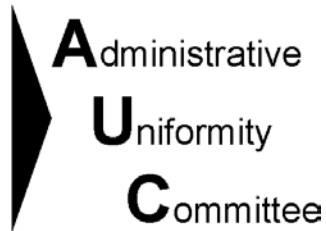




Meeting Materials
AUC Legislative TAG
Teleconference/WebEx
August 12, 2013

1. Agenda AUC Legislative TAG 081213
2. Administrative Simplification Act Revised Draft



**AUC LEGISLATIVE COMMITTEE
MEETING AGENDA
August 12, 2013
3:00 p.m. – 4:30 p.m.**

Teleconference line: 1-857-232-0300

Participant passcode: 337213 (Note: Participants are responsible for their long distance charges)

WebEx instructions:

1. To start the WebEx session, go to: <https://health-state-mn-ustraining.webex.com>
2. Under “Attend a Session,” click “Live Sessions”
3. Click on the session for “AUC Legislative TAG”
4. Provide your name, email address, and the following password: Leg2013! (Note: The exclamation mark at the end is part of the password.)
5. Click “Join now”

Meeting Objectives:

- Review the Administrative Simplification Act (ASA) to identify and suggest possible technical changes that may be needed to address outdated language and to keep the ASA current.

Agenda items

1. Meeting to order
2. Anti-trust statement
3. Review and update Administrative Simplification Act (ASA) – Minnesota Statutes, Sections 62J.50 – 62J.61
4. Other Business

Members Include:

Aetna ◇ Aging Services of Minnesota ◇ Allina Hospitals and Clinics ◇ American Association of Healthcare Administrative Management ◇ America’s TPA ◇
Blue Cross Blue Shield of MN ◇ Care Providers of Minnesota ◇ CentraCare Health System ◇ Children’s Hospitals and Clinics ◇ CVS Pharmacy ◇ Delta Dental of MN ◇ Fairview Health Services ◇ HealthEast ◇ HealthPartners – Health Plan ◇ HealthPartners – Medical Group and Regions Hospital ◇ Hennepin County Medical Center ◇ Mayo Clinic ◇ Medica Health Plan ◇ Metropolitan Health Plan ◇ MN Chiropractic Association ◇ MN Council of Health Plans ◇ MN Dental Association ◇ MN Department of Health ◇ MN Department of Human Services ◇ MN Department of Labor and Industry ◇ MN Home Care Association ◇ MN Hospital Association ◇ MN Medical Association ◇ MN Medical Group Management Association ◇ MN Pharmacists Association ◇ Noridian Administrative Services, L.L.C. - Medicare Part A ◇ Olmsted Medical Center ◇ Park Nicollet Health Services ◇ PreferredOne ◇ PrimeWest Health ◇ REM Health Inc. ◇ Sanford Health ◇ Sanford Health Plan ◇ Silverscript ◇ St. Mary’s/Duluth Clinic Health System ◇ UCare MN ◇ UnitedHealth Group ◇ University of Minnesota Physicians

Visit our website at: <http://www.health.state.mn.us/auc/index.html>

**Next Meeting –
August 21, 2013
3:00 p.m. – 4:30 p.m.
Teleconference / WebEx only**

62J.50 CITATION AND PURPOSE.

Comment [KK1]:

Subdivision 1. Citation.

Sections 62J.50 to 62J.61 may be cited as the Minnesota Health Care Administrative Simplification Act of 1994.

Subd. 2. Purpose.

The legislature finds that significant savings throughout the health care industry can be accomplished by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange. The legislature finds that initial steps have been taken at the national level by the federal ~~Health Care Financing Administration~~ Centers for Medicare and Medicaid Services in its implementation of nationally accepted electronic transaction sets for its Medicare program. The legislature further recognizes the work done by the workgroup for electronic data interchange and the American National Standards Institute and its accredited standards committee X12, at the national level, and the Minnesota administrative uniformity committee, a statewide, voluntary, public-private group representing payers, hospitals, state programs, physicians, and other health care providers in their work toward administrative simplification in the health care industry.

