROVISIONS

R 418.10106 Procedure codes; relative value units; other billing information.

Rule 106. (1) Upon annual promulgation of R 418.10107, the health care services division of the workers' compensation agency shall provide separate from these rules a manual, tables, and charts containing all of the following information on the agency's website, www.michigan.gov/wca:

- (a) All Current Procedural Terminology (CPT®) procedure codes used for billing health care services.
- (b) Medicine, surgery, and radiology procedures and their associated relative value units.
- (c) Hospital maximum payment ratios.
- (d) Billing forms and instruction for completion.

(2) The procedure codes and standard billing and coding instructions for medicine, surgery, and radiology services is adopted from the most recent publication entitled "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107. However, billing and coding guidelines published in the CPT codebook do not guarantee reimbursement. A carrier shall only reimburse medical procedures for a work-related injury or illness that are reasonable and necessary and are consistent with accepted medical standards.

(3) The formula and methodology for determining the relative value units is adopted from the "Medicare RBRVS: The Physicians Guide" as adopted by reference in R 418.10107 using geographical information for the state of Michigan. The geographical information, (GPCI), for these rules is a melded average using 60% of the figures published for the city of Detroit added to 40% of the figures published for the rest of this state.

(4) The maximum allowable payment for medicine, surgery, and radiology services is determined by multiplying the relative value unit assigned to the procedure times the conversion factor listed in the reimbursement section, part 10, of these rules.

(5) Procedure codes from "HCPCS 2017 Level II Professional Edition," as adopted by reference in R 418.10107, shall be used to describe all of the following services:

- (a) Ambulance services.
- (b) Medical and surgical expendable supplies.
- (c) Dental procedures.
- (d) Durable medical equipment.
- (e) Vision and hearing services.
- (f) Home health services.

(6) Medical services considered "By Report" (BR) if a procedure code listed in "HCPCS 2017 Level II Professional Edition" or "Current Procedural Terminology (CPT®) 2017 Professional Edition" as adopted by reference in R 418.10107 does not have an assigned value.

R 418.10107 Source documents; adoption by reference.

Rule 107. The following documents are adopted by reference in these rules and are available for distribution from the indicated sources, at the cost listed in subdivisions (a) to (h) of this rule:

(a) "Current Procedural Terminology (CPT®) 2017 Professional Edition," published by the American Medical Association, P.O. Box 930876, Atlanta GA, 31193-0876, item #EP054117, 1-800-621-8335. The publication may be purchased at a cost of \$114.95 plus \$16.95 shipping and handling as of the time of adoption of these rules. Permission to use this publication is on file in the workers' compensation agency.

(b) "HCPCS 2017 Level II Professional Edition," published by the American Medical Association, P.O. Box 930876 Atlanta GA 31193-0876, item #OP231517, customer service 1-800-621-8335. The publication may be purchased at a cost of \$99.95, plus \$11.95 for shipping and handling, as of the time of adoption of these rules.

(c) "Medicare RBRVS 2017: The Physicians' Guide," published by The American Medical Association, P.O. Box 930876, Atlanta GA 31193-0876, item #OP059617, 1-800-621-8335. The publication may be purchased at a cost of \$91.95, plus \$11.95 shipping and handling, as of the time of adoption of these rules.

(d) "International Classification of Diseases, ICD-10-CM 2017: The Complete Official Codebook," American Medical Association, P.O. Box 930876, Atlanta, GA 31193-0876, item #OP201417, 1-800-621-8335. The publication may be purchased at a cost of \$99.95, plus \$11.95 shipping and handling, as of the time of adoption of these rules.

(e) "International Classification of Diseases, ICD-10-PCS 2017: The Complete Official Codebook," American Medical Association, P.O. Box 930876, Atlanta, GA 31193-0876, item #OP201117, 1-800-621-8335. The publication may be purchased at a cost of \$99.95, plus \$11.95 shipping and handling, as of the time of adoption of these rules.

(f) Red Book Online subscription service of Truven Health Analytics, contact:
<http://www.redbook.com/redbook/online/>.

(g) Medi-Span Drug Information Database, a part of Wolters Kluwer Health, contact:
<http://www.medispan.com>.

(h) "Official UB-04 Data Specifications Manual 2018, July 1, 2017" adopted by the National Uniform Billing Committee, © Copyright 2017 American Hospital Association. As of the time of adoption of these rules, the cost of this eBook for a single user is \$160.00 and is available at www.nubc.org.

PART 2. MEDICINE

R 418.10207 Mental health services.

Rule 207. (1) A psychiatrist only, shall use procedure code 90792 to describe a psychiatric diagnostic evaluation with medical services, or shall use a new patient evaluation and management code instead of 90792 to describe a psychiatric diagnostic evaluation. A psychologist shall use procedure code 90791 to describe a diagnostic evaluation without medical services. Procedure codes 90791 and 90792 shall not be reported on the same day as a psychotherapy or evaluation and management service procedure code.

(2) A psychiatrist only, shall use add on procedure codes 90833, 90836 and 90838, which shall be reported in conjunction with an evaluation and management services code.

(3) An individual performing psychological testing shall report the services using procedure codes 96101-96127.

(4) Mental health providers shall use the following modifiers to describe the practitioner providing the health services:

- (a) -AH, for services provided by a licensed psychologist.
- (b) -AL, for services provided by a limited licensed psychologist.
- (c) -AJ, for services provided by a certified social worker.
- (d) -LC, for services provided by a licensed professional counselor.
- (e) -CS, for services provided by a limited licensed counselor.
- (f) -MF, for services provided by a licensed marriage and family therapist.
- (g) -ML, for services provided by a limited licensed marriage and family therapist.

R 418.10208 Vision services.

Rule 208. (1) A medical diagnostic eye evaluation by a practitioner is an integral part of all vision services.

(2) Intermediate and comprehensive ophthalmological services include medical diagnostic eye evaluation and services, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, determination of refractive state, tonometry, or motor evaluation. These procedures shall not be billed in conjunction with procedure codes 92002, 92004, 92012, and 92014.

(3) Only an ophthalmologist or a doctor of optometry shall use procedure codes 92002, 92004, 92012, and 92014.

(4) A doctor of optometry shall use procedure codes 92002-92287 to describe services.

(5) An employer is not required to reimburse or cause to be reimbursed charges for an optometric service unless that service is included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(6) Suppliers of vision and prosthetic optical procedures shall use the appropriate procedure code V0000-V2999 listed in the HCPCS Level II codebook, as adopted by reference in 418.10107, to describe services provided.

(7) Payment shall be made for the following vision CPT codes: \$50.00 for V2744, V2750, and V2760; \$25.00 for V2715; and \$160.00 for V2020.

R418.10212 Physical and occupational therapy; physical medicine services; physical treatment.

Rule 212. (1) For the purposes of workers' compensation, physical medicine services, procedure codes 97010-97799, shall be referred to as "physical treatment" when the services are provided by a practitioner other than a physical therapist or an occupational therapist. Physical therapy means physical treatment provided by a licensed physical therapist. Occupational therapy means physical treatment provided by an occupational therapist.

(2) Physical medicine services shall be restorative. If documentation does not support the restorative nature of the treatment, then the service shall not be reimbursed.

(3) Any of the following may provide physical treatment, to the extent that licensure, registration, or certification law allows:

- (a) A doctor of medicine.
- (b) A doctor of osteopathic medicine and surgery.
- (c) A doctor of dental surgery.
- (d) A doctor of chiropractic.
- (e) A doctor of podiatric medicine and surgery.
- (f) A physical therapist.
- (g) An occupational therapist.

(4) Only a licensed physical therapist, licensed occupational therapist, or licensed practitioner may use procedure codes 97161-97168 to describe the physical medicine and rehabilitation evaluation services. Job-site evaluations may be paid to a licensed occupational therapist, a licensed physical therapist, or a physician. Job-site evaluations for workers' compensation are by report and are described on the bill using codes WC500-WC600.

(5) If a practitioner performs and bills for physical treatment, then the practitioner shall do all of the following:

- (a) Perform an initial evaluation.
- (b) Develop a treatment plan.
- (c) Modify the treatment as necessary.

(d) Perform a discharge evaluation. The practitioner shall provide the carrier with an initial evaluation and a progress report every 30 calendar days and at discharge. Documentation requirements are the same as the requirements in R 418.10204(2).

(6) A provider shall report procedure code 97750 to describe a functional capacity evaluation. The carrier shall reimburse a maximum of 24 units or 6 hours for the initial evaluation. Not more than 4 additional units shall be billed for a re-evaluation occurring within 2 months.

(7) Physical medicine modalities are those agents applied to produce therapeutic changes to tissue and include, but are not limited to, thermal, acoustic, light, mechanical, or electric energy. Both of the following apply:

(a) Supervised modalities include procedure codes 97010-97028. These codes do not require direct 1-on-1 patient contact by the provider. These modalities shall be performed in conjunction with a therapeutic procedure including manipulative services or the modalities shall not be reimbursed.

(b) Constant attendance modalities are those procedure codes 97032-97039 that require direct 1-on-1 patient contact by the provider.

(8) Therapeutic procedure codes 97110-97546 are procedures that effect change through the application of clinical skills and services that attempt to improve function. The physician or therapist shall have direct 1-on-1 patient contact.

(9) The following provisions apply to the listed modality services:

(a) Whirlpool shall only be reimbursed when done for debridement or as part of a restorative physical treatment program.

(b) Procedure 97010 is a bundled procedure code and shall not be reimbursed separately.

