State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: New ___; Amendment _x_; Repeal ___; Repeal and Reenact ___		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R590-164**	**Filing ID: Office Use Only**

Agency Information

1. Department:	Insurance	
Agency:	Administration	
Room number:	Suite 2300	
Building:	Taylorsville State Office Building	
Street address:	4315 S. 2700 W.	
City, state and zip:	Taylorsville, UT 84129	
Mailing address:	PO Box 146901	
City, state and zip:	Salt Lake City, UT 84114-6901	
Contact persons:		
Name:	**Phone:**	**Email:**
Steve Gooch	801-957-9322	sgooch@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:

R590-164. Uniform Health Billing Rule

3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**

The rule is being changed in compliance with Executive Order 2021-12. During the review of this rule, the department discovered a number of minor issues that needed to be amended. It also updates several standards that are incorporated by reference.

4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**

The majority of the changes are being done to fix style issues to bring the rule text more in line with current rulewriting standards. Other changes make the language of the rule more clear, and update the Severability section to use the department's current language. The changes do not add, remove, or change any regulations or requirements.

Several standards published by the Utah Health Information Network and incorporated by reference in this rule are also being updated. They are:

999 Implementation Acknowledgement For Health Care Insurance Standard 3.4. Updates the name of the standard.
Adaptive Behavior Services/Applied Behavioral Analysis (ABA) Billing Standard 3.1. Updated to include the permanent national codes published in late 2018.
Benefits Enrollment and Maintenance Standard 3.1. Updates the name of the standard.
Dental Claim Billing Standard -- J430 4.0. Revised to point to external resources as applicable and to ensure the standard does not conflict with those resources.
Eligibility Inquiry and Response Standard 3.3. Updated for readability and to remove an outdated statement.
Health Plan Identifier (HPID) and Other Entity Identifier (OEID) Standard 1.1. Updates the name of the standard.
Home Health Standard 3.1. Updated for readability and accuracy, and makes changes to the implementation section, "Table 2 - Line Item Codes", and "Table 3 - Per Diem Codes".
NPI and Atypical Provider Standard 3.1. Updated for readability and accuracy, and to update the name of the standard.
Transparency Administration Performance Standard 1.8. Updated for readability, and to require that data be submitted directly to the UID rather than through UHIN.
Patient Identification Number 3.0. Updates the name of the standard.
Premium Payment 3.0. Updates the name of the standard.
Transparency Denial Standard 1.8. Updated for readability, and to require that data be submitted directly to the UID rather than through UHIN.
UB04 Form Locator Elements 3.0. Updates the name of the standard.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated cost or savings to the state budget. The changes are largely clerical in nature, and will not change how the department functions.

B) Local governments:

There is no anticipated cost or savings to local governments. The changes are largely clerical in nature, and will not affect local governments.

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

There is no anticipated cost or savings to small businesses. The changes are largely clerical in nature, and will not affect small businesses.

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 changes are largely clerical in nature, and will not affect non-small businesses.

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 changes are largely clerical in nature.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs for any affected persons. The changes are largely clerical in nature.

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 Table

Fiscal Cost	**FY2023**	**FY2024**	**FY2025**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2023**	**FY2024**	**FY2025**
State Government	$0	$0	$0
Local Governments	$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 comments on fiscal impact and approval of regulatory impact analysis:

The Commissioner of Insurance, Jonathan T. Pike, has reviewed and approved this regulatory impact analysis.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 31A-2-201	Section 31A-22-614.5	

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables)**:**	
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*)**:**	
Official Title of Materials Incorporated (from title page)	999 Implementation Acknowledgement For Health Care Insurance Standard
Publisher	Utah Health Information Network
Issue Date	11/06/2013
Issue or Version	3.4

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*)**:**	
Official Title of Materials Incorporated (from title page)	Adaptive Behavior Services/Applied Behavioral Analysis (ABA) Billing Standard
Publisher	Utah Health Information Network
Issue Date	02/02/2019
Issue or Version	3.1

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*)**:**	
Official Title of Materials Incorporated (from title page)	Benefits Enrollment and Maintenance Standard
Publisher	Utah Health Information Network
Issue Date	11/05/2014
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*)**:**	
Official Title of Materials Incorporated (from title page)	Dental Claim Billing Standard -- J430
Publisher	Utah Health Information Network
Issue Date	09/07/2019
Issue or Version	4

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*)**:**	
Official Title of Materials Incorporated (from title page)	Eligibility Inquiry and Response Standard
Publisher	Utah Health Information Network
Issue Date	11/03/2021
Issue or Version	3.3

F) 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*)**:**	
Official Title of Materials Incorporated (from title page)	Health Care Claim/Encounter Standard
Publisher	Utah Health Information Network
Issue Date	06/18/2011

Issue or Version	3.2

G) 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*)**:**	
Official Title of Materials Incorporated (from title page)	Health Plan Identifier (HPID) and Other Entity Identifier (OEID) Standard
Publisher	Utah Health Information Network
Issue Date	06/06/2015
Issue or Version	1.1

