MMSEA Section 111
Medicare Secondary Payer Mandatory Reporting

Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation USER GUIDE

Chapter IV: TECHNICAL INFORMATION

Version 4.1

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Revision History

Date	Version	Reason for Changes
November 17, 2008	N/A	First publication of Interim Record Layout Information
December 5, 2008	N/A	Second publication of Interim Record Layout Information
March 16, 2009	1.0	Initial Publication of User Guide
July 31, 2009	2.0	Changes listed in Section 1 including the reporting of multiple TPOC Amounts, an updated Claim Input File Auxiliary Record, updated Claim Response File layout and addition of reporting thresholds.
February 22, 2010	3.0	Changes listed in Section 1.
July 12, 2010	3.1	Changes listed in Section 1.
August 17, 2011	3.2	Changes listed in Section 1.
December 16, 2011	3.3	Changes listed in Section 1.
July 3, 2012	3.4	NGHP User Guide was split into 5 Chapters: Introduction & Overview, Registration Procedures, Policy Guidance, Technical Information, and Appendices. Specific changes are listed in Section 1 of each chapter.
April 22, 2013	3.5	Changes listed in Section 1.
May 6, 2013	3.6	Corrections made to Claimant Information Requirements. See Section 1
October 7, 2013	4.0	• Change Request (CR) #10701: Implementation of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) for diagnosis coding. • Outdated hyperlinks have been replaced. • The definition for Disposition Code 50 has been clarified. • The registration process for computer based training (CBT) has been modified
February 3, 2014 (January Release B)	4.1	Change Request (CR) #10770: Prevent certain diagnosis codes that are unrelated to the incident from applying to no-fault records found in the Common Working File (CWF). Branding changes for the Benefits Coordination & Recovery Center (BCRC).

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Chapter 1: Summary of Version 4.1 User Guide Updates

The updates listed below have been made to the Technical Information Chapter Version 4.1of the NGHP User Guide. As indicated on prior Section 111 NGHP Town Hall teleconferences, the Centers for Medicare & Medicaid Services (CMS) continue to review reporting requirements and will post any applicable updates in the form of revisions to Alerts and the User Guide as necessary.

Certain codes are not valid for No-Fault insurance types (Plan Insurance Type is “D” in field 51), because they are not related to the accident, and may result in inappropriately denied claims (Section 6.2.5). See Appendix J in Chapter V for a list of these codes.

Chapter 2: Introduction

The Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide, Version 4.0 has been written for use by all Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation Responsible Reporting Entities (RREs). The five chapters of the User Guide - referred to collectively as the "Section 111 NGHP User Guide" - provide information and instructions for the Medicare Secondary Payer (MSP) NGHP reporting requirements mandated by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173).

This **Technical Information Chapter** of Version 4.1 of the MMSEA Section 111 NGHP User Guide provides detailed information on the technical requirements of Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, and workers' compensation Responsible Reporting Entities (RREs).The other four chapters of the NGHP User Guide: Introduction and Overview, Registration Procedures, Policy Guidance, and Appendices should be references as needed for applicable guidance.

Please note that CMS continues to implement the Section 111 reporting requirements in phases. New versions of the Section 111 User Guide will be issued, when necessary, to document revised requirements and add clarity. At times, certain information may be released in the form of an Alert document. Any Alert dated subsequent to the date of the currently published User Guide supersedes the applicable language in the User Guide. All updated Section 111 policy and technical reporting requirements published in the form of an Alert will be incorporated into the next version of the User Guide. RREs must refer to the current User Guide and any subsequent Alerts for complete information on Section 111 reporting requirements. The NGHP User Guide Appendices Chapter (Appendix K) contains a list of all the applicable NGHP Alert posted prior to the publication of this User Guide.

All official instructions pertinent to Section 111 reporting are on the Section 111 Website found at: http://go.cms.gov/mirnghp. Please check this site often for the latest version of this guide and for other important information such as the aforementioned Alerts. In order to be notified via e-mail of updates to this Web page, click on the "Subscription Sign-up for Mandatory Insurer Reporting (NGHP) Web Page Update Notification" link found in the Related Links section of the web page and add your e-mail address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. Additional information related to Section 111 can be found on the login page of the Section 111 Coordination of Benefits Secure Web site (COBSW) at http://www.section111.cms.hhs.gov.