(c) Not more than 1 deep heat procedure shall be billed on the same date of service for the same diagnosis. Deep heat procedures include diathermy, microwave, ultrasound, and phonophoresis.

(d) Phonophoresis shall be billed using procedure code 97035 with modifier code -22 and shall be reimbursed at the same rate as procedure code 97035, plus \$2.00 for the active ingredient used in the process.

- (e) Iontophoresis shall include the solution, medication, and the electrodes.
- (f) Electrical stimulation shall include the electrodes.
- (g) Procedure codes 97032, 97033, and 97035 shall not be reimbursed to a doctor of chiropractic.
- (h) Fluidotherapy, a dry whirlpool treatment, shall be reported using code 97022.

R418.10214 Orthotic and prosthetic equipment.

Rule 214. (1) A copy of a prescription by 1 of the following is required for prosthetic and orthotic equipment:

- (a) A doctor of medicine.
 - (b) A doctor of osteopathic medicine and surgery.
 - (c) A doctor of chiropractic.
 - (d) A doctor of podiatric medicine and surgery.
- (2) Orthotic equipment may be any of the following:

- (a) Custom-fit.
- (b) Custom-fabricated.
- (c) Non-custom supply that is prefabricated or off-the-shelf.

(3) A non-custom supply shall be billed using procedure code 99070, appropriate L-codes or A4570 for a prefabricated orthosis.

(4) An orthotist or prosthetist that is certified by the American board for certification in orthotics and prosthetics shall bill orthosis and prostheses that are custom-fabricated, molded to the patient, or molded to a patient model. Licensed physical and licensed occupational therapists may bill orthoses using L-codes within their discipline's scope of practice. In addition, a doctor of podiatric medicine and surgery may bill for a custom fabricated or custom-fit, or molded patient model foot orthosis using procedure codes L3000-L3649.

(5) If a licensed occupational therapist or licensed physical therapist constructs an extremity orthosis that is not adequately described by another L-code, then the therapist shall bill the service using an unlisted or "not otherwise specified" L-code. The carrier shall reimburse this code as a "by report" or "BR" procedure. The provider shall include the following information with the bill:

- (a) A description of the orthosis.
- (b) The time taken to construct or modify the orthosis.
- (c) The charge for materials, if applicable.
- (6) L-code procedures shall include fitting and adjustment of the equipment.

(7) The health care services division shall provide the maximum allowable payments for L-code procedures separate from these rules on the agency's website, www.michigan.gov/wca. If an L-code procedure does not have an assigned maximum allowable payment, then the procedure shall be by report, "BR."

(8) A provider may not bill more than 4 dynamic prosthetic test sockets without documentation of medical necessity. If the physician's prescription or medical condition requires utilization of more than 4 test sockets, then a report shall be included with the bill that outlines a detailed description of the medical condition or circumstances that necessitate each additional test socket provided.

PART 4. SURGERY

R 418.10404 Follow-up care occurring during global service.

Rule 404. (1) Follow-up care for a diagnostic procedure shall refer only to the days required to recover from the diagnostic procedure and not the treatment of the underlying condition.

(2) Follow-up care for therapeutic surgical procedures includes only that care that is usually part of the surgical service. Complications, exacerbations, recurrence, or the presence of other compensable diseases or injuries requiring additional services should be reported with the identification of appropriate

procedures. The follow-up days for the surgical procedures are adopted from the "Medicare RBRVS: The Physicians Guide," as referenced in R 418.10107. The follow-up days for each surgical procedure are provided separate from these rules on the agency website, www.michigan.gov/wca. All of the following apply to the global service provider:

(a) If a carrier requests the surgeon to see an injured worker during the global service period for the purpose of job restrictions, job adjustments, or return to work, then the visit shall not be considered part of the global surgery package. If the carrier requests the visit, then the carrier shall prior authorize the visit assigning an authorization number. The provider shall bill the visit using procedure 99455 and modifier -32, including the authorization number in box 23 of the CMS 1500 form. The carrier shall not deny a prior authorized visit and shall reimburse the provider for the prior authorized visit. The maximum allowable payment for 99455-32 shall be listed in the manual published separate from these rules.

(b) The medical record shall reflect job adjustments, job restrictions or limitations, or return to work date, and the provider shall include the medical record with the bill.

(c) If an insured employer requests the surgeon to see an injured worker during the global surgery period for the purpose of job adjustments, restrictions, or return to work, then the employer shall obtain the prior authorization number from the carrier for the visit.

(3) Hospital follow-up care or a hospital visit by the practitioner responsible for the surgery shall be considered part of the surgical follow-up days listed for the procedure and shall not be paid as an independent procedure.

R 418.10416 Assistant surgeon.

Rule 416. (1) The carrier shall reimburse for an assistant surgeon service for those surgical procedures designated by CMS as allowing additional reimbursement for a surgical assistant. The surgical procedures allowing reimbursement for an assistant surgeon shall be provided separate from these rules on the agency website, www.michigan.gov/wca.

(2) Any of the following may bill assistant surgeon services using modifier -80:

(a) A doctor of dental surgery.

(b) A doctor of osteopathy.

(c) A doctor of medicine.

(d) A doctor of podiatry.

(3) A physician's assistant or an advanced practice nurse with a specialty licensure certification issued by the state may bill assistant surgeon services using modifier -81.

PART 9. BILLING

SUBPART A. PRACTITIONER BILLING

R 418.10904 Procedure codes and modifiers.

Rule 904. (1) A health care service shall be billed with procedure codes adopted from "Current Procedural Terminology (CPT®) 2017 Professional Edition" or "HCPCS 2017 Level II Professional Edition," as referenced in R 418.10107. Procedure codes from the CPT code set shall not be included in these rules, but shall be provided on the workers' compensation agency's website at www.michigan.gov/wca. Refer to "Current Procedural Terminology (CPT®) 2017 Professional Edition," as referenced in R 418.10107, for standard billing instructions, except where otherwise noted in these rules. A provider billing services described with procedure codes from "HCPCS 2017 Level II Professional Edition" shall refer to the publication as adopted by reference in R 418.10107 for coding information.

(2) The following ancillary service providers shall bill codes from "HCPCS 2017 Level II Professional Edition," as adopted by reference in R 418.10107, to describe the ancillary services:

- (a) Ambulance providers.
- (b) Certified orthotists and prosthetists.
- (c) Medical suppliers, including expendable and durable equipment.
- (d) Hearing aid vendors and suppliers of prosthetic eye equipment.
- (e) A home health agency.

(3) If a practitioner performs a procedure that cannot be described by 1 of the listed CPT or HCPCS procedure codes, then the practitioner shall bill the unlisted procedure code. An unlisted procedure code shall only be reimbursed when the service cannot be properly described with a listed code and the documentation supporting medical necessity includes all of the following:

- (a) Description of the service.
- (b) Documentation of the time, effort, and equipment necessary to provide the care.
- (c) Complexity of symptoms.
- (d) Pertinent physical findings.
- (e) Diagnosis.
- (f) Treatment plan.

(4) The provider shall add a modifier code, found in Appendix A of the CPT codebook as adopted by reference in R 418.10107, following the correct procedure code describing unusual circumstances arising in the treatment of a covered injury or illness. When a modifier code is applied to describe a procedure, a report describing the unusual circumstances shall be included with the charges submitted to the carrier.

(5) Applicable modifiers from table 10904 shall be added to the procedure code to describe the type of practitioner performing the service. The required modifier codes for describing the practitioner are as follows:

Table 10904 Modifier Codes

- AA Anesthesia services performed personally by anesthesiologist.
- AD When an anesthesiologist provides medical supervision for more than 4 qualified individuals being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.
- AH When a licensed psychologist bills a diagnostic service or a therapeutic service, or both.
- AJ When a certified social worker bills a therapeutic service.
- AL A limited license psychologist billing a diagnostic service or a therapeutic service.
- CS When a limited licensed counselor bills for a therapeutic service.
- GF Non-physician (nurse practitioner, advanced practice nurse, or physician assistant) provides services in an office or clinic setting or in a hospital setting.
- LC When a licensed professional counselor performs a therapeutic service.
- MF When a licensed marriage and family therapist performs a therapeutic service.
- ML When a limited licensed marriage and family therapist performs a service.
- TC When billing for the technical component of a radiology service.
- QK When an anesthesiologist provides medical direction for not more than 4 qualified individuals being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.
- QX When a certified registered nurse anesthetist or certified anesthesiologist assistant performs a service under the medical direction of an anesthesiologist.
- QZ When a certified registered nurse anesthetist performs anesthesia services without medical direction.

R 418.10905 Billing for physical and occupational therapy.

Rule 905. (1) A physical or occupational therapist shall bill procedure codes 97010-97799. A licensed occupational therapist or licensed physical therapist in independent practice shall place his or her signature and license or certification number on the bill.

(2) Only a physician, licensed occupational therapist or a licensed physical therapist shall bill for job site evaluation or treatment. The reimbursement for these procedures shall be contractual between the carrier and provider and shall be billed as listed in the following table: Code Descriptor WC500 Job site evaluation; patient specific, initial 60 minutes WC505 each additional 30 minutes, by contractual agreement WC550 Job site treatment; patient specific, initial 60 minutes WC555 each additional 30 minutes, by contractual agreement WC600 Mileage for job site evaluation or job site treatment per mile.

(3) Procedures 97760 and 97761 shall only be reimbursed when billed by a licensed occupational or licensed physical therapist.

(4) Only a licensed physical or occupational therapist shall bill for work hardening services, "by report" or "BR," procedure codes 97545 and 97546.

R 418.10909 Billing for home health services.

