and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals:

(i) Prevention.
(ii) Diagnosis.
(iii) Treatment.
(iv) Management.


EFFECTIVE DATE NOTE: At 77 FR 54720, Sept. 5, 2012, §162.1002 was amended by revising paragraph (b) introductory text and paragraph (c) introductory text, effective Nov. 5, 2012. For the convenience of the user, the revised text is set forth as follows:

§ 162.1002 Medical data code sets.
* * * * *

(b) For the period on and after October 16, 2003 through September 30, 2014:
* * * * *

(c) For the period on and after October 1, 2014:
* * * * *

§ 162.1011 Valid code sets.

Each code set is valid within the dates specified by the organization responsible for maintaining that code set.

Subpart K—Health Care Claims or Equivalent Encounter Information

§ 162.1101 Health care claims or equivalent encounter information transaction.

The health care claims or equivalent encounter information transaction is the transmission of either of the following:

(a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.

(b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

§ 162.1102 Standards for health care claims or equivalent encounter information transaction.

The Secretary adopts the following standards for the health care claims or equivalent encounter information transaction:

(a) For the period from October 16, 2003 through March 16, 2009:


(b) For the period from March 17, 2009 through December 31, 2011, both:

(1)(i) The standards identified in paragraph (a) of this section; and
§ 162.1201 Eligibility for a Health Plan

The eligibility for a health plan transaction is the transmission of either of the following:

(a) An inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee:

(1) Eligibility to receive health care under the health plan.
(2) Coverage of health care under the health plan.
(3) Benefits associated with the benefit plan.

(b) A response from a health plan to a health care provider's (or another health plan's) inquiry described in paragraph (a) of this section.

§ 162.1202 Standards for eligibility for a health plan transaction.

The Secretary adopts the following standards for the eligibility for a health plan transaction:

(a) For the period from October 16, 2003 through March 16, 2009:


(ii) For retail pharmacy supplies and professional services claims, the following: The ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096, October 2002 (incorporated by reference in §162.920); and

(C) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222. (incorporated by reference in §162.920.)

(c) For the period on and after the January 1, 2012, the standards identified in paragraph (b)(2) of this section, except the standard identified in paragraph (b)(2)(v)(A) of this section.