State of Utah
Administrative Rule Analysis
Revised October 2019

NOTICE OF PROPOSED RULE		
TYPE OF RULE: New ___; Amendment _x_; Repeal ___; Repeal and Reenact ___		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R590-164**	**Filing No. (Office Use Only)**
Changed to Admin. Code Ref. (R no.):	**R**	

Agency Information

1. Agency:	Insurance Department	
Room no.:	3110	
Building:	State Office Building	
Street address:	450 N. State St.	
City, state, zip:	Salt Lake City, UT, 84114	
Mailing address:	PO Box 146901	
City, state, zip:	Salt Lake City, UT, 84114-6901	
Contact person(s):		
Name:	**Phone:**	**Email:**
Steve Gooch	801-538-3803	sgooch@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:

Uniform Health Billing Rule.

3. Purpose of the new rule or reason for the change (If this is a new rule, what is the purpose of the rule? If this is an amendment, repeal, or repeal and reenact, what is the reason for the filing?)**:**

This rule is being amended to bring the standards in the rule up to date with standards that are already in use by industry.

4. Summary of the new rule or change:

The primary change updates the electronic data interchange standards previously adopted by the Utah Health Information Network (UHIN). UHIN is a nonprofit organization that brings together payers and providers for the efficient processing of claims. The updated standards are already in use by industry.

Fiscal Information

5. Aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated cost or savings to the state budget. The change merely brings the rule language in line with current standards in use by industry.

B) Local governments:

There is no anticipated cost or savings to local government. The change merely brings the rule language in line with current standards in use by industry.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no anticipated cost or savings to small businesses. The change merely brings the rule language in line with current standards in use by industry.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no anticipated cost or savings to non-small businesses. The change merely brings the rule language in line with current standards in use by industry.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no anticipated cost or savings to any other persons. The change merely brings the rule language in line with current standards in use by industry.

F) Compliance costs for affected persons:

There are no compliance costs for any affected persons. The industry already uses these standards and will not need to take any further action.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Summary Table

Fiscal Costs	**FY 2020**	**FY 2021**	**FY 2022**
State Government	$0	$0	$0
Local Government	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Person	$0	$0	$0
Total Fiscal Costs:	**$0**	**$0**	**$0**
Fiscal Benefits			
State Government	$0	$0	$0
Local Government	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits:	**$0**	**$0**	**$0**
Net Fiscal Benefits:	**$0**	**$0**	**$0**

H) Department head sign-off on regulatory impact:

The head of the Insurance Department, Todd E. Kiser, has reviewed and approved this fiscal analysis.

6. A) Comments by the department head on the fiscal impact this rule may have on businesses:

After conducting a thorough analysis, it was determined that this proposed rule will not result in a fiscal impact to businesses.

B) Name and title of department head commenting on the fiscal impacts:
Todd E. Kiser, Insurance Commissioner

Citation Information

7. This rule change is authorized or mandated by state law, and implements or interprets the following state and federal laws. State code or constitution citations (required):		
31A-22-614.5		

Incorporations by Reference Information

(If this rule incorporates more than two items by reference, please include additional tables)

8. A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

	First Incorporation
Official Title of Materials Incorporated (from title page)	Adaptive Behavior Services/Applied Behavior Analysis (ABA) Billing Standard
Publisher	Utah Health Information Network
Date Issued	02/02/2019
Issue, or version	3.1

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

	Second Incorporation
Official Title of Materials Incorporated (from title page)	Dental Claim Billing Standard - J430
Publisher	Utah Health Information Network
Date Issued	09/07/2019
Issue, or version	4

C) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

	Third Incorporation
Official Title of Materials Incorporated (from title page)	NPI and Atypical Provider Identifier Standard
Publisher	Utah Health Information Network
Date Issued	09/07/2019
Issue, or version	3.1

D) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

	Fourth Incorporation
Official Title of Materials Incorporated (from title page)	Transparency Administration Performance Standard
Publisher	Utah Health Information Network

Date Issued	02/02/2019
Issue, or version	1.5

E) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

	Fifth Incorporation
Official Title of Materials Incorporated (from title page)	Transparency Denial Standard
Publisher	Utah Health Information Network
Date Issued	02/02/2019
Issue, or version	1.5

Public Notice Information

9. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. The agency is required to hold a hearing if it receives requests from ten interested persons or from an association having not fewer than ten members. Additionally, the request must be received by the agency not more than 15 days after the publication of this rule in the Utah State Bulletin. See Section 63G-3-302 and Rule R15-1 for more information.)