Rule 909. (1) Services provided by a home health agency are considered ancillary services requiring a written prescription by a licensed practitioner certifying medical necessity. A copy of the prescription shall be attached to the bill.

(2) A home health agency shall submit charges to the workers' compensation carrier using the UB-04 claim form.

(3) A home health agency shall use procedure codes from the HCPCS Level II codebook, as adopted by reference in R 418.10107 to identify services provided.

(4) A home health agency shall not bill for the services of a social worker unless the certified social worker is providing medically necessary therapeutic counseling.

(5) A home health agency may bill supplies with 99070, the unlisted CPT® code for miscellaneous supplies, or the appropriate supply code from the HCPCS Level II codebook as adopted by reference in R 418.10107.

(6) When a procedure code is described by the HCPCS Level II codebook as per diem, the "by report" service is reimbursed per visit. When the HCPCS Level II codebook describes a service as time-based the service is "by report," and the procedure is reimbursed according to the time provided.

R 418.10912 Billing for prescription medications.

Rule 912. (1) Prescription drugs may be dispensed to an injured worker by either an outpatient pharmacy or a health care organization as defined in these rules. These rules shall apply to the pharmacy dispensing the prescription drugs to an injured worker only after the pharmacy has either written or oral confirmation from the carrier that the prescriptions or supplies are covered by workers' compensation insurance.

(2) When a generic drug exists, the generic drug shall be dispensed. When a generic drug does not exist, the brand name drug may be dispensed. A physician may only write a prescription for "DAW", or dispense as written, when the generic drug has been utilized and found to be ineffective or has caused adverse effects for the injured worker. A copy of the medical record documenting the medical necessity for the brand name drug shall be submitted to the carrier.

(3) A bill or receipt for a prescription drug from an outpatient pharmacy, practitioner, or health care organization shall be submitted to the carrier and shall include the name, address, and social security number of the injured worker. An outpatient pharmacy shall bill the service using the NCPDP Workers'

Compensation/Property & Casualty Universal Claim Form or an invoice and shall include either the pharmacy's NPI or NCPDP number, and the NDC of the prescription drug. When the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form is used for billing by an outpatient pharmacy, the dispense fee shall be billed without use of the corresponding WC700 code.

(4) A health care organization or physician office dispensing the prescription drug shall bill the service on the CMS 1500 claim form. Procedure code 99070 shall be used to code the service and the national drug code shall be used to describe the drug.

(5) If an injured worker has paid for a prescription drug for a covered work illness, then the worker may send a receipt showing payment along with the drug information to the carrier for reimbursement.

(6) An outpatient pharmacy or health care organization shall include all of the following information when submitting a bill for a prescription drug to the carrier:

- (a) The brand or chemical name of the drug dispensed.
- (b) The NDC number from Red Book or Medi-Span as adopted by reference in R 418.10107.
- (c) The dosage, strength, and quantity dispensed.
- (d) The date the drug was dispensed.
- (e) The physician prescribing the drug.

(7) A practitioner or a health care organization, other than an inpatient hospital, shall bill WC700-G to describe the dispense fee for each generic prescription drug and WC700-B to describe the dispense fee for each brand name prescription drug. A provider will only be reimbursed for 1 dispense fee for each prescription drug in a 10-day period. A dispense fee shall not be billed with "OTC"s, over-the-counter drugs.

R 418.10920 Billing for supplementary radiology supplies.

Rule 920. (1) If a description of a diagnostic radiology procedure includes the use of contrast materials, then those materials shall not be billed separately as they are included in the procedure.

(2) A radiopharmaceutical diagnostic low osmolar contrast materials and paramagnetic contrast materials shall only be billed when the CPT codebook instructions indicate supplies shall be listed separately.

(3) If allowed separate reimbursement under this rule, a provider shall include an invoice documenting the wholesale price of the contrast material used and the provider shall be reimbursed the wholesale price of the contrast material.

R 418.10923b Billing for ambulatory surgery center (ASC) or freestanding surgical outpatient facility (FSOF).

Rule 923b. (1) An ASC or FSOF shall be licensed by the Michigan department of licensing and regulatory affairs under part 208 of the code or if it has an agreement with the centers for Medicare and Medicaid services (CMS) to participate in Medicare. The owner or operator of the facility shall make the facility available to other physicians, dentists, podiatrists, or providers who comprise its professional staff. The following apply:

(a) When a surgery procedure is appropriately performed in the ASC or FSOF and CMS has not assigned a payment code for that procedure, the procedure shall be considered BR.

(b) The ASC or FSOF shall be reimbursed the maximum allowable paid for the payment code, taking into consideration the multiple procedure rule for facilities as defined by CMS.

(2) Billing instructions in this rule do not apply to a hospital-owned freestanding surgical outpatient facility billing with the same tax identification number as the hospital.

(3) An ASC or FSOF shall bill the facility services on the CMS 1500 claim form and shall include modifier SG to identify the service as the facility charge. The place of service shall be "24." The

appropriate HCPCS or CPT procedure code describing the service performed shall be listed on separate lines of the bill.

(4) Modifier 50, generally indicating bilateral procedure, is not valid for the ASC or FSOF claim. Procedures performed bilaterally shall be billed on 2 separate lines of the claim form and shall be identified with modifiers, LT for left and RT for right.

(5) An ASC or FSOF shall only bill for outpatient procedures that, in the opinion of the attending physician, can be performed safely without requiring inpatient overnight hospital care and are exclusive of such surgical and related care as licensed physicians ordinarily elect to perform in their private offices.

(6) The payment for the surgical code includes the supplies for the procedure.

(7) Durable medical equipment, the technical component (-TC) of certain radiology services, certain drugs, and biologicals that are allowed separate payment under the outpatient prospective payment system (OPPS) will be provided separate from the rules on the agency's website, www.michigan.gov/wca.

(8) Items implanted into the body that remain in the body at the time of discharge (such as plates, pins, screws, mesh) from the facility are reimbursable when they are designated by CMS as pass through items. These pass through items will be provided separate from these rules on the agency's website, www.michigan.gov/wca. The facility shall bill implant items with the appropriate HCPCS code that is reimbursable under the OPPS. A report listing a description of the implant and a copy of the facility's cost invoice, including any full or partial credit given for the implant, shall be included with the bill.

(9) Those radiological services that are allowed separate payment under the OPPS will be provided separate from the rules on the agency's website, www.michigan.gov/wca. When radiology procedures are performed intraoperatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and post-operative radiology services may be globally billed.

(10) At no time shall the ASC or FSOF bill for practitioner services on the facility bill.

(11) When an allowed drug or biological, provided separate from these rules on the agency's website, www.michigan.gov/wca, is billed by the ASC or FSOF, it shall be listed by the appropriate HCPCS or CPT procedure code. All of the following apply:

- (a) Each allowable drug or biological shall be listed on a separate line.
- (b) Units administered shall be listed for each drug or biological.
- (c) A dispense fee shall not be billed.

R418.10926 Billing for air ambulance services.

Rule 926. (1) Air ambulance providers shall bill procedure codes A0430, A0431, A0435, and A0436 as appropriate from the HCPCS codebook, as adopted by reference in R 418.10107.

(2) A hospital-owned air ambulance provider billing with the same tax identification number as the hospital shall submit charges for air ambulance services on a UB-04 form. All other air ambulance providers shall submit charges for ambulance services on a CMS-1500 form.

(3) Air ambulance services are considered reasonable when a medical condition, in whole or in part, is such that transportation by either basic or advanced life support ground ambulance would constitute a threat to the patient's life or seriously endanger the patient's health.

(4) A properly submitted air ambulance bill shall include documentation indicating the necessity of air ambulance services.

(5) An air ambulance service shall be covered only to the nearest facility capable of furnishing the required level and type of care for the injury or illness involved.

(6) The ambulance point of pick up shall be reported by its 5-digit ZIP code. Charges for services and mileage shall be based on documented loaded patient mileage only. If the patient is pronounced dead by

a legally authorized professional after the air ambulance has taken off, but before being loaded onto the ambulance for transport, then the MAP is the appropriate base rate, with no amount allowed for mileage or for a rural adjustment.

(7) Ambulance origin and destination modifiers listed in the HCPCS Level II codebook, as adopted by reference in R 418.10107, shall be used on the bill as appropriate and will be listed on the agency website at www.michigan.gov/wca.

(8) All items and services associated with the ambulance transport are included in the maximum allowable payment and shall not be unbundled and billed separately.

PART 10. REIMBURSEMENT SUBPART A. PRACTITIONER REIMBURSEMENT

R 418.101002 Conversion factors for practitioner services.

Rule 1002. (1) The workers' compensation agency shall determine the conversion factors for medicine, evaluation and management, physical medicine, surgery, pathology, and radiology procedures. The conversion factor shall be used by the workers' compensation agency for determining the maximum allowable payment for medical, surgical, and radiology procedures. The maximum allowable payment shall be determined by multiplying the appropriate conversion factor times the relative value unit assigned to a procedure. The relative value units are provided for the medicine, surgical, and radiology procedure codes separate from these rules on the agency's website, www.michigan.gov/wca. The relative value units shall be updated by the workers' compensation agency using codes adopted from "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107(a). The workers' compensation agency shall determine the relative values by using information found in the "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107(c).

(2) The conversion factor for medicine, radiology, and surgical procedures shall be \$47.19 for the year 2017 and shall be effective for dates of service on the effective date of these rules.

R 418.101003 Reimbursement for "by report" and ancillary procedures.

