R590. Insurance, Administration.
R590-164. Uniform Health Billing Rule.
R590-164-6. Electronic Data Interchange Transactions.

(1) 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. In developing standards for the commissioner, the UHIN Standards Committee shall consult with national standard setting entities including but not limited to Centers for Medicare and Medicaid Services (CMS), the National Uniform Claim Form Committee, ASC X12, NCPDP, and the National Uniform Billing Committee.

(2) Standards developed and adopted by the UHIN Standards Committee shall not be required for use by payers and providers, until adopted by the commissioner by rule.

(3) Payers shall accept the applicable electronic data if transmitted in accordance with the adopted electronic data interchange standard. Payers may reject electronic data if not transmitted in accordance with the adopted electronic data interchange standard.

(4) The following HIPAA+ electronic data interchange standards developed and adopted by the UHIN Standards Committee and adopted by the commissioner are hereby incorporated by reference with this rule and are available for public inspection at the department during normal business hours or at www.insurance.utah.gov.

(a) "999 Implementation Acknowledgement For Health Care Insurance v4.0." Purpose: To detail the standard transaction for the reporting of transmission receipt and transaction or functional group X12 and implementation guide error. This standard adopts the use of the ASC X12 999 transaction.

(b) "Administrative Transaction Acknowledgements Standard ~~v3.0~~v4.0." Purpose: To create a process for acknowledging all electronic transactions between trading partners based on the communication, syntax semantic and business process specifications.

(~~b~~c) "Anesthesia Standard ~~v3.0~~v3.1." Purpose: to standardize the transmission of anesthesia data for health care services. This standard does not alter any contractual agreement between providers and payers.

(~~c~~d) "Benefits and Enrollment ~~and Maintenance~~ Standard ~~v3.0~~v3.1." Purpose: To detail the standard transactions for the transmission of health care benefits enrollment and maintenance.

(~~d~~e) ~~"CMS 1500 Paper Claim Form Box 17 and 17A Standard v3.1." Purpose: To establish a standard approach to reporting referring provider name and identifier number on the claim form. This standard also provides the cross walk to the ASCX12 837 Professional Claim version 005010x222A1.~~

~~(e) "CMS 1500 Paper Claim Form Standard v3.0." Purpose: To clearly describe the standard use of each Box, for print images, and its crosswalk to the HIPAA 837 005010X222A1 Professional implementation guide.~~

~~(f)~~ "Claim Acknowledgement Standard ~~v3.1~~v3.2." Purpose: To provide a standardized claim acknowledgement in response to a claim submission. This transaction is used to report on the status of a claim/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~~f) "Claim Status Inquiry and Response Standard ~~v3.1~~v3.2." Purpose: To detail the standard transactions for the transmission of health care claim status inquiries and response after January 1, 2012. The transaction is intended to allow the provider to reduce the need for claim follow-up and facilitate the correction of claims.

(g) "CMS 1500 Paper Claim Form Box 17, 17A and 17B Standard v3.2." Purpose: To establish a standard approach to reporting referring provider name and identifier number on the claim form. This standard also provides the cross walk to the ASCX12 837 Professional Claim version 005010x222A1.

(g) "CMS 1500 Paper Claim Form Standard v3.3." Purpose: To clearly describe the standard use of each Box, for print images, and its crosswalk to the HIPAA 837 005010X222A1 Professional implementation guide.

(~~h~~i) "Coordination of Benefits Standard ~~v3.0~~v3.1." Purpose: To streamline the coordination of benefits process between payers and providers or payer to payers. The standard is to define the data to be exchanged for coordination of benefits and to increase effective communications.

(~~i~~j) "Dental Claim Billing Standard – J400 v3.1." Purpose: To describe the standard use of each item number, for print images, and its crosswalk to the HIPAA 837 005010X0224A1 dental implementation guide. This standards adopts the ADA dental Claim Form J400.

(~~j~~k) ”Dental Claim Billing Standard – J340 v3.2" Purpose: To describe the standard use of each item number, for print images, and its crosswalk to the HIPAA 837 005010x02241A1 dental implementation guide. This standard adopts the ADA dental Claim Form J340.