Comment [KK2]: I believe this is the only reference in this statute that needs to be changed.

History:

1994 c 625 art 9 s 1

62J.51 DEFINITIONS.

Comment [KK3]: Everyone should review the definitions section to identify any outmoded definitions that could be eliminated from statute.

Subdivision 1. Scope.

For purposes of sections 62J.50 to 62J.61, the following definitions apply.

Subd. 2. ANSI.

"ANSI" means the American National Standards Institute.

Subd. 3. ASC X12.

"ASC X12" means the American National Standards Institute committee X12.

Subd. 3a. Card issuer.

"Card issuer" means the group purchaser who is responsible for printing and distributing identification cards to members or insureds.

Subd. 4. Category I industry participants.

"Category I industry participants" means the following: group purchasers, providers, and other health care organizations doing business in Minnesota including public and private payers; hospitals; claims clearinghouses; third-party administrators; billing service bureaus; value added networks; self-insured plans and employers with more than 100 employees; clinic laboratories; durable medical

equipment suppliers with a volume of at least 50,000 claims or encounters per year; and group practices with 20 or more physicians.

Subd. 5. Category II industry participants.

"Category II industry participants" means all group purchasers and providers doing business in Minnesota not classified as category I industry participants.

Subd. 6. Claim payment/advice transaction set (ANSI ASC X12 835).

"Claim payment/advice transaction set (ANSI ASC X12 835)" means the electronic transaction format developed and approved for implementation in October 1991, and used for electronic remittance advice and electronic funds transfer.

Subd. 6a. Claim status transaction set (ANSI ASC X12 276/277).

"Claim status transaction set (ANSI ASC X12 276/277)" means the transaction format developed and approved for implementation in December 1993 and used by providers to request and receive information on the status of a health care claim or encounter that has been submitted to a group purchaser.

Subd. 6b. Claim submission address.

"Claim submission address" means the address to which the group purchaser requires health care providers, members, or insureds to send health care claims for processing.

Subd. 6c. Claim submission number.

"Claim submission number" means the unique identification number to identify group purchasers as described in section [62J.54](#), with its suffix identifying the claim submission address.

Subd. 7. Claim submission transaction set (ANSI ASC X12 837).

"Claim submission transaction set (ANSI ASC X12 837)" means the electronic transaction format developed and approved for implementation in October 1992, and used to submit all health care claims information.

Subd. 8. EDI or electronic data interchange.

"EDI" or "electronic data interchange" means the computer application to computer application exchange of information using nationally accepted standard formats.

Subd. 9. Eligibility transaction set (ANSI ASC X12 270/271).

"Eligibility transaction set (ANSI ASC X12 270/271)" means the transaction format developed and approved for implementation in February 1993, and used by providers to request and receive coverage information on the member or insured.

Subd. 10. Enrollment transaction set (ANSI ASC X12 834).

Comment [KK4]: Question as to whether these definitions should be deleted. A quick search of the statute indicates these two terms also show up in 62J.53, 62J.56 and 62J.59. Is this necessary to keep in statute?

Comment [KK5]: Does this need updating to reflect the latest changes to X12?

Comment [KK6]: Does this need updating to reflect the latest changes to X12?

"Enrollment transaction set (ANSI ASC X12 834)" means the electronic transaction format developed and approved for implementation in February 1992, and used to transmit enrollment and benefit information from the employer to the payer for the purpose of enrolling in a benefit plan.

Comment [KK7]: Does this need updating to reflect the latest changes to X12?

Subd. 11. Group purchaser.

"Group purchaser" has the meaning given in section [62J.03, subdivision 6](#).

Subd. 12. ISO.

"ISO" means the International Standardization Organization.

Subd. 13. NCPDP.

"NCPDP" means the National Council for Prescription Drug Programs, Inc.

Subd. 14. NCPDP telecommunication standard format 3.2.

