**R590. Insurance, Administration.**

**R590-164. Uniform Health Billing Rule.**

**R590-164-1. Authority.**

This rule is promulgated by the commissioner pursuant to Sections 31A-2-201 and 31A-22-614.5.

**R590-164-2. Purpose and Scope.**

(1) The purpose of this rule is to designate uniform claim forms, billing codes, and compatible electronic data interchange standards for use by health payers and providers.

(2) This rule applies to a health claim, a health encounter, and any electronic data interchange between a payer and a provider.

(3) Except as otherwise specifically provided, this rule applies to a payer and a provider.

(4) This rule does not prohibit a payer from requesting additional information to determine eligibility of a claim under the terms of the policy or certificate issued to the claimant.

(5) This rule does not prohibit a payer or provider from using alternative forms or procedures specified in a written contract between the payer and provider.

(6) This rule does not exempt a payer or provider from data reporting requirements under state or federal law or regulation.

**R590-164-3. Definitions.**

Terms used in this rule are defined in Section 31A-1-301. Additional terms are defined as follows:

(1) "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(2) "Electronic Data Interchange Standard" means:

(a) the ASC X12N standard format developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute and the ASC X12N implementation guides as modified by the UHIN Standards Committee; and

(b) any other standard developed by the UHIN Standards Committee at the request of the commissioner and incorporated by the commissioner in rule.

(3) "HIPAA" means the federal Health Insurance Portability and Accountability Act.

(4) "HPID" means Health Plan Identifier, which is the national unique health plan identifier assigned to identify each individual health plan.

(5) "NUBC" means the National Uniform Billing Committee.

(6) "NUCC" means the National Uniform Claim Committee.

(7) "Payer" means an insurer or third-party administrator that pays, or reimburses for, the costs of health care.

(8) "Provider" means any person, partnership, association, corporation, or other facility or institution that renders health care or professional services, and any officer, employee, or agent of any of the above acting in the course and scope of their employment.

(9) "UHIN Standards Committee" means the Standards Committee of the Utah Health Information Network.

(10) Uniform Claim Codes are defined as:

(a) "ASA codes" means the codes contained in the ASA Relative Value Guide maintained by the American Society of Anesthesiologists to describe anesthesia services and related modifiers.

(b) "CDT codes" means the Current Dental Terminology published by the American Dental Association.

(c) "CPT codes" means the Current Procedural Terminology published by the American Medical Association.

(d) "DRG codes" means Diagnosis Related Group codes, which are universal grouping codes used to clarify the type of inpatient care received, and, when used with a diagnosis code and the length of the inpatient stay, to determine payment and reimbursement for claims.

(e) "HCPCS" means Healthcare Common Procedure Coding System, a coding system that describes products, supplies, procedures, and health professional services, including:

(i) "HCPCS Level 1 codes," which are CPT codes and modifiers for professional services and procedures; and

(ii) "HCPCS Level 2 codes," which are national alphanumeric codes and modifiers for health care products and supplies, as well as some codes for professional services not included in CPT codes.

(f) "ICD-CM codes" means the diagnosis and procedure codes in the International Classification of Diseases, Clinical Modifications published by the U.S. Department of Health and Human Services.

(g) "NDC" means the National Drug Codes of the Food and Drug Administration.

(h) "UB-04 Rate Codes" means the code structure and instructions established for use by the NUBC.

(12) Uniform Claim Forms are defined as:

(a) "UB-04" means the health insurance claim form maintained by NUBC for use by institutional care providers.

(b) "Form CMS 1500" means the health insurance claim form maintained by NUCC for use by health care providers.

(c) "J400" means the uniform dental claim form approved by the American Dental Association for use by dentists.

(d) "NCPDP" means the National Council for Prescription Drug Program's Claim Form or its electronic counterpart.

**R590-164-4. Paper Claim Transactions.**

(1) A payer may require the applicable uniform claim forms competed with the uniform claim codes.

(2) A payer shall accept the applicable uniform claim forms completed with the uniform claim codes.

**R590-164-5. Electronic Data Interchange Transactions.**

(1)(a) The commissioner shall use the UHIN Standards Committee to develop electronic data interchange standards for use by payers and providers transacting health insurance business electronically.

(b) In developing standards for the commissioner, the UHIN Standards Committee shall consult with national standard-setting entities including CMS, NUCC, ASC X12N, NCPDM, and NUBC.

(2) The commissioner shall incorporate a standard adopted by the UHIN Standards Committee into rule before it is required for use by payers and providers.

(3) A payer shall accept the applicable electronic data if transmitted in accordance with the electronic data interchange standard that is incorporated in rule.

(4) A payer may reject electronic data if not transmitted in accordance with the electronic data interchange standard that is incorporated in rule.

(5) The HIPAA electronic data interchange standards described in this Subsection (5) and adopted by the UHIN Standards Committee are incorporated by reference by the commissioner and are available at https://insurance.utah.gov.

(a) "999 Implementation Acknowledgement For Health Care Insurance Standard v3.4." The purpose of the standard is to detail the standard transaction for the reporting of transmission receipt and transaction or functional group X12 and implementation guide error, and adopt the use of the ASC X12 999 transaction.

