

§ 162.100

162.1202 Standards for eligibility for a health plan transaction.

Subpart M—Referral Certification and Authorization

162.1301 Referral certification and authorization transaction.

162.1302 Standard for referral certification and authorization transaction.

Subpart N—Health Care Claim Status

162.1401 Health care claim status transaction.

162.1402 Standards for health care claim status transaction.

Subpart O—Enrollment and Disenrollment in a Health Plan

162.1501 Enrollment and disenrollment in a health plan transaction.

162.1502 Standards for enrollment and disenrollment in a health plan transaction.

Subpart P—Health Care Payment and Remittance Advice

162.1601 Health care payment and remittance advice transaction.

162.1602 Standards for health care payment and remittance advice transaction.

Subpart Q—Health Plan Premium Payments

162.1701 Health plan premium payments transaction.

162.1702 Standards for health plan premium payments transaction.

Subpart R—Coordination of Benefits

162.1801 Coordination of benefits transaction.

162.1802 Standards for coordination of benefits information transaction.

AUTHORITY: Secs. 1171 through 1179 of the Social Security Act (42 U.S.C. 1320d-1320d-8), as added by sec. 262 of Pub. L. 104-191, 110 Stat. 2021-2031, and sec. 264 of Pub. L. 104-191, 110 Stat. 2033-2034 (42 U.S.C. 1320d-2 (note)).

SOURCE: 65 FR 50367, Aug. 17, 2000, unless otherwise noted.

Subpart A—General Provisions

§ 162.100 Applicability.

Covered entities (as defined in § 160.103 of this subchapter) must comply with the applicable requirements of this part.

45 CFR Subtitle A (10-1-03 Edition)

§ 162.103 Definitions.

For purposes of this part, the following definitions apply:

Code set means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

Code set maintaining organization means an organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted in this part.

Data condition means the rule that describes the circumstances under which a covered entity must use a particular data element or segment.

Data content means all the data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not data content.

Data element means the smallest named unit of information in a transaction.

Data set means a semantically meaningful unit of information exchanged between two parties to a transaction.

Descriptor means the text defining a code.

Designated standard maintenance organization (DSMO) means an organization designated by the Secretary under § 162.910(a).

Direct data entry means the direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer.

Format refers to those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

HCPCS stands for the Health [Care Financing Administration] Common Procedure Coding System.

Maintain or *maintenance* refers to activities necessary to support the use of a standard adopted by the Secretary, including technical corrections to an implementation specification, and enhancements or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or

modification to an adopted standard or implementation specification.

Maximum defined data set means all of the required data elements for a particular standard based on a specific implementation specification.

Segment means a group of related data elements in a transaction.

Standard transaction means a transaction that complies with the applicable standard adopted under this part.

[65 FR 50367, Aug. 17, 2000, as amended at 68 FR 8374, Feb. 20, 2003]

Subparts B–E [Reserved]

Subpart F—Standard Unique Employer Identifier

SOURCE: 67 FR 38020, May 31, 2002, unless otherwise noted.

§ 162.600 Compliance dates of the implementation of the standard unique employer identifier.

(a) *Health care providers.* Health care providers must comply with the requirements of this subpart no later than July 30, 2004.

(b) *Health plans.* A health plan must comply with the requirements of this subpart no later than one of the following dates:

(1) *Health plans other than small health plans*— July 30, 2004.

(2) *Small health plans*— August 1, 2005.

(c) *Health care clearinghouses.* Health care clearinghouses must comply with the requirements of this subpart no later than July 30, 2004.

§ 162.605 Standard unique employer identifier.

The Secretary adopts the EIN as the standard unique employer identifier provided for by 42 U.S.C. 1320d-2(b).

§ 162.610 Implementation specifications for covered entities.

(a) The standard unique employer identifier of an employer of a particular employee is the EIN that appears on that employee's IRS Form W-2, Wage and Tax Statement, from the employer.

(b) A covered entity must use the standard unique employer identifier (EIN) of the appropriate employer in

standard transactions that require an employer identifier to identify a person or entity as an employer, including where situationally required.

Subparts G–H [Reserved]

Subpart I—General Provisions for Transactions

§ 162.900 Compliance dates for transaction standards and code sets.

(a) *Small health plans.* All small health plans must comply with applicable requirements of subparts I through R of this part no later than October 16, 2003.

(b) *Covered entities that timely submitted a compliance plan.* Any covered entity, other than a small health plan, that timely submitted a compliance plan with the Secretary under the provisions of section 2 of Pub. L. 107-105, 115 Stat. 1003 (ASCA) must comply with the applicable requirements of subparts I through R of this part no later than October 16, 2003.

(c) *Covered entities that did not timely submit a compliance plan.* Any covered entity, other than a small health plan, that did not timely submit a compliance plan under the provisions of section 2 of Pub. L. 107-105, 115 Stat. 1003 (ASCA) must comply with the applicable requirements of subparts I through R of this part—

(1) Beginning on October 16, 2002, and ending on October 15, 2003—

(i) For the corresponding time period; or

(ii) For the time period beginning on October 16, 2003.

(2) Beginning on and after October 16, 2003, for the corresponding time period.

[68 FR 8396, Feb. 20, 2003]

§ 162.910 Maintenance of standards and adoption of modifications and new standards.

(a) *Designation of DSMOs.* (1) The Secretary may designate as a DSMO an organization that agrees to conduct, to the satisfaction of the Secretary, the following functions:

(i) Maintain standards adopted under this subchapter.