"NCPDP telecommunication standard format 3.2" means the recommended transaction sets for claims transactions adopted by the membership of NCPDP in 1992.

Subd. 15. NCPDP tape billing and payment format 2.0.

"NCPDP tape billing and payment format 2.0" means the recommended transaction standards for batch processing claims adopted by the membership of the NCPDP in 1993.

Subd. 16. Provider.

"Provider" or "health care provider" has the meaning given in section [62J.03, subdivision 8](#).

Comment [KK8]: Should the following allied providers be added to this definition: naturopaths, acupuncturists, and massage therapists? It was suggested this is a technical change.

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 developed by the National Uniform Billing Committee.

Subd. 18. Uniform billing form CMS 1500.

"Uniform billing form CMS 1500" means the most current version of the health insurance claim form, CMS 1500, developed by the National Uniform Claim Committee.

Subd. 19. Uniform dental billing form.

"Uniform dental billing form" means the most current version of the uniform dental claim form developed by the American Dental Association.

Comment [KK9]: CMS 1450 or CMS 1500: should we change the references to institutional or professional to include paper and electronic and to reflect current practice under the MN Companion Guides? Also, how does this affect the dental form, if at all?

Subd. 19a. Uniform explanation of benefits document.

"Uniform explanation of benefits document" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a patient.

Subd. 19b. Uniform remittance advice report.

"Uniform remittance advice report" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a provider.

Subd. 20. Uniform pharmacy billing form.

"Uniform pharmacy billing form" means the National Council for Prescription Drug Programs/universal claim form (NCPDP/UCF).

Subd. 21. WEDI.

"WEDI" means the National Workgroup for Electronic Data Interchange report issued in October 1993.

History:

1994 c 625 art 9 s 2; 1996 c 440 art 1 s 22-25; 2000 c 460 s 2,3; 2002 c 307 art 2 s 3; 2002 c 330 s 19; 2005 c 106 s 1,2; 2008 c 305 s 1,2

62J.52 ESTABLISHMENT OF UNIFORM BILLING FORMS.

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.

(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/DD's**, and home health (Medicare part B); institutional owned or operated outpatient services such as waived 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

Comment [KK10]: Should this be changed to "institutional format"?

Comment [KK11]: This could be deleted as subd. 5 has been repealed.

Comment [KK12]: Should this Subd. 1 (b) mirror the language of Subd. 2 (b)?

Comment [KK13]: The recommendation from the mtg on 11/18/09 was to cross-referenced with 62J.536 rather than move this section to 62J.536.

Comment [KK14]: Reflects updated reference in statute. I believe this is the only place it appears in 62J.

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 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.

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, waived 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.

Subd. 3. Uniform dental billing form.

(a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American Dental Association uniform dental billing form.

Comment [KK15]: Question was raised as to whether this should be changed to "professional format"?

Comment [KK16]: Again, this should be deleted as subd. 5 has been repealed.

Comment [KK17]: See above comment for Subd. 1 (b) of this section.

Comment [KK18]: It was agreed upon that this should cross reference 62J.536.

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

Comment [KK19]: Should this be changed/updated?

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.

(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.

Comment [KK20]: Should this be changed/updated?

Subd. 5.

[Repealed, [2008 c 305 s 11](#)]

History:

1994 c 625 art 9 s 3; 2000 c 460 s 4-6; 1Sp2003 c 14 art 7 s 14,15; 2005 c 106 s 3-5; 2007 c 147 art 9 s 6,7; 2008 c 305 s 3-5

62J.53 ACCEPTANCE OF UNIFORM BILLING FORMS BY GROUP PURCHASERS.

On and after January 1, 1996, all category I and II group purchasers in Minnesota shall accept the uniform billing forms prescribed under section [62J.52](#) as the only nonelectronic billing forms used for payment processing purposes.