Rule 1003. (1) If a procedure code does not have a listed relative value, or is noted BR, then the carrier shall reimburse the provider's usual and customary charge or reasonable payment, whichever is less, unless otherwise specified in these rules.

(2) The following ancillary services are by report and the provider shall be reimbursed either at the practitioner's usual and customary charge or reasonable payment, whichever is less:

- (a) Ground ambulance services.
- (b) Dental services.
- (c) Vision and prosthetic optical services.
- (d) Hearing aid services.
- (e) Home health services.

(3) Orthotic and prosthetic procedures, L0000-L9999, shall be reimbursed by the carrier at Medicare plus 5%. The health care services division shall provide maximum allowable payments for L-code procedures separate from these rules on the agency's website, www.michigan.gov/wca. Orthotic and prosthetic procedures with no assigned maximum allowable payment shall be considered by report procedures and require a written description accompanying the charges on the CMS-1500 claim form. The report shall include date of service, a description of the service or services provided, the time involved, and the charge for materials and components.

R 418.101003a Reimbursement for dispensed medications.

Rule 1003a. (1) Prescription medication shall be reimbursed at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span referenced in R 418.10107, plus a dispense fee. All of the following apply:

(a) The dispense fee for a brand name drug shall be \$3.50 and shall be billed with WC700-B.

(b) The dispense fee for a generic drug shall be \$5.50 and shall be billed with WC700-G.

(c) Reimbursement for repackaged pharmaceuticals shall be at a maximum reimbursement of AWP minus 10% based upon the original manufacturer's NDC number, as published by Red Book or Medi-Span, plus a dispensing fee of \$3.50 for brand name and \$5.50 for generic.

(d) All pharmaceutical bills submitted for repackaged products shall include the original manufacturer or distributor stock package national drug code or NDC number.

(e) When an original manufacturer's NDC number is not available in either Red Book or Medi-Span and a pharmaceutical is billed using an unlisted or "not otherwise specified code," the payer shall select the most closely related NDC number to use for reimbursement of the pharmaceutical.

(2) Over-the-counter drugs (OTC's), dispensed by a provider other than a pharmacy, shall be dispensed in 10-day quantities and shall be reimbursed at the average wholesale price, as determined by Red Book or Medi-Span or \$2.50, whichever is greater.

(3) Commercially manufactured topical medications, which are over-the-counter or contain over-the-counter ingredients and do not meet the definition of "custom compound" as defined in R 418.10108, dispensed by a pharmacy or a provider other than a pharmacy, shall be dispensed in a 30-day supply. Regardless of dispensing party, reimbursement shall be at a maximum of the acquisition cost invoice, plus a single dispense fee. The single dispense fee shall be \$8.50 and shall be billed with WC700-T.

R 418.101008a Required documentation for reimbursement of treatment for chronic, non-cancer pain with opioids.

Rule 1008a. (1) In order to receive reimbursement for opioid treatment beyond 90 days, the physician seeking reimbursement shall submit a written report to the payer not later than 90 days after the initial opioid prescription fill for chronic pain and every 90 days thereafter. The written report shall include all of the following:

(a) A review and analysis of the relevant prior medical history, including any consultations that have been obtained, and a review of data received from an automated prescription drug monitoring program in the treating jurisdiction, such as the Michigan Automated Prescription System (MAPS), for identification of past history of narcotic use and any concurrent prescriptions.

(b) A summary of conservative care rendered to the worker that focused on increased function and return to work.

(c) A statement on why prior or alternative conservative measures were ineffective or contraindicated.

(d) A statement that the attending physician has considered the results obtained from appropriate industry accepted screening tools to detect factors that may significantly increase the risk of abuse or adverse outcomes including a history of alcohol or other substance abuse.

(e) A treatment plan that includes all of the following:

(i) Overall treatment goals and functional progress.

(ii) Periodic urine drug screens.

(iii) A conscientious effort to reduce pain through the use of non-opioid medications, alternative non-pharmaceutical strategies, or both.

(iv) Consideration of weaning the injured worker from opioid use.

(f) An opioid treatment agreement that has been signed by the worker and the attending physician. This agreement shall be reviewed, updated, and renewed every 6 months. The opioid treatment agreement

shall outline the risks and benefits of opioid use, the conditions under which opioids will be prescribed, and the responsibilities of the prescribing physician and the worker.

(2) The provider may bill the additional services required for compliance with these rules utilizing CPT procedure code 99215 for the initial 90-day report and all subsequent follow-up reports at 90-day intervals.

(3) Providers may bill \$25.00 utilizing code MPS01 for accessing MAPS or other automated prescription drug monitoring program in the treating jurisdiction.

(4) A provider performing drug testing, drug screening, and drug confirmation testing shall use the appropriate procedure codes G0480-G0483, G0659, or 80305-80307 listed in the HCPCS or CPT codebook, as adopted by reference in R418.10107.

R418.101010 Reimbursement for air ambulance services

Rule 1010. (1) Reimbursement for air ambulance services, when not provided by a hospital owned air ambulance provider billing with the same tax identification number as the hospital, shall be determined by using the reimbursement rate published by CMS. The formula for determining the maximum allowable paid (MAP) for ambulance services is determined by multiplying the (Medicare rate) X (1.40). The MAP shall be published in the health care services fee schedule and shall utilize the practice expense (PE) of the geographical information (GPCI), which shall be a melded average using 60% of the figures published for the city of Detroit added to 40% of the figures published for the rest of this state.

(2) The MAP for procedure codes A0430, A0431, A0435, and A0436 shall list 2 values for each procedure code, an urban and a rural MAP. Reimbursement is based on the zip code at the ambulance point of pick up and based on documented loaded patient mileage only. Urban or rural designations for each zip code shall be based on CMS and indicated on the agency website at www.michigan.gov.

(3) Mileage shall be reimbursed per documented loaded patient miles flown and is expressed in statute mile.

(a) For trips totaling up to 100 covered miles, the mileage shall be rounded up to the nearest tenth of a mile.

(b) For trips totaling 100 covered miles or greater, mileage shall be rounded up to the nearest whole number mile without use of a decimal.

(4) If the patient was pronounced dead by a legally authorized professional after the air ambulance was dispatched but before the ambulance arrived at the scene, reimbursement shall be made for a fixed wing or rotary wing base rate, as applicable. Neither mileage nor a rural adjustment shall be paid. The base rate shall be indicated on the agency website at www.michigan.gov.

(5) The MAP for procedure codes A0430, A0431, A0435, and A0436 includes all items, services, and supplies associated with such transport, which shall not be unbundled and billed separately.

(6) A hospital owned air ambulance provider billing with the same tax identification number as the hospital shall be reimbursed based on the hospital's cost-to-charge ratio, which shall be indicated on the agency website at www.michigan.gov.

PART 15 PROCEDURE CODE AND REIMBURSEMENT TABLES

R 418.101501 Tables for health care services and procedures.

Rule 1501. The agency shall provide separate from these rules a manual, tables, and charts containing all of the following on the agency's website, www.michigan.gov/wca:

(a) Procedure codes and relative value units for the medical, surgical, and radiology services.

(b) Reference to the ancillary services identified in the HCPCS Level II codebook as adopted by reference in R 418.10107.

(c) Maximum payment ratios for hospitals.

(d) A copy of the billing forms and instructions for completion.

R 418.101503 Laboratory procedure codes and maximum allowable payments.

Rule 1503. (1) The workers' compensation agency shall determine the maximum allowable payment for the laboratory procedure codes found in the CPT and HCPCS codebooks, as adopted by reference in R418.10107. The rate shall be determined by multiplying the Medicare rate established for this state by 110%.

(2) The pathology procedure codes found in the 80000 series of the CPT code set have assigned relative values and shall be provided on the agency's website at www.michigan.gov/wca.

(3) The maximum allowable payments for the laboratory and pathology procedures shall be provided on the agency's website, www.michigan.gov/wca.

(4) A provider performing drug testing, drug screening, and drug confirmation testing shall use the appropriate procedure codes G0480-G0483, G0659, or 80305-80307 listed in the HCPCS or CPT codebook, as adopted by reference in R418.10107. A maximum of one service unit per procedure code per date of service shall be billed with these codes.

ADMINISTRATIVE RULES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BUREAU OF COMMUNITY SERVICES-CRIME VICTIM'S SERVICES COMMISSION

GENERAL RULES

Filed with the Secretary of State on March 5, 2018

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, or 45(a)(6) of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

(By authority conferred on the crime victims compensation board by section 3 of 1976 PA 223, MCL 18.353.)

R 18.351 and R 18.354 of the Michigan Administrative Code are amended, as follows:

R 18.351 Definitions.

Rule 1. (1) As used in these rules:

(a) "Accomplice" means any person who knowingly aids or assists another person in the commission of a crime, either before, during, or after the crime.

(b) "Act" means 1976 PA 223, MCL 18.351 to 18.368.

(c) "Civil infraction" has the meaning prescribed by section 6a of 1949 PA 300, MCL 257.6

(d) "Closed session" means a meeting or part of a meeting of the commission that is closed to the public in order to protect certain rights of confidentiality.

(e) "Crime" means an act or omission forbidden by law that is not designated as a civil infraction and that is punishable, upon conviction, by imprisonment, a fine that is not a civil fine, or other penal discipline.

(f) "Criminally responsible" means legally accountable or legally answerable for a crime.

(g) "Household" means persons who dwell together as a family under 1 roof and who are related by blood, marriage, or judicial decree.

(h) "Intimate personal privacy" means matters dealing with the mental or physical health of a person or the details of a crime involving sexual assault in any degree.

