CHAPTER 43--H.F.No. 2193

An act relating to workers' compensation; adopting recommendations of the workers' compensation advisory council regarding inpatient hospital payments; regulating electronic transactions; modifying injury reporting requirements; authorizing rulemaking; requiring a report;amending Minnesota Statutes 2014, sections 176.135, by adding a subdivision; 176.136, subdivision 1b; 176.221, subdivision 8; 176.231, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 176.

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

Section 1. Minnesota Statutes 2014, section 176.135, is amended by adding a subdivision to read:

Subd. 7a. **Electronic transactions.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "workers' compensation payer" means a workers' compensation insurer and an employer, or group of employers, that is self-insured for workers' compensation;

(2) "clearinghouse" has the meaning given in section 62J.51, subdivision 11a; and

(3) "electronic transactions" means the health care administrative transactions described in section 62J.536.

(b) In addition to the requirements of section 62J.536, workers' compensation payers and health care providers must comply with the requirements in paragraphs (c) to (e).

(c) No later than January 1, 2016, each workers' compensation payer must place the following information in a prominent location on its Web site or otherwise provide the information to health care providers:

(1) the name of each clearinghouse with which the workers' compensation payer has an agreement to exchange or transmit electronic transactions, along with the identification number each clearinghouse has assigned to the payer in order to route electronic transactions through intermediaries or other clearinghouses to the payer;

(2) information about how a health care provider can obtain the claim number assigned by the workers' compensation payer for an employee's claim and how the provider should submit the claim number in the appropriate field on the electronic bill to the payer; and

(3) the name, phone number, and e-mail address of contact persons who can answer questions related to electronic transactions on behalf of the workers' compensation payer and the clearinghouses with which the payer has agreements.

(d) No later than July 1, 2016:

(1) health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the most recently approved version

of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter"), according to the requirements in the corresponding implementation guide. The ASC X12N 275 transaction is the only one that shall be used to electronically submit attachments unless a national standard is adopted by federal law or rule. If a new version of the attachment transaction is approved, it must be used one year after the approval date;

(2) workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the most recently approved ASC X12 electronic acknowledgment for the attachment transaction. If a new version of the acknowledgment transaction is approved, it must be used one year after the approval date; and

(3) if a different national claims attachment or acknowledgment requirement is adopted by federal law or rule, it will replace the ASC X12N 275 transaction, and the new standard must be used on the date that it is required by the federal law or rule.

(e) No later than September 1, 2015, workers' compensation payers must provide the patient's name and patient control number on or with all payments made to a provider under this chapter, whether payment is made by check or electronic funds transfer. The information provided on or with the payment must be sufficient to allow providers to match the payment to specific bills. If a bulk payment is made to a provider for more than one patient, the check or electronic funds transfer statement must also specify the amount being paid for each patient. For purposes of this paragraph, the patient control number is located on the electronic health care claim 837 transaction, loop 2300, segment CLM01, and on the electronic health care claim payment/advice 835 transaction, loop 2100, CLP01.

(f) The commissioner may assess a monetary penalty of $500 for each violation of this section, not to exceed $25,000 for identical violations during a calendar year. Before issuing a penalty for a first violation of this section, the commissioner must provide written notice to the noncompliant payer, clearinghouse, or provider that a penalty may be issued if the violation is not corrected within 30 days. Penalties under this paragraph are payable to the commissioner for deposit in the assigned risk safety account.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. Minnesota Statutes 2014, section 176.136, subdivision 1b, is amended to read:

Subd. 1b. **Limitation of liability.** (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a ~~small hospital~~ Critical Access Hospital certified by the Centers for Medicare and Medicaid Services shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive. ~~A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds.~~

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a ~~or~~, 1c ~~or~~, paragraph (a), or section 176.1362 shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph. A prevailing charge established under Minnesota Rules, part 5221.0500, subpart 2, must be based on no more than two years of billing data immediately preceding the date of the service.

(c) The limitation of liability for charges provided by paragraph (b) does not apply to a nursing home that participates in the medical assistance program and whose rates are established by the commissioner of human services.

(d) An employer's liability for treatment, articles, and supplies provided under this chapter by a health care provider located outside of Minnesota is limited to the payment that the health care provider would receive if the treatment, article, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.

EFFECTIVE DATE. This section is effective for billing and payment of inpatient hospital services, articles, and supplies provided to patients discharged on or after January 1, 2016.