H) 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*)**:**	
Official Title of Materials Incorporated (from title page)	Home Health Standard
Publisher	Utah Health Information Network
Issue Date	06/27/2020
Issue or Version	3.1

I) 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*)**:**	
Official Title of Materials Incorporated (from title page)	NPI and Atypical Provider Standard
Publisher	Utah Health Information Network
Issue Date	09/07/2019
Issue or Version	3.1

J) 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*)**:**	
Official Title of Materials Incorporated (from title page)	Patient Identification Number
Publisher	Utah Health Information Network
Issue Date	03/02/2011
Issue or Version	3.0

K) 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*)**:**	
Official Title of Materials Incorporated (from title page)	Premium Payment
Publisher	Utah Health Information Network
Issue Date	03/02/2011
Issue or Version	3.0

L) 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*)**:**	
Official Title of Materials Incorporated (from title page)	Transparency Administration Performance Standard
Publisher	Utah Health Information Network
Issue Date	12/03/2021
Issue or Version	1.8

M) 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*)**:**	
Official Title of Materials Incorporated (from title page)	Transparency Denial Standard
Publisher	Utah Health Information Network
Issue Date	12/03/2021
Issue or Version	1.8

N) 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*)**:**	
Official Title of Materials Incorporated (from title page)	UB04 Form Locator Elements
Publisher	Utah Health Information Network
Issue Date	06/18/2011
Issue or Version	3.0

Public Notice Information

8. 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. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		**10/17/2022**
B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

9. This rule change MAY become effective on:	**10/24/2022**
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

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, Public Information Officer	**Date:**	**09/01/2022**

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

This rule is promulgated by the [~~Insurance C~~]commissioner pursuant to [~~Subsection~~]Sections 31A-2-201 and 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 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.

[
~~**R590-164-3. Applicability and Scope.**~~**|**

([~~1~~]2) This rule applies to a health claim[~~s~~], a health encounter[~~s~~], and any electronic data interchange between a payer[~~s~~] and a provider[~~s~~].

([~~2~~]3) Except as otherwise specifically provided, [~~the requirements of~~]this rule [~~apply~~]applies to a payer[~~s~~] and a provider[~~s~~].

([~~3~~]4) This rule does not prohibit a payer from requesting additional information [~~required~~]to determine eligibility of [~~the~~]a claim under the terms of the policy or certificate issued to the claimant.

([4]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.

([~~5~~]6) This rule does not exempt a payer or provider from data reporting requirements under state or federal law or regulation.

R590-164-[4]3. 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 th3e 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~~]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-[~~5~~]4. Paper Claim Transactions.

[~~Payers shall accept and may require the applicable uniform claim forms completed with the uniform claim codes~~](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-[~~6~~]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 [~~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~~]CMS, NUCC, ASC X12N, NCPDM, and NUBC.

(2) [~~S~~]A standard[~~s developed and~~] adopted by the UHIN Standards Committee [~~shall~~]may not be required for use by payers and providers[~~,~~] until [~~adopted~~]incorporated by the commissioner [~~by~~]in rule.

(3) [~~P~~]A payer[~~s~~] shall accept the applicable electronic data if transmitted in accordance with the [~~adopted~~]electronic data interchange standard that is incorporated in rule.

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

([~~4~~]5) The following HIPAA+ electronic data interchange standards [~~developed and~~]adopted by the UHIN Standards Committee [~~and adopted by the commissioner are hereby~~]are incorporated by reference by the commissioner[~~with this rule~~]and are available [~~for public inspection at the department during normal business hours or at www.~~]at https://insurance.utah.gov.

(a) "999 Implementation Acknowledgement For Health Care Insurance Standard 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) "Adaptive Behavior Services/Applied Behavior Analysis (ABA) Billing Standard" v3.1." Purpose: To detail the billing for the transmission of ABA services.

(c) "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)~~](d) "Anesthesia Standard v3.1." Purpose: [~~t~~]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." Purpose: To provide detail of the billing for the transmission of ABA services.~~]

(e) "Benefits [~~and~~]Enrollment and Maintenance 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[~~/~~] 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." Purpose: To detail the standard transactions for the transmission of health care claim status inquiries and response[~~. The transaction is intended to~~]; allows 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~~]; defines 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~~]3." 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~~]To inform providers of the HIPD and OEID and their usage within the administrative transactions.

(p) "Home Health Standard v3.[~~0~~]1." 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~~]and any other people associated with these records.

(s) "[~~National Provider Identifier Standard v3.0~~]NPI and Atypical Provider 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~~]and any other people associated with these transactions[~~. T~~]; these data values should only be used when the data is [~~truly~~]not available or known[~~. These values should not to~~] and may not 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~~,~~]8." Purpose: To establish performance measures that report the average telephone answer time and claim turnaround time.

(aa) "Transparency Denial Standard v1.[4]8." 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 UB-04 claim billing form and its crosswalk to the HIPAA 837 005010X223A2 institutional implementation guide.

R590-164-[~~7~~]6. 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.~~]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
Date of Last Change: 2022[~~August 14, 2018~~]
Notice of Continuation: March 6, 2020
Authorizing, and Implemented or Interpreted Law: 31A-22-614.5

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