(i) "Legally incapacitated person" means a person, other than a minor, for whom a guardian has been appointed by a court.

(j) "Meeting" means the convening of the commission at which a majority of the board are present for the purpose of deliberating toward or rendering a decision on a public policy.

(k) "Minor" means a person who is less than 18 years of age.

(l) "Other services necessary" means recognized medical treatment, convalescent aids, supplies, and other equipment needed by the victim because of physical incapacity sustained as a direct result of the crime.

(m) "Peace officer" means an employee of this state, or any political subdivision of this state thereof, who is employed as a police officer, sheriff, firefighter, conservation officer, or similar officer exercising powers of a police officer.

(n) "Resident" means a person who is living in this state when the crime occurs. Resident does not include a person who resides in another state or foreign country and who is temporarily in this state for business, recreation, or personal matters.

(o) "Unreimbursed and unreimbursable expenses" means expenses for which the claimant has no means of payment other than the claimant's assets or through an award of the commission.

(p) "Writing" means any of the following:

(i) Handwriting.

(ii) Typewriting.

(iii) Printing.

(iv) Photostating.

(v) Photographing.

(vi) Photocopying.

(vii) Any other means of recording, including the recording of letters, words, pictures, sounds, symbols, or any combination thereof.

(viii) Maps.

(ix) Papers.

(x) Magnetic or punched cards.

(xi) Discs.

(xii) Drums.

(xiii) Any other means of recording or retaining meaningful contents.

(2) Terms defined in the act have the same meanings when used in these rules.

R 18.354 Claim filing time.

Rule 4. (1) A claim is subject to the time limits for filing that are set forth in section 5 of the act; however, if a claim is filed after the time limits in section 5 of the act, the commission may presume that good cause to file a claim late exists unless contrary evidence exists.

(2) Children of a victim born after the victim's death are surviving children and are eligible for an award.

(3) A child support order demonstrates eligibility for a support award when the parent ordered to pay support was a victim of a crime who died as a direct result of the crime.

**PROPOSED ADMINISTRATIVE RULES,
NOTICES OF PUBLIC HEARINGS**

MCL 24.242(3) states in part:

“... the agency shall submit a copy of the notice of public hearing to the Office of Regulatory Reform for publication in the Michigan register. An agency's notice shall be published in the Michigan register before the public hearing and the agency shall file a copy of the notice of public hearing with the Office of Regulatory Reform.”

MCL 24.208 states in part:

“Sec. 8. (1) The Office of Regulatory Reform shall publish the Michigan register at least once each month. The Michigan register shall contain all of the following:

* * *

(d) Proposed administrative rules.

(e) Notices of public hearings on proposed administrative rules.”

PROPOSED ADMINISTRATIVE RULES

DEPARTMENT OF ~~COMMUNITY HEALTH AND HUMAN SERVICES~~

BUREAU OF ~~LEGAL AFFAIRS~~ **EMS TRAUMA AND PREPAREDNESS**

EMERGENCY MEDICAL SERVICES - LIFE SUPPORT AGENCIES & MEDICAL CONTROL

Filed with the Secretary of State on

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, or 45a (6) of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

(By authority conferred on the director of the department of ~~community health and human services~~ by section ~~20910~~ **20975** of 1978 PA 368, MCL 333. ~~2091075~~, and ~~Executive Reorganization Order Nos. 1996-1, 1996-2, and 2003-18, MCL 330.3101, 445.2001, and 445.2011~~ **section 2233 of 1978 PA 368, MCL 333.2233.**)

R 325.22181 is amended in the Michigan Administrative Code as follows:

R 325.22181 Ground ambulance; requirements.

Rule 181. (1) An ambulance operation shall maintain the manufacturer's certificate of compliance on file at the time of application to the department for licensure of each ground ambulance. The certificate of compliance shall be executed by the final manufacturer of each ground ambulance and be on a form prescribed by the department.

(2) The manufacturer of a ground ambulance executing a certificate of compliance shall comply with the ambulance structural and mechanical specifications **with one of the following standards** that ~~were~~ **was** in effect at the time of manufacture ~~and shall maintain test data demonstrating compliance:~~

(a) Federal ~~(KKK-A-1822)~~ standards, excluding the paint scheme.

(b) **The Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Standard for Ambulances (GVSA) in its entirety.**

(c) **The National Fire Protection Association (NFPA) 1917 Standard for Automotive Ambulances in its entirety.**

(3) **The manufacturer** shall maintain test data demonstrating compliance.

(4) Once licensed for service, an ambulance shall not be required to meet later modified state vehicle standards during its use by the ambulance operation that obtained the license.

(35) A ground ambulance referred to in subrule (2) of this rule shall not be modified to alter its original design upon which the certificate of compliance was based, unless a new certificate is issued verifying that the modifications have not altered the integrity of the vehicle.

(46) The patient compartment of a ground ambulance that has met applicable ~~federal~~ standards at the time of manufacture may be remounted on to a different chassis by a qualified vehicle modifier as designated by the chassis manufacturer. A new manufacturer's certificate of compliance shall be issued that identifies the new vehicle identification number and demonstrates compliance with either KKK, **GVSA, or NFPA** standards in accordance with subrule (2) of this rule.

NOTICE OF PUBLIC HEARING

NOTICE OF PUBLIC HEARING
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of EMS and Trauma / Bureau of EMS Trauma and Preparedness
Administrative Rules for Emergency Medical Services-Life Support Agencies and Medical Control
.Rule Set 2017-046 HS

The Michigan Department of Health and Human Services will hold a public hearing to receive public comments on amendments to the Emergency Medical Services-Life Support Agencies and Medical Control rule set.

Monday, April 23, 2018
9:00 A.M. to 12 P.M.
JAR Conference Room
1001 Terminal Road
Lansing, Michigan 48909
Email: MDHHS-AdminRules@michigan.gov

The general purpose of these rules is to address the service requirements of a life support agency, including ambulance operational standards in the State. The current federal standards are subjected to a sunset provision and will expire. New standards are needed as a guideline for the proper construction of ambulances. The EMS Coordination Committee has provided revised language to allow for nationally approved and accepted safety standards.

By authority conferred on the Director of the Department of Health and Human Services by section 20975 of 1978 PA 368, MCL 333.20975; and section 2233 of 1978 PA 368, MCL 333.2233. These rules will take effect 30 days after filing with the Secretary of State. The rules (Rule Set 2017-046 HS) are published on the Michigan Government web site at <http://www.michigan.gov/orr> and in the Michigan Register in the April 1, 2018 issue. Copies of the draft rules may also be obtained by mail or electronic transmission at the following address:

Department of Health and Human Services
Attn: Sabrina Slee
1001 Terminal Road, Lansing, MI 48909
Telephone: 517-241-3025
E-mail: MDHHS-AdminRules@michigan.gov

Comments on the rules may be made in person at the hearing or by mail or electronic mail until Friday, April 27, 2018.

The public hearings will be conducted in compliance with the 1990 Americans with Disabilities Act, in accessible buildings with handicap parking available. Anyone needing assistance to take part in the hearings due to disability may call 517-335-4276 to make arrangements.

**CORRECTION OF OBVIOUS
ERRORS IN PUBLICATION**

MCL 24.256(1) states in part:

“Sec. 56. (1) The Office of Regulatory Reform shall perform the editorial work for the Michigan register and the Michigan Administrative Code and its annual supplement. The classification, arrangement, numbering, and indexing of rules shall be under the ownership and control of the Office of Regulatory Reform, shall be uniform, and shall conform as nearly as practicable to the classification, arrangement, numbering, and indexing of the compiled laws. The Office of Regulatory Reform may correct in the publications obvious errors in rules when requested by the promulgating agency to do so...”

**CORRECTION OF OBVIOUS
ERRORS IN PUBLICATION**

Ms. Deidre O'Berry
Office of Performance and Transformation Romney Building
111 S. Capitol - 8th Floor Lansing, MI 48909

RE: Leasing State-Owned Metallic Mineral Rights R 299.4001 - R 299.4007 Dear Ms. O'Berry:
The Department of Natural Resources (DNR) has determined that a correction is needed to an obvious error and, under MCL 24.256(1), the Office of Regulatory Reform may correct obvious errors in rules when requested by the promulgating agency.

The DNR requests corrections to R 299.4001 (g), R 299 .4004(8), and R 299.4006(6) to add missing words in each rule.

In R 299.4001(g), the DNR requests that the word "the" be added between "means" and "director" as shown in bold:

R 299.4001 Definitions.
Rule 1. As used in these rules:

(g) "Lessor" means **the** director of the Michigan department of natural resources, or the director's designee, for the state of Michigan.

In R 299.4004(8), the DNR requests that the word "lands" be added between "Available" and "on" as shown in bold:

R 299.4004 Offer at public auction; procedure.

* * *

(8) Available **lands** on which bids were not accepted or where the successful bidder defaults must be offered at the following lease auction unless withdrawn from auction for any stated reason, or leased under R 299.4005 .

In R 299.4006(6), the DNR requests that the words "to the lessee and" be added between "lease" and "retain" as shown in bold:

R 299.4006 Awarding of leases.

* * *

(6) The department shall return the original of the fully executed lease **to the lessee and** retain a copy.

**CORRECTION OF OBVIOUS
ERRORS IN PUBLICATION**

Deidre O’Berry
Office of Regulatory Reinvention

RE: 2017-031 TY—Charitable Gaming Rules
Request for Correction to R 432.21514(3) and (4)
Filed with the Secretary of State on March 5, 2018

Dear Deidre,

Pursuant to our discussion, I am writing to request that a correction be made to the above-referenced rule restoring the word “shall” that was replaced with the word “are” in the text filed with the Secretary of State. Please correct Rule 514(3) and (4) so that it will read:

(3) Raffle ticket sellers in a licensed raffle, other than an in-house raffle, shall not be entitled to and shall not receive anything of value for their services except as prescribed by R 432.21517.

