§ 162.915  Trading partner agreements.

A covered entity must not enter into a trading partner agreement that would do any of the following:

(a) Change the definition, data condition, or use of a data element or segment in a standard or operating rule, except where necessary to implement State or Federal law, or to protect against fraud and abuse.

(b) Add any data elements or segments to the maximum defined data set.

(c) Use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s).

(d) Change the meaning or intent of the standard’s implementation specification(s).

(45 CFR Subtitle A (10–1–11 Edition))

§ 162.920 Availability of implementation specifications and operating rules.

Certain material is incorporated by reference into this subpart with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, the Department of Health and Human Services must publish notice of change in the Federal Register and the material must be available to the public. All approved material is available for inspection at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 714–6630, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. The materials are also available for inspection by the public at the Centers for Medicare & Medicaid Services (CMS), 7500 Security Boulevard, Baltimore, Maryland 21244. For more information on the availability on the materials at CMS, call (410) 786–6597. The materials are also available from the sources listed below.

(a)  ASC X12N specifications and the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3. The implementation specifications for the ASC X12N and the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (and accompanying Errata or Type 1 Errata) may be obtained from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; Telephone (703) 970–4480; and FAX (703) 970–4488. They are also available through the internet at http://www.X12.org. A fee is charged for all implementation specifications, including Technical Reports Type 3. Charging for such publications is consistent with the policies of other publishers of standards. The transaction implementation specifications are as follows:


(10) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Dental (837), May 2006, ASC X12N/005010X224, and Type 1 Errata to Health Care Claim: Dental (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X224A1, as referenced in §162.1102 and §162.1802.

(11) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222, as referenced in §162.1102 and §162.1802.


(13) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim Payment/Advice (835), April 2006, ASC X12N/005010X221, as referenced in §162.1602.

(14) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Benefit Enrollment and Maintenance (834), August 2006, ASC X12N/005010X220, as referenced in §162.1502.

(15) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Payroll Deducted and Other Group Premium Payment for Insurance Products (820), February 2007, ASC X12N/005010X218, as referenced in §162.1702.


(18) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Eligibility Benefit Inquiry and Response (270/271),
(b) Retail pharmacy specifications and Medicaid subrogation implementation guides. The implementation specifications for the retail pharmacy standards and the implementation specifications for the batch standard for the Medicaid pharmacy subrogation transaction may be obtained from the National Council for Prescription Drug Programs, 9240 East Raintree Drive, Scottsdale, AZ 85260. Telephone (480) 477-1800; FAX (480) 767-1042. They are also available through the Internet at http://www.ncpdp.org. A fee is charged for all NCPDP Implementation Guides. Charging for such publications is consistent with the policies of other publishers of standards. The transaction implementation specifications are as follows:


(c) Council for Affordable Quality Healthcare’s (CAQH) Committee on Operating Rules for Information Exchange (CORE), 601 Pennsylvania Avenue, NW, South Building, Suite 500 Washington, DC 20004; Telephone (202) 861-1492; Fax (202) 861-1454; E-mail info@CAQH.org; and Internet at http://www.caqh.org/benefits.php.

(1) CAQH, Committee on Operating Rules for Information Exchange, CORE Phase I Policies and Operating Rules, Approved April 2006, v5010 Update March 2011.

(i) Phase I CORE 152: Eligibility and Benefit Real Time Companion Guide Rule, version 1.1.0, March 2011, as referenced in §162.1203.

(ii) Phase I CORE 153: Eligibility and Benefits Connectivity Rule, version 1.1.0, March 2011, as referenced in §162.1203.

(iii) Phase I CORE 154: Eligibility and Benefits 270/271 Data Content Rule, version 1.1.0, March 2011, as referenced in §162.1203.

(iv) Phase I CORE 155: Eligibility and Benefits Batch Response Time Rule, version 1.1.0, March 2011, as referenced in §162.1203.

(v) Phase I CORE 156: Eligibility and Benefits Real Time Response Time Rule, version 1.1.0, March 2011, as referenced in §162.1203.

(vi) Phase I CORE 157: Eligibility and Benefits System Availability Rule, version 1.1.0, March 2011, as referenced in §162.1203.


(3) CAQH, Committee on Operating Rules for Information Exchange, CORE Phase II Policies and Operating Rules, Approved July 2008, v5010 Update March 2011.

(i) Phase II CORE 250: Claim Status Rule, version 2.1.0, March 2011, as referenced in §162.1403.
§ 162.923 Requirements for covered entities.

(a) General rule. Except as otherwise provided in this part, if a covered entity conducts, with another covered entity that is required to comply with a transaction standard adopted under this part (or within the same covered entity), using electronic media, a transaction for which the Secretary has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction.

(b) Exception for direct data entry transactions. A health care provider electing to use direct data entry offered by a health plan to conduct a transaction for which a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan.

(c) Use of a business associate. A covered entity may use a business associate, including a health care clearinghouse, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following:

(1) Comply with all applicable requirements of this part.

(2) Require any agent or subcontractor to comply with all applicable requirements of this part.

§ 162.925 Additional requirements for health plans.

(a) General rules. (1) If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so.

(2) A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction.

(3) A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information).

(4) A health plan may not offer an incentive for a health care provider to conduct a transaction covered by this part as a transaction described under the exception provided for in §162.923(b).

(5) A health plan that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan.

(6) During the period from March 17, 2009 through December 31, 2011, a health plan may not delay or reject a standard transaction, or attempt to adversely affect the other entity or the transaction, on the basis that it does not comply with another adopted standard for the same period.

(b) Coordination of benefits. If a health plan receives a standard transaction and coordinates benefits with another health plan (or another payer), it must store the coordination of benefits data it needs to forward the standard transaction to the other health plan (or other payer).

(c) Code sets. A health plan must meet each of the following requirements:

(1) Accept and promptly process any standard transaction that contains