Comment [KK21]: AUC Leg TAG discussed whether this should be deleted entirely. It appears that this language is superseded by 62J.536, but there was no clear direction recommended. This question also applies to 62J.53, 62J.55 and 62J.59.

History:

1994 c 625 art 9 s 4

62J.535 UNIFORM BILLING REQUIREMENTS FOR CLAIM TRANSACTIONS.

Subdivision 1.

[Repealed, [2002 c 307 art 2 s 9](#); [2002 c 330 s 35](#)]

Subd. 1a. Electronic claim transactions.

Comment [KK22]: Is there any need to retain this subdivision in light of 62J.536?

Group purchasers, including government programs, not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, that voluntarily agree with providers to accept electronic claim transactions, must accept them in the ANSI X12N 837 standard electronic format as established by federal law. Nothing in this section requires acceptance of electronic claim transactions by entities not covered under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. Notwithstanding the above, nothing in this section or other

state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 1b. Paper claim transactions.

All group purchasers that accept paper claim transactions must accept, and health care providers submitting paper claim transactions must submit, these transactions with use of the applicable medical and nonmedical data code sets specified in the federal electronic claim transaction standards adopted under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. The paper claim transaction must also be conducted using the uniform billing forms as specified in section 62J.52 and the identifiers specified in section 62J.54, on and after the compliance date required by law. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Comment [KK23]: To ensure there is not conflict with 62J.536, suggest adding a cross reference to 62J.536. Some argue this language should stay, but it would be useful to cross reference 62J.536.

Comment [KK24]: Again, P&C carriers wish to keep. No one expressed strong feelings to remove. Dave Haugen recommended keeping for now.

Subd. 2. Compliance.

Subdivision 1a is effective concurrent with the date of required compliance for covered entities established under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time.

History:

1999 c 245 art 2 s 8; 2000 c 483 s 16; 2000 c 488 art 11 s 1; 2002 c 307 art 2 s 4-6,8; 2002 c 330 s 20-22,33

62J.536 UNIFORM ELECTRONIC TRANSACTIONS AND IMPLEMENTATION GUIDE STANDARDS.

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

Comment [KK25]: This language refers to attachments and the P&C and WC carriers support keeping this language.

Comment [KK26]: MDH states that three categories of providers are not specified here and may need to be expressly included: naturopaths, massage therapists, acupuncturists

Federal Regulations, title 45, part 162, subpart L. Beginning December 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.

Subd. 2. Establishing uniform, standard companion guides.

(a) At least 12 months prior to the timelines required in subdivision 1, the commissioner of health shall promulgate 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).

(b) The commissioner of health must consult with the Minnesota Administrative Uniformity Committee on the development of the single, uniform companion guides required under subdivision 1, paragraph (e), for each of the transactions in subdivision 1. The single uniform companion guides required under subdivision 1, paragraph (e), must specify uniform billing and coding standards. The commissioner of health shall base the companion guides required under subdivision 1, paragraph (e), billing and coding rules, and standards on the Medicare program, with modifications that the commissioner deems appropriate after consulting the Minnesota Administrative Uniformity Committee.

(c) No group purchaser or health care provider may add to or modify the single, uniform companion guides defined in subdivision 1, paragraph (e), through additional companion guides or other requirements.

(d) In promulgating the rules in paragraph (a), the commissioner shall not require data content that is not essential to accomplish the purpose of the transactions in subdivision 1.

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.

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 health care 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.

Subd. 3. Definition.

Notwithstanding section [62J.03, subdivision 8](#), for purposes of this section, "health care provider" includes licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Comment [KK27]: Need to add to the definition of provider to include naturopaths, acupuncturists, and massage therapists. Some questioned whether this is a policy or technical change; there was strong opinions that this change would be technical.

History:

2007 c 147 art 15 s 4; 2008 c 305 s 6-8

62J.54 IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.

Subdivision 1. Unique identification number for health care provider organizations.

