MINNESOTA
MDH
DEPARTMENT OF HEALTH

06 - 0086

Protecting, maintaining and improving the health of all Minnesotans

January 13, 2006

Gretchen Thomson, Chair
Administrative Uniformity Committee
Duluth Clinic
400 East Third Street
Duluth, MN 55805

Dear Ms. Thomson:

This letter is the report to the Minnesota Administrative Uniformity Committee (AUC) required by Minnesota Statutes, section 62J.61, subdivision 5, which states:

> "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 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."

Pursuant to subdivision 5, a Request for Comments was published in the December 12, 2005, State Register. In addition to publishing in the State Register, the Department e-mailed copies of the Request for Comments to all persons on the AUC mailing lists.

The Request for Comments asked for comments regarding the rulemaking exemption under section 62J.61 and gave notice of a meeting to be held on January 12, 2006, at which the Department would accept oral and written comments.

The Department received two written comments in response to the December 12, 2005, State Register publication. The Administrative Uniformity Committee provided comments dated January 11, 2006, and Delta Dental Plan of Minnesota provided comments dated January 12, 2006. Copies of the letters are attached. No member of the public attended the January 12, 2006, meeting.

Sincerely,

Scott Leitz, Director
Office of Health Policy, Statistics and Informatics

Enclosure

Administrative
Uniformity
Committee

January 11, 2006

Barb Wills
Minnesota Department of Health
121 East 7th Place
P.O. Box 64975
St. Paul, Minnesota 55164-0975

Dear Ms. Wills:

The Administrative Uniformity Committee (AUC) would like to extend our support for the continuation of expedited rulemaking authority as it pertains to the Minnesota Health Care Administrative Simplification Act, *Minnesota Statues*, sections 62J.50 to 62J.61.

As you are aware, the AUC is a broad-based group representing Minnesota health care public and private payers, hospitals, physicians, other providers and State agencies. Our mission is to develop agreement among Minnesota payers and providers on standardized administrative processes when implementation will reduce administrative costs. The purposes of the AUC include acting as a consulting body on matters related to the AUC's mission, researching new issues that may lead to administrative uniformity, bringing issues and recommendations to private industry and/or governmental entities, and communicating important health care issues to the community.

As a frequent advisor to the Minnesota Department of Health on administrative simplification issues, the AUC often needs to react quickly to changes in the health care system. Traditional rulemaking timeframes and the costs involved may diminish the AUC's ability to react quickly. This could cause us to lose some of our effectiveness to

improve administrative processes and reduce administrative costs. In our role as advisor to the department, the AUC is confident that the continuation of expedited rulemaking is in the best interest of Minnesota's health care community.

Finally, we in the AUC, believe that the current expedited process has proven effective over the past years, allowing us to disseminate relevant information widely and in a timely manner.

In summary, the AUC would like to go on record as supporting the continuation of expedited rulemaking authority as it pertains to the Minnesota Health Care Administrative Simplification Act.

Thank you for allowing us to respond to the request for comments on this important health care issue.

Sincerely,

Gretchen J. Thomson

Gretchen Thomson, Chair
Administrative Uniformity Committee
St. Mary's Duluth Clinic

Lois M. Wakefield, Chair
AUC Communications Technical
Advisory Group
Allina Hospitals and Clinics

DELTA DENTAL
Delta Dental Plan of Minnesota

January 12, 2006

Ms. Colleen Morse
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Dear Ms. Morse:

This letter is in response to the request for comments regarding the effectiveness of the expedited rulemaking procedures, and about the quality and effectiveness of rules related to the Minnesota Health Care Administrative Simplification Act ("the Act"). As an affected party, Delta Dental Plan of Minnesota ("DDPMN") submits the following comments about both the rulemaking procedures and the Act.

1. Expedited Rulemaking

While expedited rulemaking offers cost-savings for the Department of Health and is intended to speed the overall process, the traditional rulemaking affords better opportunities for a range of viewpoints to be considered. Expedited rulemaking should be reserved for situations in which there is full consensus by affected parties and not used in a setting where there are conflicting views on how best to accomplish the statutory purpose. The traditional rulemaking process permits review by an Administrative Law Judge as a neutral third-party.

With regard to these particular rules, some aspects of this expedited process disadvantaged DDPMN and the dental community. From 2002 through 2004, expedited rulemaking was used to mandate standards for, among other things, paper Explanations of Benefits and Remittance Advices (EOB/RA) in connection with Minnesota Statute §62J.581 and the related *EOB/RA Manual* created by the Administrative Uniformity Committee ("AUC") and adopted by the Department of Health. Contrary to federal HIPAA law, which does not extend to paper transactions, Minnesota stands as the lone state in the nation to require these new standards for paper remittance transactions. HIPAA applies its standards to electronic transactions. These Minnesota-only standards create a more complex and more costly environment for processing dental claims, especially for DDPMN, which has a national customer base.

