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.

§ 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.

(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 codes that are valid, as provided in subpart J of this part.

(2) Keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan's coverage.

§ 162.930 Additional rules for health care clearinghouses.

When acting as a business associate for another covered entity, a health care clearinghouse may perform the following functions:

(a) Receive a standard transaction on behalf of the covered entity and translate it into a nonstandard transaction (for example, nonstandard format and/or nonstandard data content) for transmission to the covered entity.

(b) Receive a nonstandard transaction (for example, nonstandard format and/or nonstandard data content) from the covered entity and translate it into a standard transaction for transmission on behalf of the covered entity.

§ 162.940 Exceptions from standards to permit testing of proposed modifications.

(a) *Requests for an exception.* An organization may request an exception from the use of a standard from the Secretary to test a proposed modification to that standard. For each proposed modification, the organization must meet the following requirements:

(1) *Comparison to a current standard.* Provide a detailed explanation, no more than 10 pages in length, of how the proposed modification would be a significant improvement to the current standard in terms of the following principles:

(i) Improve the efficiency and effectiveness of the health care system by leading to cost reductions for, or improvements in benefits from, electronic health care transactions.