(a) Not later than 24 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and any health care provider organization that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use a national provider identifier to identify health care provider organizations in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a national provider identifier to identify health provider organizations no later than 36 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers established by the federal Secretary of Health and Human Services under United States Code, title 42,

sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for health care provider organizations in Minnesota under this section.

(d) All health care provider organizations in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify health care provider organizations when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Health care provider organizations in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 2. Unique identification number for individual health care providers.

(a) Not later than 24 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers in Minnesota and any individual health care provider that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use the national provider identifier to identify an individual health care provider in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use the national provider identifier to identify an individual health care provider no later than 36 months after the date on which a national provider identifier for health care providers is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for individual health care providers.

(d) All individual health care providers in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify individual health care providers when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Individual health care providers in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 3. Unique identification number for group purchasers.

(a) Not later than 24 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify group purchasers no later than 36 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for health plans and employers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for group purchasers.

(d) Group purchasers shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) The unique group purchaser identifier, as described in this section, shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 4. Unique patient identification number.

(a) Not later than 24 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify each patient who receives health care services in Minnesota no later than 36 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for individuals adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique patient identification number, except as provided in paragraphs (e) and (f).

(d) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) Within the limits of available appropriations, the commissioner shall develop a proposal for an alternate numbering system for patients who do not have or refuse to provide their Social Security numbers, if:

(1) a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments);

(2) the unique health identifier is the Social Security number of the patient;

(3) there is no federal alternate numbering system for patients who do not have or refuse to provide their Social Security numbers; and

(4) federal law or the federal Secretary of Health and Human Services explicitly allows a state to develop an alternate numbering system for patients who do not have or refuse to provide their Social Security numbers.

(f) If an alternate numbering system is developed under paragraph (e), patients who use numbers issued by the alternate numbering system are not required to provide their Social Security numbers and group purchasers or providers may not demand the Social Security numbers of patients who provide numbers issued by the alternate numbering system. If an alternate numbering system is developed under paragraph (e), group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their Social Security number used as the unique patient identifier.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

History:

1994 c 625 art 9 s 5; 1995 c 234 art 5 s 17; 1996 c 440 art 1 s 26-28; 1997 c 228 s 2; 1Sp1997 c 5 s 16; 2005 c 106 s 6,7

62J.55 PRIVACY OF UNIQUE IDENTIFIERS.

(a) When the unique identifiers specified in section 62J.54 are used for data collection purposes, the identifiers must be encrypted, as required in section 62J.321, subdivision 1. Encryption must follow encryption standards set by the National Bureau of Standards and approved by the American National Standards Institute as ANSIX3. 92-1982/R 1987 to protect the confidentiality of the data. Social Security numbers must not be maintained in unencrypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat medical records, including the Social Security number if it is used as a unique patient identifier, in accordance with sections 144.291 to 144.298. The Social Security number may be disclosed by providers and group purchasers to the commissioner as necessary to allow performance of those duties set forth in section 144.05.

History:

1994 c 625 art 9 s 6; 1995 c 234 art 5 s 18; 2007 c 147 art 10 s 15

62J.56 IMPLEMENTATION OF ELECTRONIC DATA INTERCHANGE STANDARDS.

Subdivision 1. General provisions.

Comment [KK28]: Does this section need to be retained at all? Should this be kept or not?

(a) The legislature finds that there is a need to advance the use of electronic methods of data interchange among all health care participants in the state in order to achieve significant administrative cost savings. The legislature also finds that in order to advance the use of health care electronic data interchange in a cost-effective manner, the state needs to implement electronic data interchange standards that are nationally accepted, widely recognized, and available for immediate use. The legislature intends to set forth a plan for a systematic phase in of uniform health care electronic data interchange standards in all segments of the health care industry.

(b) The commissioner of health, with the advice of the Minnesota Health Data Institute and the Minnesota Administrative Uniformity Committee, shall administer the implementation of and monitor compliance with, electronic data interchange standards of health care participants, according to the plan provided in this section.

Comment [KK29]: This should be deleted.

