CHAPTER 305–H.F.No. 3372

An act relating to health; changing provisions for uniform billing forms and electronic claim filing; establishing compliance procedures for electronic transactions; amending Minnesota Statutes 2006, sections 62J.51, subdivisions 17, 18; 62J.52, subdivision 4; 62J.59; 72A.201, subdivision 4; Minnesota Statutes 2007 Supplement, sections 62J.52, subdivisions 1, 2; 62J.536, subdivision 1, by adding subdivisions; repealing Minnesota Statutes 2006, sections 62J.52, subdivision 5; 62J.58.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2006, section 62J.51, subdivision 17, is amended to read:

Subd. 17. **Uniform billing form CMS 1450.** "Uniform billing form CMS 1450" means the most current version of the uniform billing form known as the CMS 1450 ~~or UB92,~~ developed by the National Uniform Billing Committee ~~in 1992 and approved for implementation in October 1993, and any subsequent amendments to the form~~.

Sec. 2. Minnesota Statutes 2006, section 62J.51, subdivision 18, is amended to read:

Subd. 18. **Uniform billing form CMS 1500.** "Uniform billing form CMS 1500" means the ~~1990~~ most current version of the health insurance claim form, CMS 1500, developed by the National Uniform Claim Committee ~~and any subsequent amendments to the form~~.

Sec. 3. Minnesota Statutes 2007 Supplement, section 62J.52, subdivision 1, is amended to read:

Subdivision 1. **Uniform billing form CMS 1450.** (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, institutionally owned or operated outpatient services rendered by providers in Minnesota, and institutional or noninstitutional home health services that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form CMS 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee~~, as adopted and finalized by the Minnesota Uniform Billing Committee~~.

(c) Services to be billed using the uniform billing form CMS 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are

exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, ICF/MR's, and home health (Medicare part B); institutional owned or operated outpatient services such as waivered services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, federally qualified health centers, and community mental health centers; home health services such as home health intravenous therapy providers, ~~waivered services, personal care attendants,~~ and hospice; and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

(e) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Sec. 4. Minnesota Statutes 2007 Supplement, section 62J.52, subdivision 2, is amended to read:

Subd. 2. **Uniform billing form CMS 1500.** (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form CMS 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the Administrative Uniformity Committee entitled standards for the use of the CMS 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form CMS 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, waivered services, personal care attendants, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

(d) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Sec. 5. Minnesota Statutes 2006, section 62J.52, subdivision 4, is amended to read:

Subd. 4. **Uniform pharmacy billing form.** (a) On and after January 1, 1996, all pharmacy services provided by pharmacists in Minnesota that are not currently being billed using an equivalent electronic billing format shall be billed using the NCPDP/universal claim form~~, except as provided in subdivision 5~~.

(b) The instructions and definitions for the use of the uniform claim form shall be in accordance with instructions specified by the commissioner of health~~, except as provided in subdivision 5~~.

Sec. 6. Minnesota Statutes 2007 Supplement, section 62J.536, subdivision 1, is amended to read:

Subdivision 1. **Electronic claims and eligibility transactions required.** (a) Beginning January 15, 2009, all group purchasers must accept from health care providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all group purchasers must accept from health care providers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(b) Beginning January 15, 2009, all group purchasers must transmit to providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December ~~1~~ 15, 2009, all group purchasers must transmit to providers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(c) Beginning January 15, 2009, all health care providers must submit to group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all health care providers must submit to group purchasers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(d) Beginning January 15, 2009, all health care providers must accept from group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 15, 2009, all health care providers must accept from group purchasers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(e) Each of the transactions described in paragraphs (a) to (d) shall require the use of a single, uniform companion guide to the implementation guides described under Code of Federal Regulations, title 45, part 162. The companion guides will be developed pursuant to subdivision 2.

(f) Notwithstanding any other provisions in sections 62J.50 to 62J.61, all group purchasers and health care providers must exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines required under this subdivision. Group purchasers may not impose any fee on providers for the use of the transactions prescribed in this subdivision.

(g) Nothing in this subdivision shall prohibit group purchasers and health care providers from using a direct data entry, Web-based methodology for complying with the requirements of this subdivision. Any direct data entry method for conducting the transactions specified in this subdivision must be consistent with the data content component of the single, uniform companion guides required in paragraph (e) and the implementation guides described under Code of Federal Regulations, title 45, part 162.