The AUC solicited comments on the *EOB/RA Manual* from interested parties and discussed some of these comments at AUC meetings. Medical industry representatives, however, also submitted comments regarding the application of these requirements to the dental industry --when in fact these comments were often irrelevant to the unique aspects of dental claim administration at issue.

DDPMN repeatedly raised concerns over the course of the discussion period, urging for separate requirements for dental administrators, yet the AUC voted with the majority members. Too much weight was given to opinions by AUC members on the medical side who had little or no direct experience in limited dental plan administration and who incorrectly assumed that the problems associated with medical administration must also apply in the dental world. Consequently, we urge the Department of Health to sparingly use the expedited rulemaking process and limit its application to matters where consensus exists, and not as an end-run around the protections and process associated with traditional rulemaking.

2. Minnesota Health Care Administrative Simplification Act

In addition to the procedural issues referenced above, DDPMN has concerns about several statutes in this Act, especially §62J.54. This statute requires submission of the National Provider Identifier ("NPI") on paper claims, yet the state-mandated dental claim form is entirely unprepared to meet this requirement. The state requires use of the American Dental Association ("ADA") claim form, but the NPI requirements for paper claims are unique to Minnesota, and the standard national form has not been amended to accommodate the Minnesota-only rule. At DDPMN, the majority of claims we receive from dentists are paper, not electronic. Because of our concerns, we offer the following explanation of the problem as we see it, along with a summary of the contrasting state of readiness in the medical industry for submission of NPI on paper claims.

Our concerns result from the interplay of three provisions of the Act:

- **Minnesota Statute §62J.52, subd. 3** requires use of the ADA dental billing form.
- **Minnesota Statute §62J.51, subd. 19** requires that the dental form be "the most current version" of the ADA form.
- **Minnesota Statute §62J.54, subd. 2(e)(7)** requires that the NPI be used to identify providers on paper claims.

As a dental plan administrator, DDPMN receives paper claims from providers located in every state in the nation. DDPMN administers benefits for 15 of the 18 Fortune 500 companies based in Minnesota (most of which have employees nationwide), as well as Wells Fargo. Our customers' employees seek dental care from providers in every state, yet **only Minnesota** requires the NPI on paper claims.

While uniformity and cost-savings were stated goals of this Act, the fact that Minnesota is unique in its requirement causes a disruption in the efficiency of our multi-state claims processing, directly impacting the cost of coverage. DDPMN's administrative costs are among the lowest of any limited dental plan in the country. To maintain our outstanding economic efficiencies, it is critical that disruptions in processing be kept to a minimum.

Moreover, this law imposes a requirement for which the ADA -- creator of the claim form -- is completely unprepared. Ultimately, the requirements of §62J.54 add complexity and costs to our claims administration. Contrary to the overall goals of uniformity and cost-savings, the end result for DDPMN is a **lack of uniformity and increased costs**.

The ADA Claim Form ("Form J515") is not adequate to meet compliance with §62J.54, subd. 2(e)(7) and because only Minnesota requires the NPI on paper claims, the ADA is under no broad or imminent pressure to update its form.

3. ADA Dental Claim Form – Form J515

ADA Form J515 does not contain boxes for **Billing Provider NPI** or **Treating Provider NPI**. According to our information, the ADA has no plans to modify Form J515 to include them. The ADA is currently contemplating a change to the *Instructions* to Form J515 in which dentists would be directed to put the **Billing Provider NPI** and **Treating Provider NPI** in the broad **Remarks** box along with all other remarks related to the claim.

This workaround attempt is certain to cause problems for DDPMN. Every paper claim must be entered on our computer system by our data entry staff. It will be difficult for our data entry staff to determine whether digits placed in the **Remarks** box are the **Billing Provider NPI**, the **Treating Provider NPI**, or some other number. If the contents of the **Remarks** box are not clear and include other remarks and comments related to the claim, this will delay claim processing further and increase administrative costs for DDPMN. Secondly, if dentists do not read the new *Instructions*, they will end up placing the NPI in some other random location, perhaps even in the margins. Scanning the form to find the NPI will be a needless waste of time for data entry personnel.