(l) "Electronic Remittance Advice Standard ~~v 3.4~~v3.5." Purpose: To detail the standard transaction for the reporting of transmission receipt and transaction or functional group X12 and implementation guide errors. This standard adopts the use of the ASC X12 999 transaction.

(~~k~~m) "Eligibility Inquiry and Response Standard ~~v3.1~~v3.2." Purpose: To detail the standard transactions for the transmission of health care eligibility inquiries and responses.

(~~l~~n) "Health Care Claim Encounter Standard v3.2." Purpose: To detail the standard transactions for the transmission of health care claims and encounters and associated transactions.

(~~m~~o) "Health Identification Card Standard v1.2." Purpose: To standardize the patient health identification card information. This identification card addresses the human-readable appearance and machine-readable information used by the healthcare industry to obtain eligibility.

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

(~~n~~q) "Home Health Standard v3.0." Purpose: To provide a uniform standard of billing for home health care claims and encounters.

(~~o~~r) "~~Implementation Acknowledgement For Health Care Insurance v3.2." Purpose: To detail the standard transaction for the~~

~~reporting of transmission receipt and transaction or functional group X12 and implementation guide error. This standard adopts the use of the ASC X12 999 transaction.~~ICD-10 Standard v1.2. Purpose: To create the business requirement for payers and providers to implement the International Classification of Diseases 10th Revisions, ICD-10, within the administrative transaction.

(~~p~~s) "Individual Name Standard v2.0." Purpose: To provide guidance for entering names into provider, payer or sponsor systems for patients, enrollees, as well as all other people associated with these records.

(~~q~~t) "Medicaid Enrollment Implementation Guide v3.0." Purpose: This standard establishes the use of the ASC X12 834 enrollment transaction for Medicaid enrollments.

(~~r~~u) "Metabolic Dietary Products Standard v3.0." Purpose: To provide a uniform standard for billing of metabolic dietary products for those providers and payers using the UB04, the CMS 1500, the NCPDP, or an electronic equivalent.

(~~s~~v) "National Provider Identifier Standard v3.0." Purpose: To inform providers of the national provider identifier requirements and the usage within the transactions.

(~~t~~w) "Pain Management Standard ~~v3.0~~v3.1." Purpose: To provide a uniform method of submitting pain management claims, encounters, pre-authorizations, and notifications.

(~~u~~x) "Patient Identification Number Standard v3.0." Purpose: To describe the standard for the patient identification number.

(~~v~~y) "Premium Payment Standard v3.0." Purpose: To detail the standard transactions for the transmission of premium payments.

(~~w~~z) "Prior Authorization/Referral Standard v3.0." Purpose: To provide general recommendations to payers and providers about handling electronic prior authorization and referrals.

(~~x~~aa) "Required Unknown Values Standard v~~-~~3.0." Purpose: To provide guidance for the use of common data values that can be used within the HIPAA transactions when a required data element is not known by the provider, payer or sponsor for patients, enrollees, as well as all other people associated with these transactions. These data values should only be used when the data is truly not available or known. These values should not to be used to replace known data.

(~~y~~ab) "Telehealth Standard ~~v3.0~~v3.1." Purpose: To provide a uniform standard of billing for health care claims and encounters delivered via telehealth.

(~~z~~ac) "Transparency Administration Performance Standard ~~v 1.0~~v1.2," Purpose: To establish performance measures that report the average telephone answer time and claim turnaround time.

(~~aa~~ad) "Transparency Denial Standard ~~v 1.1~~v1.2." Purpose: To establish performance measures that report the number and cost of an insurer's denied health claims and to provide guidance pertaining to the reporting method and timeline.

(~~bb~~ae) "UB04 Form Locator Elements Standard v3.0." Purpose: To clearly describe the use of each form locator in the UB04 claim billing form and its crosswalk to the HIPAA 837 005010X223A2 institutional implementation guide.