Sec. 3. **[176.1362] INPATIENT HOSPITAL PAYMENT.**

Subdivision 1. **Payment based on Medicare MS-DRG system.** (a) Except as provided in subdivisions 2 and 3, the maximum reimbursement for inpatient hospital services, articles, and supplies is 200 percent of the amount calculated for each hospital under the federal Inpatient Prospective Payment System developed for Medicare, using the inpatient Medicare PC-Pricer program for the applicable MS-DRG as provided in paragraph (b). All adjustments included in the PC-Pricer program are included in the amount calculated, including but not limited to any outlier payments.

(b) Payment under this section is effective for services, articles, and supplies provided to patients discharged from the hospital on or after January 1, 2016. Payment for services, articles, and supplies provided to patients discharged on January 1, 2016, through December 31, 2016, must be based on the Medicare PC-Pricer program in effect on January 1, 2016. Payment for inpatient services, articles, and supplies for patients discharged in each calendar year thereafter must be based on the PC-Pricer program in effect on January 1 of the year of discharge.

(c) Hospitals must bill workers' compensation insurers using the same codes, formats, and details that are required for billing for hospital inpatient services by the Medicare program. The bill must be submitted to the insurer within the time period required by section 62Q.75, subdivision 3. For purposes of this section, "insurer" includes both workers' compensation insurers and self-insured employers.

Subd. 2. **Payment for catastrophic, high-cost injuries.** (a) If the hospital's total usual and customary charges for services, articles, and supplies for a patient's hospitalization exceed a threshold of $175,000, annually adjusted as provided in paragraph (b), reimbursement must not be based on the MS-DRG system, but must instead be paid at 75 percent of the hospital's usual and customary charges.

(b) Beginning January 1, 2017, and each January 1 thereafter, the commissioner must adjust the previous year's threshold by the percent change in average total charges per inpatient case, using data available as of October 1 for non-Critical Access Hospitals from the Health Care Cost Information System maintained by the Department of Health pursuant to chapter 144. The commissioner must annually publish notice of the updated threshold in the State Register.

Subd. 3. **Critical Access Hospitals.** Hospitals certified by the Centers for Medicare and Medicaid Services as Critical Access Hospitals shall be reimbursed as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 4. **Submission of information when payment is by MS-DRG.** Except when a postpayment audit is allowed under subdivision 6, an insurer must not require an itemization of charges or additional

documentation to support a bill from a non-Critical Access Hospital when all of the following requirements are met:

(1) the hospital must submit its charges to the insurer on the 837 institutional standard electronic transaction required by section 62J.536;

(2) an MS-DRG must apply to the hospitalization; and

(3) the hospital's total charges must be less than the threshold amount in subdivision 2, as annually adjusted.

Subd. 5. **Prompt payment requirement when MS-DRG payment is made.** (a) When the requirements in subdivision 4 have been met, the insurer must take one of the following actions within 30 days of receipt of the hospital's bill:

(1) pay the hospital's bill as provided in subdivision 1, with no reductions based on a review of charges for specific services, articles, or supplies; or

(2) deny payment for the entire hospitalization for one of the following reasons:

(i) the patient's workers' compensation injury claim is denied;

(ii) the diagnosis for which the patient was hospitalized is not related to the insurer's admitted workers' compensation injury; or

(iii) the hospitalization was not reasonably required to cure and relieve the employee from the effects of the injury under section 176.135 or rules adopted under section 176.83, subdivision 5.

(b) When the requirements of subdivision 4 are met, an insurer must not deny payment for one or more charges on the basis that the charge should have been bundled into another charge, or on the basis that a particular service, article, or supply was not reasonably required, except that the insurer may raise these issues during a postpayment audit under subdivision 6.

Subd. 6. **Postpayment audits; records; interest.** (a) The insurer may conduct a postpayment audit if both of the following requirements are met:

(1) the insurer paid the hospital's bill within 30 days according to the PC-Pricer program amount described in subdivision 1; and

(2) the amount paid according to the PC-Pricer program in subdivision 1 included an outlier payment.

(b) If an audit is permitted under paragraph (a), the insurer must request any additional records needed to conduct the audit within six months after payment. The records requested may include an itemized statement of charges. Within 30 days of the insurer's request, the hospital must provide the additional documentation requested. An insurer must not request additional information from a hospital more than three times per audit.

(c) An insurer must pay the hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional hospital charges following a postpayment audit. A hospital must pay the insurer interest at an annual rate of four percent if it is determined that the hospital owes the insurer reimbursement following the insurer's audit. Interest is payable by the insurer from the date payment was

due under this section or section 176.135. Interest is payable by the hospital from the date the overpayment was made.