Sec. 7. Minnesota Statutes 2007 Supplement, section 62J.536, is amended by adding a subdivision to read:

Subd. 2a. **Group purchasers not covered by HIPAA.** (a) For transactions with group purchasers defined in section 62J.03, subdivision 6, that are not covered under United States Code, title 42, sections 1320d to 1320d-8, the requirements of this section are modified as follows:

(1) The group purchasers may be exempt from one or more of the requirements to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines in subdivision 1 if the commissioner of health determines that:

(i) a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or

(ii) another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.

(2) If group purchasers are exempt from one or more of the requirements to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines in subdivision 1, providers shall also be exempt from exchanging those transactions with the group purchaser.

(3) If the commissioner of health exempts a group purchaser from one or more of the requirements because a transaction is incapable of exchanging data that are currently being exchanged on paper and are necessary to accomplish the purpose of the transaction, the commissioner shall review that exemption annually. If the commissioner determines that the exemption is no longer necessary or appropriate, the commissioner of health shall adopt rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph (e). Group purchasers and providers shall have 12 months to implement any rules adopted.

(4) If the commissioner of health exempts a group purchaser from one or more of the requirements because another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction, the commissioner shall adopt rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the national electronic transaction standard. Group purchasers and providers shall have 12 months to implement any rules adopted.

(5) The requirement of paper claims attachments shall not indicate that a health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K, is incapable of exchanging data that are currently being exchanged on paper provided that the electronic health care claims transaction has a mechanism to link the paper attachments to the electronic claim.

Sec. 8. Minnesota Statutes 2007 Supplement, section 62J.536, is amended by adding a subdivision to read:

Subd. 2b. **Compliance and investigations.** (a) The commissioner of health shall, to the extent practicable, seek the cooperation of health care providers and group purchasers in obtaining compliance with this section and may provide technical assistance to health care providers and group purchasers.

(b) A person who believes a health care provider or group purchaser is not complying with the requirements of this section may file a complaint with the commissioner of health. Complaints filed under this section must meet the following requirements:

(1) A complaint must be filed in writing, either on paper or electronically.

(2) A complaint must name the person that is the subject of the complaint and describe the acts or omissions believed to be in violation of this section.

(3) A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred.

(4) The commissioner may prescribe additional procedures for the filing of complaints as required to satisfy the requirements of this section.

(c) The commissioner of health may investigate complaints filed under this section. The investigation may include a review of the pertinent policies, procedures, or practices of the health care provider or group purchaser and of the circumstances regarding any alleged violation. At the time of initial written communication with the health care provider or group purchaser about the complaint, the commissioner of health shall describe the acts or omissions that are the basis of the complaint. The commissioner may conduct compliance reviews to determine whether health care providers and group purchasers are complying with this section.

(d) Health care providers and group purchasers must cooperate with the commissioner of health if the commissioner undertakes an investigation or compliance review of the policies, procedures, or practices of the health care provider or group purchaser to determine compliance with this section. This cooperation includes, but is not limited to:

(1) A health care provider or group purchaser must permit access by the commissioner of health during normal business hours to its facilities, books, records, accounts, and other sources of information that are pertinent to ascertaining compliance with this section.

(2) If any information required of a health care provider or group purchaser under this section is in the exclusive possession of any other agency, institution, or person and the other agency, institution, or person fails or refuses to furnish the information, the health care provider or group purchaser must so certify and set forth what efforts it has made to obtain the information.

(3) Any individually identifiable health information obtained by the commissioner of health in connection with an investigation or compliance review under this section may not be used or disclosed by the commissioner of health, except as necessary for ascertaining or enforcing compliance with this section.

(e) If an investigation of a complaint indicates noncompliance, the commissioner of health shall attempt to reach a resolution of the matter by informal means. Informal means may include demonstrated compliance or a completed corrective action plan or other agreement. If the matter is resolved by informal means, the commissioner of health shall so inform the health care provider or group purchaser and, if the matter arose from a complaint, the complainant, in writing. If the matter is not resolved by informal means, the commissioner of health shall:

(1) inform the health care provider or group purchaser and provide an opportunity for the health care provider or group purchaser to submit written evidence of any mitigating factors or other considerations. The health care provider or group purchaser must submit any such evidence to the commissioner of health within 30 calendar days of receipt of the notification; and

(2) inform the health care provider or group purchaser, through a notice of proposed determination according to paragraph (i), that the commissioner of health finds that a civil money penalty should be imposed.