As part of a 38-member national association, DDPMN is working to urge revision of Form J515 to include boxes for the **Billing Provider NPI** and **Treating Provider NPI**. Yet even among our sister Delta Plans, there is no marked urgency as the problem is relevant only in Minnesota. These modifications will almost surely not happen by May 23, 2007, the deadline for compliance with Minn. Stat. §62J.54. Nor are we certain that the ADA will **ever** modify the paper form to accommodate Minn. Stat. §62J.54, since no other state has an NPI requirement for paper claims.

Specifically, we will urge the ADA to add a **Billing Provider NPI** box (just above the **Billing Provider ID** box), and a **Treating Provider NPI** box (just above the **Treating Dentist Provider ID**). To make space for these new boxes, we suggest removal of one or more of the current available procedure lines, because the majority of claims contain only two to five procedures.

4. Medical Industry Comparison

Differences between the processing of medical claims versus dental claims are compelling in this discussion. Dental administration is different from medical claims in cost, overall economics,

provider service delivery, standard claim form and other significant ways. Medical claims are overwhelmingly electronic, while the majority of dental claims are still submitted on paper. Dollar amounts of medical claims are larger than dental (by a ratio of roughly twelve-to-one), so providers get a larger return-on-investment to purchase hardware and software for electronic transactions. Electronic transactions are quick and accurate. Processing paper claims, by contrast, is time-intensive and involves human analysis. Hence, any glitches in standardizing the handling of paper claims (i.e., placement of the NPI) have a huge impact on efficiency. We handle over 25,000 claims per day, and over 70% of these are paper.

Contrast also the fact that some medical carriers do not process claims from all states at one central location, as DDPMN does. Instead, they are large enough to have processing centers in each state that handle only claims from the "home" state. DDPMN must handle the complexity of claims coming from **all** states, with Minnesota requiring the NPI, but no other state forcing such a change.

Specifically, contrast the ADA's Form J515 with a comparable medical claim form, the 1500 Claim Form. The National Uniform Claim Committee updated the medical form in August 2005 to add several boxes for the NPI (Boxes 17b, 24j, 32a and 33a). The updated form provides clear spaces to submit NPIs for:

- referring provider (if any)
- rendering provider for each listed procedure
- service facility
- billing provider

All these differences between dental claim administration and medical provide compelling support for the idea to treat dental differently than medical. The Minnesota Rules largely lump the two together and assume a common solution for different challenges, and, in the process, contradict the statutory goal of simplification and cost reduction.

5. Minnesota Standards for the Use of the ADA Dental Claim Form Manual

Another update needed regarding use of the NPI is to the AUC's *Minnesota Standards for the Use of the ADA Dental Claim Form Manual.* It needs revision to match the upcoming changes to the ADA Form J515 regarding instructions on where to place the **Billing Provider NPI** and **Treating Provider NPI**. Instructions to Boxes 49 and 54 are currently inaccurate in this manual.

6. ADA Form – Primary Paid Amount

In addition to the NPI problem, Form J515 lacks clarity in another area. It does not contain a box for the **Primary Paid Amount**, and the ADA has no plans to modify the form to include it. Currently, the ADA instructions direct providers to put the **Primary Paid Amount** in the **Remarks** box.

It will be difficult for DDPMN data entry staff to determine whether the numbers entered in the **Remarks** box are the **Primary Paid Amount**, or some other number. The **Remarks** box in this national form should not serve as the dumping ground for all data elements required only in Minnesota. If the contents of the **Remarks** box are not clear, this will delay claim processing and increase costs for DDPMN.

DDPMN is working through its national association to propose updates to Form J515 to include a box for the **Primary Paid Amount**. DDPMN will propose to the ADA that a new box for **Primary Paid Amount** be added just above the **Other Fee(s)** box.

7. Summaries and Conclusion

In summary, Delta Dental suggests that the Minnesota Department of Health use sparingly its statutory authority to conduct expedited rulemaking, especially in cases where there is not consensus among affected parties. Just as one wouldn't ask the Department of Revenue to comment on health policy, medical insurers and hospital administrators should not dictate the details of dental claims administration. Our comments above also point out the many substantive, economic and procedural differences between dental and medical claims administration and adjudication. These differences form the basis for our concerns about these rules. Because of the severity of these claims processing issues, DDPMN requests that dental claims be made exempt from the requirements of Minn. Stat. Ch. §62J. Alternatively, we also suggest that the State of Minnesota become involved in advocacy with the ADA to update the national claim form to avoid unnecessary costs and delay associated with these Minnesota-only rules.

Sincerely,

Joseph P. Lally
Vice President, Strategic Planning

cc: Bert McKasy, Lindquist & Vennum