(4) Raffle ticket sellers in a licensed in-house raffle shall not be entitled to and shall not receive anything of value for their services except as prescribed by R 432.21516 and R 432.21517.

Thank you in advance Deidre, for enabling this correction.

Sincerely,

Margaret Patterson
Regulatory Affairs Officer
Department of Treasury

**EXECUTIVE ORDERS
AND
EXECUTIVE REORGANIZATION ORDERS**

MCL 24.208 states in part:

“Sec. 8. (1) The Office of Regulatory Reform shall publish the Michigan register at least once each month. The Michigan register shall contain all of the following:

(a) Executive orders and executive reorganization orders.”

EXECUTIVE ORDERS

**EXECUTIVE ORDER
No. 2018 - 3**

MICHIGAN STATISTICAL ANALYSIS CENTER

WHEREAS, to promote safe communities and support an effective criminal justice system, there is a continued need for the evaluation and dissemination of criminal justice data; and

WHEREAS, certain grant funding made available to the State of Michigan by the United States Department of Justice is dependent on the authorization of a statistical analysis center within the state by executive order;

NOW, THEREFORE, I, Richard D. Snyder, Governor of the state of Michigan, by virtue of the power and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, do hereby create the Michigan Statistical Analysis Center and designate the Michigan State University School of Criminal Justice to operate the center and carry out the following responsibilities:

1. Collect, analyze and interpret state and local data on criminal and juvenile justice;
2. Produce statistical reports on crime, delinquency, and the criminal and juvenile justice systems;
3. Provide information and statistics about crime and delinquency and criminal and juvenile justice policy to state and local agencies;
4. Provide state and local government with access to federal resources in criminal and juvenile justice data and documents;
5. Serve as an information center and repository for criminal and juvenile justice data and documents; and
6. Provide and coordinate the sharing of data with the Federal Bureau of Justice Statistics and other federal and state agencies.

This Order shall become effective upon filing.

Given under my hand and the Great Seal of
the state of Michigan this _____ day of
March, in the Year of our Lord Two
Thousand Eighteen

RICHARD D. SNYDER
GOVERNOR

BY THE GOVERNOR:

SECRETARY OF STATE

**MICHIGAN ADMINISTRATIVE CODE TABLE
(2017 SESSION)**

MCL 24.208 states in part:

“Sec. 8. (1) The Office of Regulatory Reform shall publish the Michigan register at least once each month. The Michigan register shall contain all of the following:

* * *

“(2) The office of regulatory reform shall publish a cumulative index for the Michigan register.”

The following table cites administrative rules promulgated during the year 2017, and indicates the effect of these rules on the Michigan Administrative Code (1979 ed.).

**MICHIGAN ADMINISTRATIVE CODE TABLE
(2017 RULE FILINGS)**

R Number	Action	2018 MR Issue	R Number	Action	2018 MR Issue	R Number	Action	2018 MR Issue
18.351	*	5	338.7001a	*	5	340.1799c	*	2
18.354	*	5	338.10204	*	5	408.10001	*	2
257.531	*	5	338.10207	*	5	408.10002	A	2
257.532	*	5	338.10208	*	5	408.10003	*	2
257.533	*	5	338.10209	*	5	408.10004	*	2
257.534	*	5	338.10210	*	5	408.10005	*	2
257.535	*	5	338.10212	*	5	408.10011	*	2
257.536	*	5	338.10213	*	5	408.10012	*	2
257.537	*	5	338.10301	*	5	408.10013	A	2
257.538	*	5	338.10303	*	5	408.10015	*	2
257.539	*	5	338.10303a	*	5	408.10016	R	2
257.540	*	5	338.10303b	*	5	408.10017	*	2
299.4001	*	4	338.10303c	*	5	408.10021	R	2
299.4002	*	4	338.10303d	A	5	408.10022	R	2
299.4003	*	4	338.10305	*	5	408.10026	*	2
299.4004	*	4	338.10305a	*	5	408.10031	*	2
299.4006	*	4	338.10305b	*	5	408.10034	*	2
299.4007	*	4	338.10305c	*	5	408.10036	*	2
299.4051	*	4	338.10306	*	5	408.10098	R	2
299.4052	*	4	338.10307	*	5	408.10201	*	2
299.4053	*	4	338.10308	*	5	408.10202	A	2
299.4054	*	4	338.10309	*	5	408.10203	A	2
299.4055	*	4	338.10310	*	5	408.10204	A	2
325.2651	*	2	338.10401	*	5	408.10205	*	2
325.2652	*	2	338.10403	*	5	408.10206	R	2
325.2653	*	2	338.10404c	A	5	408.10207	R	2
325.2654	*	2	338.10405c	A	5	408.10208	R	2
325.2655	*	2	338.10601	*	5	408.10211	R	2
325.2656	R	2	338.10602	*	5	408.10213	R	2
325.2657	R	2	338.10702	*	5	408.10215	R	2
325.14202	*	3	338.10703	*	5	408.10217	R	2
325.14205	*	3	338.10704	*	5	408.10219	R	2
325.34001	A	3	340.241	*	2	408.10220	R	2
325.34005	A	3	340.242	*	2	408.10221	R	2
325.34010	A	3	340.1707	*	2	408.10223	R	2
338.201	A	2	340.1719	R	2	408.10227	R	2
338.202	A	2	340.1723c	*	2	408.10228	R	2
338.203	A	2	340.1724d	*	2	408.10230	R	2
338.204	A	2	340.1742	*	2	408.10231	R	2

(* Amendment to Rule, A Added Rule, N New Rule, R Rescinded Rule)

2018 MR 5 – April 1, 2018

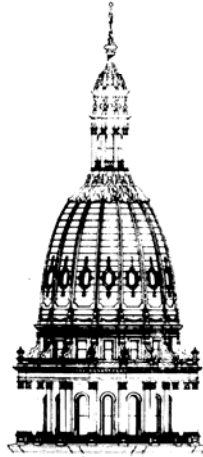
R Number	Action	2018 MR Issue	R Number	Action	2018 MR Issue	R Number	Action	2018 MR Issue
408.10232	R	2	408.10404	R	2	408.10526	R	3
408.10233	R	2	408.10406	R	2	408.10527	R	3
408.10235	R	2	408.10407	R	2	408.10528	R	3
408.10236	R	2	408.10408	R	2	408.10529	R	3
408.10237	R	2	408.10421	R	2	408.10530	R	3
408.10239	R	2	408.10422	R	2	408.10531	R	3
408.10240	R	2	408.10427	R	2	408.10532	R	3
408.10241	R	2	408.10428	R	2	408.10533	R	3
408.10301	R	2	408.10431	R	2	408.10534	R	3
408.10305	R	2	408.10432	R	2	408.10535	R	3
408.10306	R	2	408.10433	R	2	408.10541	R	3
408.10307	R	2	408.10441	R	2	408.10542	R	3
408.10308	R	2	408.10442	R	2	408.10543	R	3
408.10310	R	2	408.10443	R	2	408.10544	R	3
408.10311	R	2	408.10445	R	2	408.10545	R	3
408.10321	R	2	408.10446	R	2	408.11801	*	3
408.10323	R	2	408.10447	R	2	408.11807	*	3
408.10324	R	2	408.10451	R	2	408.11808	*	3
408.10325	R	2	408.10452	R	2	408.11821	*	3
408.10326	R	2	408.10454	R	2	408.11823	*	3
408.10328	R	2	408.10456	R	2	408.11824	*	3
408.10331	R	2	408.10501	*	3	408.11835	*	3
408.10333	R	2	408.10502	*	3	408.11843	*	3
408.10335	R	2	408.10503	*	3	408.11844	*	3
408.10341	R	2	408.10504	*	3	408.11852	*	3
408.10342	R	2	408.10505	*	3	408.11854	*	3
408.10345	R	2	408.10506	*	3	408.11863	*	3
408.10351	R	2	408.10507	*	3	408.11865	*	3
408.10352	R	2	408.10508	*	3	408.11871	*	3
408.10353	R	2	408.10509	*	3	408.11872	*	3
408.10354	R	2	408.10511	R	3	408.11873	*	3
408.10355	R	2	408.10512	R	3	408.12111	*	3
408.10357	R	2	408.10513	R	3	408.12131	*	3
408.10361	R	2	408.10518	A	3	408.12155	*	3
408.10365	R	2	408.10521	R	3	408.12164	*	3
408.10371	R	2	408.10522	R	3	408.12165	*	3
408.10372	R	2	408.10523	R	3	408.12169	*	3
408.10401	R	2	408.10524	R	3	408.12176	*	3
408.10403	R	2	408.10525	R	3	408.12190	*	3

(* Amendment to Rule, **A** Added Rule, **N** New Rule, **R** Rescinded Rule)

