

2.1 or noninstitutional home health services that are not being billed using an equivalent
2.2 electronic billing format, must be billed using the uniform billing form CMS 1450, except
2.3 as provided in subdivision 5.

2.4 (b) The instructions and definitions for the use of the uniform billing form CMS
2.5 1450 shall be in accordance with the uniform billing form manual specified by the
2.6 commissioner. In promulgating these instructions, the commissioner may utilize the
2.7 manual developed by the National Uniform Billing Committee, ~~as adopted and finalized~~
2.8 ~~by the Minnesota Uniform Billing Committee.~~

2.9 (c) Services to be billed using the uniform billing form CMS 1450 include:
2.10 institutional inpatient hospital services and distinct units in the hospital such as psychiatric
2.11 unit services, physical therapy unit services, swing bed (SNF) services, inpatient state
2.12 psychiatric hospital services, inpatient skilled nursing facility services, home health
2.13 services (Medicare part A), and hospice services; ancillary services, where benefits are
2.14 exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals,
2.15 skilled nursing facilities, ICF/MR's, and home health (Medicare part B); institutional
2.16 owned or operated outpatient services such as waived services, hospital outpatient
2.17 services, including ambulatory surgical center services, hospital referred laboratory
2.18 services, hospital-based ambulance services, and other hospital outpatient services,
2.19 skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive
2.20 outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural
2.21 health clinics, federally qualified health centers, and community mental health centers;
2.22 home health services such as home health intravenous therapy providers, ~~waived~~
2.23 ~~services, personal care attendants~~, and hospice; and any other health care provider certified
2.24 by the Medicare program to use this form.

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

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

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

2.32 Subd. 2. **Uniform billing form CMS 1500.** (a) On and after January 1, 1996, all
2.33 noninstitutional health care services rendered by providers in Minnesota except dental
2.34 or pharmacy providers, that are not currently being billed using an equivalent electronic

3.1 billing format, must be billed using the health insurance claim form CMS 1500, except as
3.2 provided in subdivision 5.

3.3 (b) The instructions and definitions for the use of the uniform billing form CMS
3.4 1500 shall be in accordance with the manual developed by the Administrative Uniformity
3.5 Committee entitled standards for the use of the CMS 1500 form, dated February 1994,
3.6 as further defined by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.1 Subd. 4. **Group purchasers not covered by HIPAA.** (a) For transactions with
5.2 group purchasers defined in section 62J.03, subdivision 8, that are not covered under
5.3 United States Code, title 42, sections 1320d to 1320d-8, the requirements of this section
5.4 are modified as follows:

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

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

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

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

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

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

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

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

6.3 Subd. 5. **Compliance and investigations.** (a) The commissioner of health shall, to
6.4 the extent practicable, seek the cooperation of health care providers and group purchasers
6.5 in obtaining compliance with this section and may provide technical assistance to health
6.6 care providers and group purchasers.

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

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

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

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

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

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

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

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

6.34 (2) If any information required of a health care provider or group purchaser under
6.35 this section is in the exclusive possession of any other agency, institution, or person and
6.36 the other agency, institution, or person fails or refuses to furnish the information, the

7.1 health care provider or group purchaser must so certify and set forth what efforts it has
7.2 made to obtain the information.

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

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

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

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

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

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

7.29 (1) filing of a complaint under this section;

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

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

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

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

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

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

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

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

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

8.18 (iv) whether the violation resulted in financial harm;

8.19 (v) whether the violation was intentional;

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

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

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

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

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

8.34 (i) If a penalty is proposed according to this section, the commissioner of health
8.35 must deliver, or send by certified mail with return receipt requested, to the respondent

9.1 written notice of the commissioner of health's intent to impose a penalty. This notice
 9.2 of proposed determination must include:

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

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

9.6 (3) the amount of the proposed penalty;

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

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

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

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

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

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

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

9.26 **62J.59 IMPLEMENTATION OF NCPDP TELECOMMUNICATIONS**
 9.27 **STANDARD FOR PHARMACY CLAIMS.**

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

9.32 (b) ~~Beginning January 1, 1996,~~ All category I and category II group purchasers
 9.33 in this state shall use the most recent HIPAA-mandated version of the NCPDP
 9.34 telecommunication standard format 3.2 or NCPDP ~~tape billing and payment format 2.0~~

- 10.1 batch standard for the electronic submission of payment information NCPDP response
10.2 transaction to pharmacists pharmacies as appropriate.

10.3 Sec. 10. **REPEALER.**

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