(c) The commissioner may grant exemptions to category I and II industry participants from the requirements to implement some or all of the provisions in this section if the commissioner determines that the cost of compliance would place the organization in financial distress, or if the commissioner determines that appropriate technology is not available to the organization.

Subd. 2. Identification of core transaction sets.

(a) All category I and II industry participants in Minnesota shall comply with the standards developed by the ANSI ASC X12 for the following core transaction sets, according to the implementation plan outlined for each transaction set.

(1) ANSI ASC X12 835 health care claim payment/advice transaction set.

(2) ANSI ASC X12 837 health care claim transaction set.

(3) ANSI ASC X12 834 health care enrollment transaction set.

(4) ANSI ASC X12 270/271 health care eligibility transaction set.

(5) ANSI ASC X12 276/277 health care claims status request/notification transaction set.

Comment [KK30]: Again, this should be updated to reflect the latest X12 terminology.

(b) The commissioner, with the advice of the Minnesota Health Data Institute and the Minnesota Administrative Uniformity Committee, and in coordination with federal efforts, may approve the use of new ASC X12 standards, or new versions of existing standards, as they become available, or other nationally recognized standards, where appropriate ASC X12 standards are not available for use. These alternative standards may be used during a transition period while ASC X12 standards are developed.

Comment [KK31]: This should be deleted.

Subd. 3. Implementation guides.

(a) The commissioner, with the advice of the Minnesota Administrative Uniformity Committee, and the Minnesota Center for Health Care Electronic Data Interchange shall review and recommend the use of guides to implement the core transaction sets. Implementation guides must contain the background and technical information required to allow health care participants to implement the transaction set in the most cost-effective way.

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American Hospital Association through the national Uniform Billing Committee and its state representative organization; the American Medical Association through the Uniform Claim Task Force; the American Dental Association; the National Council of Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

Comment [KK32]: Is this even necessary? What did we decide here?

History:

1994 c 625 art 9 s 7; 1996 c 440 art 1 s 29

62J.57 MINNESOTA CENTER FOR HEALTH CARE ELECTRONIC DATA INTERCHANGE.

Comment [KK33]: Is this worth keeping? MDH wants to keep as a placeholder – is this necessary? There is no funding appropriated for this function right now.

(a) It is the intention of the legislature to support, to the extent of funds appropriated for that purpose, the creation of the Minnesota Center for Health Care Electronic Data Interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota Center for Health Care Electronic Data Interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

(1) coordinating and ensuring the availability of quality electronic data interchange education and training in the state;

(2) developing an extensive, cohesive health care electronic data interchange education curriculum;

(3) developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;

(4) administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents database, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and

(5) providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.

History:

1994 c 625 art 9 s 8

62J.58 [Repealed, 2008 c 305 s 11]

62J.581 STANDARDS FOR MINNESOTA UNIFORM HEALTH CARE REIMBURSEMENT DOCUMENTS.

Subdivision 1. Minnesota uniform remittance advice report.

(a) All group purchasers shall provide a uniform remittance advice report to health care providers when a claim is adjudicated. The uniform remittance advice report shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 2. Minnesota uniform explanation of benefits document.

(a) All group purchasers shall provide a uniform explanation of benefits document to health care patients when an explanation of benefits document is provided as otherwise required or permitted by law. The uniform explanation of benefits document shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. Scope.

For purposes of sections 62J.50 to 62J.61, the uniform remittance advice report and the uniform explanation of benefits document format specified in subdivision 4 shall apply to all health care services delivered by a health care provider or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis,

Comment [KK34]: This probably affects only a very small segment of the market i.e., WC remits for massage therapists.

Comment [KK35]: Is this confusing that it may exclude non-HIPAA entities? How does this interact with 62J.536? Should there be a cross reference to 62J.536? Per our meeting on 11/18/09, there wasn't agreement that these two paragraphs should be deleted, so it was decided they should stay in for now.

