

§ 160.562

(d) For good cause, the ALJ may order appropriate redactions made to the record.

§ 160.562 Post hearing briefs.

The ALJ may require the parties to file post-hearing briefs. In any event, any party may file a post-hearing brief. The ALJ must fix the time for filing the briefs. The time for filing may not exceed 60 days from the date the parties receive the transcript of the hearing or, if applicable, the stipulated record. The briefs may be accompanied by proposed findings of fact and conclusions of law. The ALJ may permit the parties to file reply briefs.

§ 160.564 ALJ decision.

(a) The ALJ must issue a decision, based only on the record, which must contain findings of fact and conclusions of law.

(b) The ALJ may affirm, increase, or reduce the penalties imposed by the Secretary.

(c) The ALJ must issue the decision to both parties within 60 days after the time for submission of post-hearing briefs and reply briefs, if permitted, has expired. If the ALJ fails to meet the deadline contained in this paragraph, he or she must notify the parties of the reason for the delay and set a new deadline.

(d) The ALJ's decision is the final decision of the Secretary.

§ 160.566 [Reserved]

§ 160.568 Judicial review.

Judicial review of a penalty that has become final is authorized by 42 U.S.C. 1320a-7a(e).

§ 160.570 Stay of ALJ decision.

(a) Pending judicial review, the respondent may file a request for stay of the effective date of any penalty with the ALJ. The request must be accompanied by a copy of the notice of appeal filed with the Federal court. The filing of the request automatically stays the effective date of the penalty until such time as the ALJ rules upon the request.

(b) The ALJ may not grant a respondent's request for stay of any pen-

45 CFR Subtitle A (10-1-04 Edition)

alty unless the respondent posts a bond or provides other adequate security.

(c) The ALJ must rule upon a respondent's request for stay within 10 days of receipt.

§ 160.572 [Reserved]

PART 162—ADMINISTRATIVE REQUIREMENTS

Subpart A—General Provisions

Sec.

162.100 Applicability.

162.103 Definitions.

Subparts B-C [Reserved]

Subpart D—Standard Unique Health Identifier for Health Care Providers

162.402 Definitions.

162.404 Compliance dates of the implementation of the standard unique health identifier for health care providers.

162.406 Standard unique health identifier for health care providers.

162.408 National Provider System.

162.410 Implementation specifications: Health care providers.

162.412 Implementation specifications: Health plans.

162.414 Implementation specifications: Health care clearinghouses.

Subpart E [Reserved]

Subpart F—Standard Unique Employer Identifier

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

162.605 Standard unique employer identifier.

162.610 Implementation specifications for covered entities.

Subparts G-H [Reserved]

Subpart I—General Provisions for Transactions

162.900 Compliance dates for transaction standards and code sets.

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

162.915 Trading partner agreements.

162.920 Availability of implementation specifications.

162.923 Requirements for covered entities.

162.925 Additional requirements for health plans.

162.930 Additional rules for health care clearinghouses.

162.940 Exceptions from standards to permit testing of proposed modifications.

Subpart J—Code Sets

- 162.1000 General requirements.
- 162.1002 Medical data code sets.
- 162.1011 Valid code sets.

Subpart K—Health Care Claims or Equivalent Encounter Information

- 162.1101 Health care claims or equivalent encounter information transaction.
- 162.1102 Standards for health care claims or equivalent encounter information transaction.

Subpart L—Eligibility for a Health Plan

- 162.1201 Eligibility for a health plan transaction.
- 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.

§ 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).