(f) If, after an investigation or a compliance review, the commissioner of health determines that further action is not warranted, the commissioner of health shall so inform the health care provider or group purchaser and, if the matter arose from a complaint, the complainant, in writing.

(g) A health care provider or group purchaser may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any individual or other person for:

(1) filing of a complaint under this section;

(2) testifying, assisting, or participating in an investigation, compliance review, proceeding, or contested case proceeding under this section; or

(3) opposing any act or practice made unlawful by this section, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve an unauthorized disclosure of a patient's health information.

(h) The commissioner of health may impose a civil money penalty on a health care provider or group purchaser if the commissioner of health determines that the health care provider or group purchaser has violated this section. If the commissioner of health determines that more than one health care provider or group purchaser was responsible for a violation, the commissioner of health may impose a civil money penalty against each health care provider or group purchaser. The amount of a civil money penalty shall be determined as follows:

(1) The amount of a civil money penalty shall be up to $100 for each violation, but not exceed $25,000 for identical violations during a calendar year.

(2) In the case of continuing violation of this section, a separate violation occurs each business day that the health care provider or group purchaser is in violation of this section.

(3) In determining the amount of any civil money penalty, the commissioner of health may consider as aggravating or mitigating factors, as appropriate, any of the following:

(i) the nature of the violation, in light of the purpose of the goals of this section;

(ii) the time period during which the violation occurred;

(iii) whether the violation hindered or facilitated an individual's ability to obtain health care;

(iv) whether the violation resulted in financial harm;

(v) whether the violation was intentional;

(vi) whether the violation was beyond the direct control of the health care provider or group purchaser;

(vii) any history of prior compliance with the provisions of this section, including violations;

(viii) whether and to what extent the provider or group purchaser has attempted to correct previous violations;

(ix) how the health care provider or group purchaser has responded to technical assistance from the commissioner of health provided in the context of a compliance effort; or

(x) the financial condition of the health care provider or group purchaser including, but not limited to, whether the healthcare provider or group purchaser had financial difficulties that affected its ability to comply or whether the imposition of a civil money penalty would jeopardize the ability of the health care provider or group purchaser to continue to provide, or to pay for, health care.

(i) If a penalty is proposed according to this section, the commissioner of health must deliver, or send by certified mail with return receipt requested, to the respondent written notice of the commissioner of health's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the amount of the proposed penalty;

(4) any circumstances described in paragraph (i) that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the respondent's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

(j) A health care provider or group purchaser may contest whether the finding of facts constitute a violation of this section, according to a contested case proceeding as set forth in sections 14.57 to 14.62, subject to appeal according to sections 14.63 to 14.68.

(k) Any data collected by the commissioner of health as part of an active investigation or active compliance review under this section are classified as protected nonpublic data pursuant to section 13.02, subdivision 13, in the case of data not on individuals and confidential pursuant to section 13.02, subdivision 3, in the case of data on individuals. Data describing the final disposition of an investigation or compliance review are classified as public.

(l) Civil money penalties imposed and collected under this subdivision shall be deposited into a revolving fund and are appropriated to the commissioner of health for the purposes of this subdivision, including the provision of technical assistance.

Sec. 9. Minnesota Statutes 2006, section 62J.59, is amended to read:

62J.59 IMPLEMENTATION OF NCPDP TELECOMMUNICATIONS STANDARD FOR PHARMACY CLAIMS.

(a) ~~Beginning January 1, 1996,~~ All category I and II ~~pharmacists~~ pharmacies licensed in this state shall ~~accept~~ use the most recent HIPAA-mandated version of the NCPDP telecommunication standard ~~format 3.2~~ or the NCPDP ~~tape billing and payment format 2.0~~ batch standard for the electronic submission of claims to group purchasers as appropriate.

(b) ~~Beginning January 1, 1996,~~ All category I and category II group purchasers in this state shall use the most recent HIPAA-mandated version of the NCPDP telecommunication standard ~~format 3.2~~ or NCPDP ~~tape billing and payment format 2.0~~ batch standard for the electronic ~~submission of payment information~~ NCPDP response transaction to ~~pharmacists~~ pharmacies as appropriate.