Comment [KK36]: Isn't the EOB process different than remits? HFMA is working on a "patient-friendly bill" format. For WC, there aren't EOBs, as the policyholder is the employer. This also impacts no fault auto.

Comment [KK37]: Per our meeting on 11/18/09, there wasn't agreement that these two paragraphs should be deleted, so it was decided they should stay in for now.

such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in subdivisions 1 and 2 if they comply with section [62A.01, subdivisions 2 and 3](#).

Subd. 4. Specifications.

The uniform remittance advice report and the uniform explanation of benefits document shall be provided by use of a paper document conforming to the specifications in this section or by use of the ANSI X12N 835 standard electronic format as established under United States Code, title 42, sections 1320d to 1320d-8, and as amended from time to time for the remittance advice. The commissioner, after consulting with the Administrative Uniformity Committee, shall specify the data elements and definitions for the uniform remittance advice report and the uniform explanation of benefits document. The commissioner and the Administrative Uniformity Committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the use of a paper document for the uniform explanation of benefits document or the uniform remittance advice report for dental care services.

Subd. 5. Effective date.

The requirements in subdivisions 1 and 2 are effective June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.

History:

2000 c 460 s 7; 2002 c 307 art 2 s 7; 2002 c 330 s 23; 2005 c 106 s 8

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

(a) All category I and II pharmacies licensed in this state shall use the most recent HIPAA-mandated version of the NCPDP telecommunication standard or the NCPDP batch standard for the electronic submission of claims to group purchasers as appropriate.

(b) All category I and category II group purchasers in this state shall use the most recent HIPAA-mandated version of the NCPDP telecommunication standard or NCPDP batch standard for the electronic NCPDP response transaction to pharmacies as appropriate.

History:

1994 c 625 art 9 s 10; 2008 c 305 s 9

62J.60 MINNESOTA UNIFORM HEALTH CARE IDENTIFICATION CARD.

Subdivision 1. Requirements for identification card.

Comment [KK38]: Check to see if there are any updates needed to this section.

Comment [KK39]: This is superseded by 62J.536 and would be good to delete.

Comment [KK40]: This is also superseded by 62J.536 and would be good to delete.

Comment [KK41]: Before the word "for", should we insert the following: "along with any applicable MN Companion Guide"

All individuals with health care coverage shall be issued Minnesota uniform health care identification cards by group purchasers as of January 1, 1998, unless the requirements of section [62A.01, subdivisions 2 and 3](#), are met. If a health benefit plan issued by a group purchaser provides coverage for prescription drugs, the group purchaser shall include uniform prescription drug information on the uniform health care identification card issued to its enrollees on or after July 1, 2003. Nothing in this section requires a group purchaser to issue a separate card containing uniform prescription drug information, provided that the Minnesota uniform health care identification card can accommodate the information necessary to process prescription drug claims as required by this section. The Minnesota uniform health care identification cards shall comply with the standards prescribed in this section.

Subd. 1a. Definition; health benefit plan.

For purposes of this section, "health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a group purchaser for the coverage of medical and hospital benefits. A health benefit plan does not include coverage that is:

- (1) limited to disability or income protection coverage;
- (2) automobile or homeowners medical payment coverage;
- (3) liability insurance or supplemental to liability insurance;
- (4) accident-only coverage;
- (5) credit accident and health insurance issued under chapter 62B;
- (6) designed solely to provide dental or vision care;
- (7) designed solely to provide coverage for a specified disease or illness;
- (8) coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or
- (9) hospital income or indemnity.

Subd. 2. General characteristics.

(a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy

identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements.

(c) Standardized labels are required next to human readable data elements and must come before the human data elements.

Subd. 2a. Issuance.