(b) "Adaptive Behavior Services/Applied Behavior Analysis (ABA) Billing Standard" v3.1." The purpose of the standard is to detail the billing for the transmission of ABA services.

(c) "Administrative Transaction Acknowledgements Standard v3.1." The purpose of the standard is to create a process for acknowledging all electronic transactions between trading partners based on the communication, syntax, semantic, and business process specifications.

(d) "Anesthesia Standard v3.1." The purpose of the standard is to standardize the transmission of anesthesia data for health care services. The standard does not alter any contractual agreement between providers and payers.

(e) "Benefits Enrollment and Maintenance Standard v3.1." The purpose of the standard is to detail the standard transactions for the transmission of health care benefits enrollment and maintenance.

(f) "Claim Acknowledgement Standard v3.2." The purpose of the standard is to provide a standardized claim acknowledgement in response to a claim submission, which is used to report on the status of a claim or encounter at the pre-adjudication processing stage, for example, before the payer is legally required to keep a history of the claim or encounter.

(g) "Claim Status Inquiry and Response Standard v3.2." The purpose of the standard is to detail the standard transactions for the transmission of health care claim status inquiries and response, allow the provider to reduce the need for claim follow-up, and facilitate the correction of claims.

(h) "CMS 1500 Paper Claim Form Standard v3.3." The purpose of the standard is to describe the standard use of each box for print images, and its crosswalk to the HIPAA 837 005010X222A1 Professional implementation guide.

(i) "Coordination of Benefits Standard v3.2." The purpose of the standard is to streamline the coordination of benefits process between payers and providers or payer to payers, define the data to be exchanged for coordination of benefits, and to increase effective communications.

(j) "Dental Claim Billing Standard -- J430 v5." The purpose of the standard is to describe the standard use of each item number for print images, and its crosswalk to the HIPAA 837 005010x02241A1 dental implementation guide, and adopt the American Dental Association Dental Claim Form J43024.

(k) "Electronic Remittance Advice Standard v3.5." The purpose of the standard is to detail the standard transaction for the transmission of a health care remittance advice.

(l) "Eligibility Inquiry and Response Standard v3.3." The purpose of the standard is to detail the standard transactions for the transmission of a health care eligibility inquiry and response.

(m) "Health Care Claim/Encounter Standard v3.2." The purpose of the standard is to detail the standard transaction for the transmission of a health care claim, encounter, and an associated transaction.

(n) "Health Identification Card Standard v1.3." The purpose of the standard is to standardize the patient health identification card information and address the human-readable appearance and machine-readable information used by the healthcare industry to obtain eligibility.

(o) "Health Plan Identifier (HPID) and Other Entity Identifier (OEID) Standard v1.1." The purpose of the standard is to inform providers of the HIPD and OEID and their usage within the administrative transactions.

(p) "Home Health Standard v3.1." The purpose of the standard is to provide a uniform standard of billing for a home health care claim and encounter.

(q) "ICD-10 Standard v1.2." The purpose of the standard is to create the business requirement for a payer and a provider to implement the International Classification of Diseases 10th Revisions, ICD-10, within the administrative transaction.

(r) "Individual Name Standard v2.1." The purpose of the standard is to provide guidance for entering names into provider, payer, or sponsor systems for a patient, enrollee, and any other person associated with a record.

(s) "Metabolic Dietary Products Standard v2.1." The purpose of the standard is to provide a uniform standard for the billing of a metabolic dietary product.

(t) "NPI and Atypical Provider Standard v3.1." The purpose of the standard is to inform a provider of the national provider identifier requirements and the usage within a transaction.

(u) "Pain Management Standard v3.1." The purpose of the standard is to provide a uniform method of submitting a pain management claim, encounter, pre-authorization, and notification.

(v) "Patient Identification Number v3.0." The purpose of the standard is to describe the standard for the patient identification number.

(w) "Premium Payment v3.0." The purpose of the standard is to detail the standard transaction for the transmission of a premium payment.

(x) "Prior Authorization/Referral Standard v3.0." The purpose of the standard is to provide general recommendations to payers and providers about handling an electronic prior authorization and referral.

(y) "Required Unknown Values Standard v3.0." The purpose of the standard is to provide guidance for the use of common data values that can be used within the HIPAA transaction when a required data element is not known by the provider, payer, or sponsor for a patient, enrollee, and any other person associated with the transaction. The data values should only be used when the data is not available or known and may not be used to replace known data.

(z) "Telehealth Standard v3.2." The purpose of the standard is to provide a uniform standard of billing for a health care claim and encounter delivered through telehealth.

(aa) "UB04 Form Locator Elements v3.0." The purpose of the standard is to describe the use of each form locator in the UB-04 claim billing form and its crosswalk to the HIPAA 837 005010X223A2 institutional implementation guide.

**R590-164-6. Severability.**

If any provision of this rule, Rule R590-164, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule that can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

**KEY: insurance law**

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**Authorizing, and Implemented or Interpreted Law: 31A-22-614.5**