2018 MR 5 – April 1, 2018

R Number	Action	2018 MR Issue	R Number	Action	2018 MR Issue	R Number	Action	2018 MR Issue
408.12501	*	3	408.13344	*	3	418.10212	*	5
408.12510	*	3	408.13355	*	3	418.10214	*	5
408.12701	*	3	408.13367	*	3	418.10404	*	5
408.12702	*	3	408.13387	*	3	418.10416	*	5
408.12711	*	3	408.13390	R	3	418.10904	*	5
408.12712	*	3	408.13395a	A	3	418.10905	*	5
408.12714	*	3	408.13395b	A	3	418.10909	*	5
408.12717	*	3	408.13395c	A	3	418.10912	*	5
408.12718	*	3	408.13395d	A	3	418.10920	*	5
408.12719	*	3	408.13395e	A	3	418.10923b	*	5
408.12724	*	3	408.13395f	A	3	418.10926	A	5
408.12726	*	3	408.13395g	A	3	418.101002	*	5
408.12727	*	3	408.15001	*	3	418.101003	*	5
408.12728	*	3	408.15003	*	3	418.101003a	*	5
408.12730	*	3	408.15004	*	3	418.101008a	*	5
408.12733	*	3	408.15201	*	3	418.101010	A	5
408.12736	*	3	408.15209	*	3	418.101501	*	5
408.12739	*	3	408.15211	*	3	418.101503	*	5
408.12741	*	3	408.15212a	*	3	432.2	*	5
408.12755	*	3	408.15222	*	3	432.5	*	5
408.12759	*	3	408.15225	*	3	432.6	*	5
408.12761	*	3	408.15226	*	3	432.16	*	5
408.12767	*	3	408.15229	*	3	432.17	*	5
408.12773	*	3	408.15231	*	3	432.21514	*	5
408.12781	*	3	408.15247	*	3	432.21516	*	5
408.12784	*	3	408.15251	*	3	474.101	R	2
408.12791	*	3	408.15254	*	3	474.102	R	2
408.12792	*	3	408.15261	*	3	474.103	R	2
408.12793	*	3	408.15271	*	3	474.104	R	2
408.12798	*	3	408.15273	*	3	474.105	R	2
408.13301	*	3	408.15275	*	3	474.106	R	2
408.13301a	*	3	408.18601	*	3			
408.13302	*	3	408.18602	*	3			
408.13303	*	3	408.18605	*	3			
408.13305	*	3	408.18610	*	3			
408.13306	*	3	418.10106	*	5			
408.13311	*	3	418.10107	*	5			
408.13325	*	3	418.10207	*	5			
408.13329	*	3	418.10208	*	5			

(* Amendment to Rule, A Added Rule, N New Rule, R Rescinded Rule)



**CUMULATIVE
INDEX**

A

**ATTORNEY GENERAL, DEPARTMENT OF
Opinions**

Application of Minimum Wage Laws to Agricultural Employees
OAG Opinion No. 7301 (2018-1)

E

Executive Order

No. 1 -2018 (2018-1)

No. 2 -2018 (2018-2)

No. 3 -2018 (2018-5)

EDUCATION, DEPARTMENT OF

Fees for Transporting Pupils to or from Nonmandatory and Noncredited Events (2018-2)
Special Education Programs and Services (2018-2)

ENVIRONMENTAL QUALITY, DEPARTMENT OF

Oil and Gas Operations (2018-2*)

Part 9. Emission Limitation and Prohibitions – Miscellaneous (2018-3*)

Supplying Water to the Public (2018-2*)

H

**HEALTH AND HUMAN SERVICES, DEPARTMENT OF
Correction:**

Birth Defect Reporting (2018-1)

Crime Victim Services – General Rules (2018-5)

EMS Organization Licensure Rules (2018-5*)

H

INSURANCE AND FINANCE, DEPARTMENT OF

Certificates of No-Fault Self -Insurance (2018-5)

L

LICENSING AND REGULATORY AFFAIRS, DEPARTMENT OF

A standing Order for Dispensing Opioid Antagonists (2018-2)

Board of Nursing – General Rules (2018-5)

Licensing Substance Use Disorder Programs (2018-3)

Michigan Gas Safety Standards (2018-4*)

Occupational Code Renewals (2018-1*)

Part 1. General Provisions GI (2018-2)

Part 2. Walking Working Surfaces GI (2018-2)

Part 3. Fixed Ladders GI (2018-2)

Part 4. Portable Ladders GI (2018-2)

Part 5. Powered Platforms for Building Maintenance GI (2018-3)

Part 18. Overhead and Gantry Cranes GI (2018-3)

Part 21. Powered Industrial Trucks GI (2018-3)

Part 25. Manlifts GI (2018-3)

Part 27. Woodworking Machinery GI (2018-3)

Part 33. Personal Protective Equipment GI (2018-3)

Part 50. Telecommunications GI (2018-3)

Part 52. Sawmills GI (2018-3)

Part 86. Electric Power Generation, Transmission, and Distribution GI (2018-3)

Part 340. Beryllium GI (2018-3)

Public Health Code – General Rules (2018-5)

Real Estate Appraisers - General Rules (2018-1*)

Responsibilities of Providers of Basic Local Exchange Service that Cease to Provide the Service (2018-5)

Securities (2018-4*)

State Boundary Commission (2018-2*)

Workers' Compensation Health Care Services (2018-5)

N

NATURAL RESOURCES, DEPARTMENT OF

Correction:

Metallic Minerals Leased on State Lands (2018-5)

Metallic Minerals Leased on State Lands (2018-4)

Underground Gas Storage Leases on State Lands (2018-4)

S

STATE POLICE, DEPARTMENT OF

Test for Breath Alcohol (2018-2)

T

TRANSPORTATION, DEPARTMENT OF

Motor Bus Transportation (2018-2)

**TREASURY, DEPARTMENT OF
Correction:**

Charitable Gaming Rules (2018-5)

Charitable Gaming Rules (2018-5)

Lottery Rules (2018-5)

**ADMINISTRATIVE RULES
ENROLLED SENATE AND HOUSE BILLS
SIGNED INTO LAW OR VETOED
(2017 SESSION)**

Mich. Const. Art. IV, §33 provides: “Every bill passed by the legislature shall be presented to the governor before it becomes law, and the governor shall have 14 days measured in hours and minutes from the time of presentation in which to consider it. If he approves, he shall within that time sign and file it with the secretary of state and it shall become law . . . If he does not approve, and the legislature has within that time finally adjourned the session at which the bill was passed, it shall not become law. If he disapproves . . . he shall return it within such 14-day period with his objections, to the house in which it originated.”

Mich. Const. Art. IV, §27, further provides: “No act shall take effect until the expiration of 90 days from the end of the session at which it was passed, but the legislature may give immediate effect to acts by a two-thirds vote of the members elected to and serving in each house.”

MCL 24.208 states in part:

“Sec. 8. (1) The Office of Regulatory Reform shall publish the Michigan register at least once each month. The Michigan register shall contain all of the following:

* * *

(b) On a cumulative basis, the numbers and subject matter of the enrolled senate and house bills signed into law by the governor during the calendar year and the corresponding public act numbers.

(c) On a cumulative basis, the numbers and subject matter of the enrolled senate and house bills vetoed by the governor during the calendar year.”

2018 Michigan Public Acts Table

Legislative Service Bureau
Legal Division, Statutory Compiling and Law Publications Unit
124 W. Allegan, Lansing, MI 48909

March 14, 2018
Through Act 56 of 2018

PA No.	ENROLLED		I.E.* Yes/No	Governor Approved	Filed Date	Effective Date	SUBJECT
	HB	SB					
1		0095	Yes	No	1/18	1/18/18	Use tax; collections; use tax on the difference; accelerate phase-in. **** Governor Veto of 7/25/17 overridden and approved by 2/3 vote on 1/17/18 **** (Sen. D. Robertson)
2		0094	Yes	No	1/18	1/18/18	Sales tax; collections; use tax on the difference; accelerate phase-in. **** Governor Veto of 7/25/17 overridden and approved by 2/3 vote on 1/17/18 **** (Sen. D. Hildenbrand)
3	4533		Yes	1/26	1/26	1/26/18	Natural resources; hunting; nonresident 3-day small game license; establish. (Rep. C. VanderWall)
4	4957		Yes	1/26	1/26	1/26/18	Natural resources; hunting; mentored youth hunting license; allow individual to purchase additional licenses. (Rep. G. Howell)
5		0207	Yes	1/26	1/26	4/26/18	Law enforcement; other; arrest power for state property security officers; modify. (Sen. M. Green)
6		0525	Yes	1/26	1/26	1/26/18	Courts; reorganization; reorganization of courts and number of judgeships; modify. (Sen. R. Jones)
7		0702	Yes	1/26	1/26	1/26/18	Local government; other; educational instruction access act; clarify deed restriction language. (Sen. P. Pavlov)
8	4849		Yes	1/26	1/26	4/26/18	Cemeteries and funerals; other; money held by a county for care and preservation of cemetery lots; require to be presumed abandoned under certain circumstances. (Rep. J. Alexander)

- * - I.E. means Legislature voted to give the Act immediate effect.
- ** - Act takes effect on the 91st day after sine die adjournment of the Legislature.
- *** - See Act for applicable effective date.
- + - Line item veto.
- ++ - Pocket veto.
- # - Tie bar.