A new Minnesota uniform health care identification card must be issued to individuals upon enrollment. Except for the medical assistance, general assistance medical care, and MinnesotaCare programs, a new card must be issued upon any change in an individual's health care coverage that impacts the content or format of the data included on the card or no later than 24 months after adoption of any change in the NCPDP implementation guide or successor document that affects the content or format of the data included on the card. Anytime that a card is issued upon enrollment or replaced by the medical assistance, general assistance medical care, or MinnesotaCare program, the card must conform to the adopted NCPDP standards in effect and to the implementation guide in use at the time of issuance. Newly issued cards must conform to the adopted NCPDP standards in effect at the time of issuance and to the implementation guide in use at the time of issuance. Stickers or other methodologies may be used to update cards temporarily.

Subd. 3. Human readable data elements.

(a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The

standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) cardholder (insured) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

(4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

(5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

(6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. The standard label for this data element is "Svc Type"; and

(7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

- (i) eligibility and benefit information;
- (ii) utilization review;
- (iii) precertification; or
- (iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section [256B.69](#), [256D.03](#), or [256L.12](#), the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section [256B.69](#) and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

Subd. 4. Machine readable data content.

The Minnesota uniform health care identification card may be machine readable or nonmachine readable. If the card is machine readable, the card must contain a magnetic stripe that conforms to ANSI and ISO standards for Tracks 1.

Subd. 5. Annual reporting.

As part of an annual filing made with the commissioner of health or commerce on or after January 1, 2003, a group purchaser shall certify compliance with this section and shall submit to the commissioner of health or commerce a copy of the Minnesota uniform health care identification card used by the group purchaser.

History:

[1994 c 625 art 9 s 11](#); [1996 c 440 art 1 s 31,32](#); [1997 c 205 s 17](#); [1997 c 225 art 2 s 62](#); [2000 c 460 s 8](#); [2001 c 110 s 1](#); [2006 c 255 s 22,23](#); [2007 c 147 art 9 s 8,9](#)

62J.61 RULEMAKING; IMPLEMENTATION.

Subdivision 1. Exemption.

The commissioner of health is exempt from chapter 14, including section [14.386](#), in implementing sections [62J.50](#) to [62J.54, subdivision 3](#), and [62J.56](#) to [62J.59](#).

Subd. 2. Procedure.

(a) The commissioner shall publish proposed rules in the State Register or, if the commissioner determines that publishing the text of the proposed rules would be unduly cumbersome, shall publish notice of the proposed rules that contains a detailed description of the rules along with a statement that a free copy of the entire set of rules is available upon request to the agency.

(b) Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish notice in the State Register that the rules have been adopted 30 days before they are to take effect.

(c) If the adopted rules are the same as the proposed rules, the notice shall state that the rules have been adopted as proposed and shall cite the prior publication. If the adopted rules differ from the proposed rules, the portions of the adopted rules which differ from the proposed rules shall be included in the notice of adoption together with a citation to the prior State Register that contained the notice of the proposed rules.

(d) The commissioner may use rulemaking to implement sections [62J.54, subdivision 4](#), [62J.55](#), and [62J.60](#).

Subd. 3. Restrictions.

The commissioner shall not adopt any rules requiring patients to provide their Social Security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter.

Subd. 4. Patient privacy.

The commissioner shall seek comments from the Ethics and Confidentiality Committee of the Minnesota Health Data Institute and the Department of Administration, Public Information Policy Analysis Division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

Subd. 5. Biennial review of rulemaking procedures and rules.

The commissioner shall biennially seek comments from affected parties about the effectiveness of and continued need for the rulemaking procedures set out in subdivision 2 and about the quality and effectiveness of rules adopted using these procedures. The commissioner shall seek comments by holding a meeting and by publishing a notice in the State Register that contains the date, time, and location of

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the meeting and a statement that invites oral or written comments. The notice must be published at least 30 days before the meeting date. The commissioner shall write a report summarizing the comments and shall submit the report to the Minnesota Health Data Institute and to the Minnesota Administrative Uniformity Committee by January 15 of every even-numbered year.

History:

1994 c 625 art 9 s 12; 1997 c 187 art 4 s 3; 1998 c 254 art 1 s 14