Sec. 10. Minnesota Statutes 2006, section 72A.201, subdivision 4, is amended to read:

Subd. 4. **Standards for claim filing and handling.** The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) except for claims made under a health insurance policy, after receiving notification of claim from an insured or a claimant, failing to acknowledge receipt of the notification of the claim within ten business days, and failing to promptly provide all necessary claim forms and instructions to process the claim, unless the claim is settled within ten business days. The acknowledgment must include the telephone number of the company representative who can assist the insured or the claimant in providing information and assistance that is reasonable so that the insured or claimant can comply with the policy conditions and the insurer's reasonable requirements. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer and dated. An appropriate notation must include at least the following information where the acknowledgment is by telephone or oral contact:

(i) the telephone number called, if any;

(ii) the name of the person making the telephone call or oral contact;

(iii) the name of the person who actually received the telephone call or oral contact;

(iv) the time of the telephone call or oral contact; and

(v) the date of the telephone call or oral contact;

(2) failing to reply, within ten business days of receipt, to all other communications about a claim from an insured or a claimant that reasonably indicate a response is requested or needed;

(3)(i) unless provided otherwise by clause (ii) or (iii), other law, or in the policy, failing to complete its investigation and inform the insured or claimant of acceptance or denial of a claim within 30 business days after receipt of notification of claim unless the investigation cannot be reasonably completed within that time. In the event that the investigation cannot reasonably be completed within that time, the insurer shall notify the insured or claimant within the time period of the reasons why the investigation is not complete and the expected date the investigation will be complete. For claims made under a health policy the notification of claim must be in writing;

(ii) for claims submitted under a health policy, the insurer must comply with all of the requirements of section 62Q.75;

(iii) for claims submitted under a health policy that are accepted, the insurer must notify the insured or claimant no less than semiannually of the disposition of claims of the insured or claimant. Notwithstanding the requirements of section 72A.20, subdivision 37, this notification requirement is satisfied if the information related to the acceptance of the claim is made accessible to the insured or claimant on a secured Web site maintained by the insurer. For purposes of this clause, acceptance of a claim means that there is no additional financial liability for the insured or claimant, either because there is a flat co-payment amount specified in the health plan or because there is no co-payment, deductible, or coinsurance owed;

(4) where evidence of suspected fraud is present, the requirement to disclose their reasons for failure to complete the investigation within the time period set forth in clause (3) need not be specific. The insurer must make this evidence available to the Department of Commerce if requested;

(5) failing to notify an insured who has made a notification of claim of all available benefits or coverages which the insured may be eligible to receive under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility;

(6) unless otherwise provided by law or in the policy, requiring an insured to give written notice of loss or proof of loss within a specified time, and thereafter seeking to relieve the insurer of its obligations if the time limit is not complied with, unless the failure to comply with the time limit prejudices the insurer's rights and then only if the insurer gave prior notice to the insured of the potential prejudice;

(7) advising an insured or a claimant not to obtain the services of an attorney or an adjuster, or representing that payment will be delayed if an attorney or an adjuster is retained by the insured or the claimant;

(8) failing to advise in writing an insured or claimant who has filed a notification of claim known to be unresolved, and who has not retained an attorney, of the expiration of a statute of limitations at least 60 days prior to that expiration. For the purposes of this clause, any claim on which the insurer has received no communication from the insured or claimant for a period of two years preceding the expiration of the applicable statute of limitations shall not be considered to be known to be unresolved and notice need not be sent pursuant to this clause;

(9) demanding information which would not affect the settlement of the claim;

(10) unless expressly permitted by law or the policy, refusing to settle a claim of an insured on the basis that the responsibility should be assumed by others;

(11) failing, within 60 business days after receipt of a properly executed proof of loss, to advise the insured of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial must be given to the insured in writing with a copy filed in the claim file;

(12) denying or reducing a claim on the basis of an application which was altered or falsified by the agent or insurer without the knowledge of the insured;

(13) failing to notify the insured of the existence of the additional living expense coverage when an insured under a homeowners policy sustains a loss by reason of a covered occurrence and the damage to the dwelling is such that it is not habitable;

(14) failing to inform an insured or a claimant that the insurer will pay for an estimate of repair if the insurer requested the estimate and the insured or claimant had previously submitted two estimates of repair.

Sec. 11. **REPEALER.**

Minnesota Statutes 2006, sections 62J.52, subdivision 5; and 62J.58, are repealed.

Presented to the governor May 9, 2008

Signed by the governor May 13, 2008, 8:22 p.m.