2018 Michigan Public Acts Table

PA No.	ENROLLED		I.E.* Yes/No	Governor Approved	Filed Date	Effective Date	SUBJECT
	HB	SB					
9	4940		Yes	1/26	1/26	4/26/18	Agriculture ; associations and commissions; dry bean act; modify apportionment of districts and create a member at large. (Rep. E. Canfield)
10	5144		Yes	1/26	1/26	1/26/18	Marihuana ; facilities; requirements for the issuance of a state operating license; revise, and provide for other general amendments. (Rep. K. Kesto)
11	4735		Yes	2/6	2/6	5/7/18	Education ; dual enrollment; definition of eligible institution for postsecondary dual enrollment; expand. (Rep. A. Miller)
12	4218		Yes	2/6	2/6	5/7/18	Juveniles ; juvenile justice services; qualifications for direct care worker of a juvenile court-operated residential care facility; modify. (Rep. E. Leutheuser)
13	4821		Yes	2/6	2/6	5/7/18 #	Probate ; wills and estates; appointment of the state or county public administrator as personal representative of a decedent's estate in a formal proceeding; require, and modify powers and duties of public administrators acting as personal representatives. (Rep. J. Runestad)
14	4822		Yes	2/6	2/6	5/7/18 #	Probate ; wills and estates; appointment of the state or county public administrator as personal representative of a decedent's estate in a formal proceeding; require, and modify powers and duties of public administrators acting as personal representatives. (Rep. J. Ellison)
15	4470		Yes	2/6	2/6	5/7/18 #	Civil procedure ; statute of limitations; appointment of receiver; clarify that appointment does not constitute an action under the "one act" rule, and clarify that statute of limitations under other act does not conflict with the revised judicature act. (Rep. B. Iden)
16	4471		Yes	2/6	2/6	5/7/18 #	Civil procedure ; remedies; uniform commercial real estate receivership act; enact. (Rep. B. Iden)
17	4644		Yes	2/12	2/13	5/14/18	Traffic control ; traffic regulation; annual multiple trip permit for vehicles; allow. (Rep. T. Cole)
18		0409	Yes	2/12	2/13	5/14/18	Natural resources ; Great Lakes; use of certain bottomlands for private harbors; provide for. (Sen. T. Casperson)

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2018 Michigan Public Acts Table

PA No.	ENROLLED		I.E.* Yes/No	Governor Approved	Filed Date	Effective Date	SUBJECT
	HB	SB					
19		0543	Yes	2/14	2/14	5/15/18	Highways; name; portion of I-94 in Kalamazoo County; designate as the "Chief Ed Switalski Memorial Highway". <i>(Sen. M. O'Brien)</i>
20		0316	Yes	2/14	2/14	2/14/18	Natural resources; other; certain regulations on the taking of frogs; repeal. <i>(Sen. D. Booher)</i>
21		0529	Yes	2/14	2/14	5/15/18 #	Human services; county services; child care fund act; establish reimbursement procedures for appeal of determination. <i>(Sen. P. MacGregor)</i>
22		0530	Yes	2/14	2/14	5/15/18 #	Human services; county services; child care fund act; designate state as first payer and clarify reimbursable expenses. <i>(Sen. P. MacGregor)</i>
23		0574	Yes	2/12	2/14	5/15/18	Education; financing; levy of regional enhancement millage; revise. <i>(Sen. D. Hildenbrand)</i>
24		0634	Yes	2/14	2/14	2/14/18	Health occupations; psychologists; temporary license for individuals seeking a limited license as a psychologist; allow for extensions or renewals under certain circumstances and exempt certain individuals from examination requirement to obtain a limited license as a psychologist. <i>(Sen. W. Schmidt)</i>
25	4787		Yes	2/14	2/14	2/14/18	Natural resources; fishing; ice shanty identification requirements and removal dates; modify. <i>(Rep. C. VanderWall)</i>
26	5284		Yes	2/12	2/14	2/14/18	Property; conveyances; transfer of certain state-owned property in Saginaw County; provide for. <i>(Rep. V. Guerra)</i>
27	4523		Yes	2/20	2/21	5/22/18	Explosives; other; Michigan explosives permitting act; repeal. <i>(Rep. S. Johnson)</i>
28	4524		Yes	2/20	2/21	5/22/18 #	Torts; liability; joint and several liability; revise to reflect repeal of explosives act of 1970. <i>(Rep. S. VanSingel)</i>

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2018 Michigan Public Acts Table

PA No.	ENROLLED		I.E.* Yes/No	Governor Approved	Filed Date	Effective Date	SUBJECT
	HB	SB					
29	5137		Yes	2/20	2/21	5/22/18	Crimes; explosives; certain activities with respect to explosive materials; prohibit and provide penalties. (Rep. S. Johnson)
30	5138		Yes	2/20	2/21	5/22/18 #	Criminal procedure; sentencing guidelines; certain activities with respect to explosive materials; prohibit, and enact sentencing guidelines. (Rep. S. Johnson)
31	4950		Yes	2/20	2/21	2/21/18	Corporate income tax; insurance companies; tax imposed on gross direct premiums; exclude health maintenance organizations. (Rep. H. Vaupel)
32	5047		Yes	2/20	2/21	2/21/18 #	Corporate income tax; insurance companies; definition of insurance company; exclude health maintenance organizations. (Rep. H. Vaupel)
33	4752		Yes	2/20	2/21	2/21/18	Probate; wills and estates; fee ratio and reporting requirement; revise, and remove sunset. (Rep. K. Kesto)
34	4813		Yes	2/20	2/21	5/22/18	Animals; other; training requirements for animal control shelters, animal protection shelters, and class B dealers to obtain a limited permit to buy, possess, and administer certain animal tranquilizers and sodium pentobarbital; revise. (Rep. H. Vaupel)
35	4956		Yes	2/20	2/21	5/22/18	Vehicles; equipment; distance requirement between kingpins and axles on certain trucks; eliminate. (Rep. T. Cole)
36	5200		Yes	2/20	2/21	2/21/18 #	Natural resources; other; certain sections in the natural resources and environmental protection act; update and eliminate certain references. (Rep. G. Howell)
37	4411		Yes	2/20	2/21	2/21/18	Liquor; licenses; eligibility of certain local governmental units to receive a scheduled event license; modify population threshold. (Rep. C. VanderWall)
38		0748	Yes	2/28	2/28	2/28/18	Individual income tax; exemptions; treatment of certain deductions and exemptions for state purposes after reduction of federal exemptions to zero; clarify and increase. (Sen. J. Brandenburg)

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2018 Michigan Public Acts Table

PA No.	ENROLLED		I.E.* Yes/No	Governor Approved	Filed Date	Effective Date	SUBJECT
	HB	SB					
39		0750	Yes	2/28	2/28	2/28/18	Individual income tax ; city; treatment of exemptions after reduction of federal exemptions to zero; clarify. <i>(Sen. M. Knollenberg)</i>
40	5175		Yes	2/28	2/28	5/29/18	Liquor ; licenses; qualifications of an eligible merchant that may fill and sell growlers of beer; revise. <i>(Rep. T. Brann)</i>
41	4472		Yes	2/28	2/28	5/29/18	Health ; pharmaceuticals; food and drug administration-designated interchangeable biological drug products; allow pharmacists to dispense under certain circumstances. <i>(Rep. J. Bizon)</i>
42	4665		Yes	2/28	2/28	2/28/18	Education ; discipline; enrollment eligibility in strict discipline academy; modify. <i>(Rep. R. VerHeulen)</i>
43	5040		Yes	3/1	3/1	3/1/18	Traffic control ; other; driver responsibility fees; eliminate collection of beginning September 30, 2018. <i>(Rep. L. Chatfield)</i>
44	5041		Yes	3/1	3/1	3/1/18	Traffic control ; other; educational outreach program for driver responsibility fee amnesty program; create. <i>(Rep. S. Santana)</i>
45	5043		Yes	3/1	3/1	3/1/18	Traffic control ; other; driver responsibility fees; eliminate collection of for certain individuals who entered into an installment payment program. <i>(Rep. R. Hauck)</i>
46	5044		Yes	3/1	3/1	3/1/18	Traffic control ; other; driver responsibility fees; eliminate assessment beginning October 1, 2018. <i>(Rep. J. Bellino)</i>
47		0613	Yes	3/1	3/1	3/1/18	Traffic control ; other; reference in enhanced driver license and enhanced official state personal identification card act to driver responsibility fees; modify. <i>(Sen. R. Jones)</i>
48	5046		Yes	3/1	3/1	3/1/18	Traffic control ; other; waiver of driver responsibility fee for successful participation in DWI sobriety court program; provide for on or after October 1, 2018. <i>(Rep. S. Marino)</i>

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	HB	SB					
49		0625	Yes	3/1	3/1	3/31/18	Traffic control; other ; workforce training payment program; create. (Sen. K. Horn)
50	5079		Yes	3/1	3/1	3/31/18	Traffic control; driver license ; driver responsibility fee; amend eligibility for alternative payment programs and reinstatement of driver license, and eliminate driver responsibility fee assessments for certain offenses. (Rep. D. Rendon)
51		0400	Yes	3/6	3/6	3/6/18	Communications; emergency 9-1-1 ; emergency 9-1-1 service enabling act; modify. (Sen. R. Jones)
52		0481	Yes	3/6	3/6	6/4/18	Highways; name ; portion of US-10; designate as the "Marine Lance Corporal Ryan Burgess Memorial Highway". (Sen. J. Stamas)
53	4191		Yes	3/6	3/6	6/4/18	Highways; name ; portion of I-75; designate as the "Officer Martin 'Marty' Chivas Memorial Highway". (Rep. M. Howrylak)
54	5216		Yes	3/6	3/6	6/4/18	Civil procedure; other ; report of prisoner actions dismissed as frivolous; eliminate. (Rep. K. Kesto)
55	5039		Yes	3/6	3/6	3/6/18	Transportation; motor fuel tax ; motor fuel tax exemptions; modify. (Rep. J. Wentworth)
56		0616	Yes	3/6	3/6	6/4/18	Children; protection ; access to electronic central registry; allow tribal entity or tribal social services representative to have access. (Sen. J. Emmons)

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