

(ii) Phase II CORE 258: Eligibility and Benefits 270/271 Normalizing Patient Last Name Rule, version 2.1.0, March 2011, as referenced in § 162.1203.

(iii) Phase II CORE 259: Eligibility and Benefits 270/271 AAA Error Code Reporting Rule, version 2.1.0, March 2011, as referenced in § 162.1203.

(iv) Phase II CORE 260: Eligibility & Benefits Data Content (270/271) Rule, version 2.1.0, March 2011, as referenced in § 162.1203.

(v) Phase II CORE 270: Connectivity Rule, version 2.2.0, March 2011, as referenced in § 162.1203 and § 162.1403.

[68 FR 8396, Feb. 20, 2003, as amended at 69 FR 18803, Apr. 9, 2004; 74 FR 3324, Jan. 16, 2009; 76 FR 40495, July 8, 2011]

§ 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 has been adopted under this part must use the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard.

(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.

[65 FR 50367, Aug. 17, 2000, as amended at 74 FR 3325, Jan. 16, 2009]

§ 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