A) Comments will be accepted until (mm/dd/yyyy)**:**	01/14/2020

B) A public hearing (optional) will be held:

On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

10. This rule change MAY* become effective on (mm/dd/yyyy)**:**	01/21/2020

*NOTE: The date above is the date on which this rule MAY become effective. It is NOT the effective date. After the date designated in Box 10, the agency must submit a Notice of Effective Date to the Office of Administrative Rules to make this rule effective. Failure to submit a Notice of Effective Date will result in this rule lapsing and will require the agency to start the rulemaking process over.

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*, and delaying the first possible effective date.

Agency head or designee, and title:	Steve Gooch	**Date** (mm/dd/yyyy)**:**	11/26/19

R590. Insurance, Administration.
R590-164. Uniform Health Billing Rule.
R590-164-1. Authority.

This rule is promulgated by the Insurance Commissioner pursuant to Subsection 31A-22-614.5 which authorizes the commissioner to adopt uniform claim forms, billing codes, and compatible systems of electronic billing.

R590-164-2. Purpose.

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.

R590-164-3. Applicability and Scope.

(1) This rule applies to health claims, health encounters, and electronic data interchange between payers and providers.

(2) Except as otherwise specifically provided, the requirements of this rule apply to payers and providers.

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

(4) 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.

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

R590-164-4. Definitions.

As used in this rule:

(1) 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.

(2) Uniform Claim Codes are defined as:

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

(b) "CDT Codes" means the current dental terminology prescribed by the American Dental Association.

(c) "CPT Codes" means the current physicians procedural terminology, published by the American Medical Association.

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

(e) "HCPCS" means HCFA's Common Procedure Coding System, a coding system that describes products, supplies, procedures and health professional services and includes, the American Medical Association's (AMA's) Physician Current Procedural Terminology, codes, alphanumeric codes, and related modifiers. This includes:

(i) "HCPCS Level 1 Codes" which are the AMA's CPT codes and modifiers for professional services and procedures.

(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 the AMA's CPT codes.

(f) "ICDCM 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) "UB04 Rate Codes" means the code structure and instructions established for use by the National Uniform Billing Committee.

(3) "Electronic Data Interchange Standard" means the:

(a) 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 Utah Health Information Network (UHIN) Standards Committee;

(b) other standards developed by the UHIN Standards Committee at the request of the commissioner; and

(c) as adopted by the commissioner by rule.

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

(5) "NPI" means National Provider Identifier. A NPI is a unique ten digit identification number required by HIPAA for all health care providers in th[~~3~~]e United States. Providers must use their NPI to identify themselves in all HIPAA transactions.

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

(7) "Provider" means any person, partnership, association, corporation or other facility or institution that renders or causes to be rendered health care or professional services, and officers, employees or agents of any of the above acting in the course and scope of their employment.

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

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

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

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

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

R590-164-5. Paper Claim Transactions.

Payers shall accept and may require the applicable uniform claim forms completed with the uniform claim codes.

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 v3.4." 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 v3.1." Purpose: To create a process for acknowledging all electronic transactions between trading partners based on the communication, syntax semantic and business process specifications.

(c) "Anesthesia Standard 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.

(d) "[~~Applied Behavioral Analysis, ABA, Billing Standard V3.0~~]Adaptive Behavior Services/Applied Behavior Analysis (ABA) Billing Standard v3.1." Purpose: To provide detail of the billing for the transmission of ABA services.

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

(f) "Claim Acknowledgement Standard 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) "Claim Status Inquiry and Response Standard v3.2." Purpose: To detail the standard transactions for the transmission of health care claim status inquiries and response. The transaction is intended to 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." Purpose: To clearly 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." 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.

(j) "Dental Claim Billing Standard -[-] J430 v[~~3.2~~]4" 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.

(k) "Electronic Remittance Advice Standard v3.5." Purpose: To detail the standard transactions for the transmission of health care remittance advices.

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

(m) "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.

(n) "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.

(o) "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.

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

(q) 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.

(r) "Individual Name Standard v2.1." 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.

(s) "[~~National Provider Identifier Standard v3.0~~]NPI and Atypical Provider Identifier Standard v3.1." Purpose: To inform providers of the national provider identifier requirements and the usage within the transactions.

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

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

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

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

(x) "Required Unknown Values Standard v3.0." 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) "Telehealth Standard v3.2." Purpose: To provide a uniform standard of billing for health care claims and encounters delivered via telehealth.

(z) "Transparency Administration Performance Standard v1.[4]5," Purpose: To establish performance measures that report the average telephone answer time and claim turnaround time.

(aa) "Transparency Denial Standard v1.[4]5." 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.

(ab) "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.

R590-164-7. Severability.

If any provision of this rule or the application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

KEY: insurance law
Date of Enactment or Last Substantive Amendment: August 14, 2018
Notice of Continuation: March 10, 2015
Authorizing, and Implemented or Interpreted Law: 31A-22-614.5