Subd. 7. **Study.** The commissioner of labor and industry shall conduct a study analyzing the impact of the reforms under this section to determine whether the objectives have been met and whether further changes are needed. The commissioner must report the results of the study to the Workers' Compensation Advisory Council and the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over workers' compensation by January 15, 2018.

Subd. 8. **Rulemaking.** The commissioner may adopt or amend rules using the authority in section 14.389, including subdivision 5, to: (1) implement this section and the Medicare Inpatient Prospective Payment System for workers' compensation; and (2) implement the Medicare Hospital Outpatient Prospective Payment System, or other fee schedule, for payment of outpatient services provided under this chapter by a hospital or ambulatory surgical center, not to take effect before January 1, 2017.

EFFECTIVE DATE. Subdivisions 1 to 6 are effective for billing and payment of inpatient hospital services, articles, and supplies provided to patients discharged on or after January 1, 2016. Subdivision 8 is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2014, section 176.221, subdivision 8, is amended to read:

Subd. 8. **Method and timeliness of payment.** (a) Except as otherwise provided in paragraph (b), payment of compensation under this chapter shall be by immediately payable negotiable instrument, or if by any other method, arrangements shall be available to provide for the immediate negotiability of the payment instrument.

All payment of compensation shall be made within 14 days of the filing of an appropriate order by the division or a compensation judge, unless the order is appealed or if a different time period is provided by this chapter.

(b) An employer or insurer responsible for payment of periodic monetary benefits under this chapter must send the payments by electronic funds transfer to a bank, savings association, or credit union, if requested by the employee or a dependent under section 176.111.

(1) If the employer or insurer has already established an electronic funds transfer arrangement with a bank, savings association, or credit union for the employee's account, the employer or insurer must begin sending periodic monetary benefit payments by electronic funds transfer to the bank, savings association, or credit union within 30 days after the employer or insurer receives a request from the employee or dependent containing the information in paragraph (c).

(2) If the employer or insurer does not already have an arrangement with the bank, savings association, or credit union for electronic funds transfer for the employee or dependent's account at the time of the request, the 30 days to begin sending periodic benefit payments by electronic funds transfer does not start to run until the arrangement has been established. The employer or insurer must make reasonable efforts to establish the electronic funds transfer arrangement within 14 days after receiving a request containing the information in paragraph (c).

(3) Payment of benefits is deemed to have been made on the date the payment is sent by electronic funds transfer to the employee or dependent's account at the bank, savings association, or credit union.

(c) The employee or dependent must provide the employer or insurer with the following information:

(1) a signed and dated written request for electronic funds transfer of benefits;

(2) the name and address of the bank, savings association, or credit union where the benefit payments are to be sent by electronic funds transfer;

(3) the account number to which the payments should be credited; and

(4) any other information or documentation required by the employer or insurer or the bank, savings association, or credit union necessary to implement electronic funds transfer.

(d) The employer or insurer must retain a copy of the request for as long as the benefits are being paid by electronic funds transfer. The employer or insurer paying the benefits must provide a copy of the request to the department upon request.

(e) Paragraph (b) does not apply if the employer or insurer reasonably determines that the periodic monetary benefit payments are likely to end before the electronic funds transfer can be arranged.

(f) The commissioner may assess a monetary penalty of $500 against the employer or insurer for a violation of paragraph (b) or (d). Before issuing a penalty for a first violation of paragraph (b) or (d), the commissioner must provide written notice to the employer or insurer that a penalty may be issued if the violation is not corrected within 30 days. Penalties under this paragraph are payable to the commissioner for deposit in the assigned risk safety account.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 5. Minnesota Statutes 2014, section 176.231, subdivision 1, is amended to read:

Subdivision 1. **Time limitation.** Where death or serious injury occurs to an employee during the course of employment, the employer shall report the injury or death to the commissioner and insurer within 48 hours after its occurrence. Where any other injury occurs which wholly or partly incapacitates the employee from performing labor or service for more than three calendar days, the employer shall report the injury to the insurer on a form prescribed by the commissioner within ten days from its occurrence. An insurer and self-insured employer shall report the injury to the commissioner no later than 14 days from its occurrence. Where an injury has once been reported but subsequently death ensues, the employer shall report the death to the commissioner and insurer within 48 hours after the employer receives notice of this fact. An employer who provides notice to the Occupational Safety and Health Division of the Department of Labor and Industry of a fatality within the eight-hour time frame required by law, or of an inpatient hospitalization ~~of three or more employees,~~ within the ~~eight-hour~~ 24-hour time frame required by law, has satisfied the employer's obligation under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Presented to the governor May 15, 2015

Signed by the governor May 19, 2015, 3:45 p.m.