Technical questions should be directed to your Electronic Data Interchange (EDI) Representative. Your EDI Representative contact information can be found in your profile report (received after registration has been completed).

Note: All requirements in this guide apply equally to RREs using a file submission method or Direct Data Entry (DDE), except those specifically related to the mechanics of constructing and exchanging an electronic file or as otherwise noted.

Chapter 3: Process Overview

Purpose: The purpose of the Section 111 MSP reporting process is to enable CMS to pay appropriately for Medicare covered items and services furnished to Medicare beneficiaries. Section 111 reporting helps CMS determine primary versus secondary payer responsibility—that is, which health insurer pays first, which pays second, and so on. A more detailed explanation of Section 111 related legislation, MSP rules, and the structure of the Section 111 reporting process is provided in the NGHP User Guide Policy Guidance Chapter.

Section 111 RREs: Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities, or "RREs". Section 111 requires RREs to submit information specified by the Secretary of Health and Human Services (HHS) in a form and manner (including frequency) specified by the Secretary. The Secretary requires data for both Medicare claims processing and for MSP recovery actions, where applicable. For Section 111 reporting, RREs are required to submit information electronically on liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims, where the injured party is a Medicare beneficiary. The actual data submission process takes place between the RREs, or their designated reporting agents, and the CMS Benefits Coordination & Recovery Center (BCRC). The COBC manages the technical aspects of the Section 111 data submission process for all Section 111 RREs.

Querying for Medicare eligibility: RREs must be able to determine whether an injured party is a Medicare beneficiary, and gather the information required for Section 111 reporting. CMS allows RREs that are file submitters to submit a *query* to the BCRC to determine the Medicare status of the injured party prior to submitting claim information for Section 111 reporting. The query record must contain the injured party's Social Security Number (SSN) (or Medicare Health Insurance Claim Number (HICN)), name, date of birth and gender. On the query response record, the BCRC will provide information on whether the individual has been identified as a Medicare beneficiary based upon the information submitted and if so, provide the Medicare HICN (and other updated information for the individual) found on the Medicare Beneficiary Database. The reason for Medicare entitlement, and the dates of Medicare entitlement and enrollment (coverage under Medicare), are not returned on the query file response.

Please note: With DDE, the separate query function is not available. Instead, the DDE application will learn, in real-time, whether an injured party is a Medicare beneficiary when the RRE enters the injured party information (i.e., Medicare HICN or SSN, first name, last name, date of birth and gender) on-line on the DDE Injured Party Information screen.

What should be submitted? For purposes of NGHP data submissions, the term "**claim**" has a specific reference. It is used to signify the overall compensation claim for liability insurance (including self-insurance), no-fault insurance or workers' compensation, rather than to a single (or disaggregated) claim for a particular medical service or item. NGHP

claim information is to be submitted where the injured party is a Medicare beneficiary and payments for medical care ("medicals") are claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals.

Web site: The BCRC maintains an application on the Section 111 COB Secure Web site (the COBSW) for Section 111 processing. Its URL is http://www.section111.cms.hhs.gov.

Please see Section Chapter 12 (: Section 111 COB Secure Web Site (COBSW) for a more thorough explanation of this Web site and instructions on how to obtain the Section 111 COBSW User Guide.

Data Submission Method: RREs may choose to submit claim information through either:

- An electronic file exchange, **OR**
- A manual direct data entry (DDE) process using the Section 111 COBSW (if the RRE has a low volume of claim information to submit),

More information on data exchange options can be found in Section Chapter 10 (Electronic Data Exchange).

RREs who select an electronic file submission method must first fully test the file exchange process. RREs who select the DDE submission method will not perform testing. More information on the testing process can be found in Section Chapter 9 (Testing the Section 111 Reporting Process).

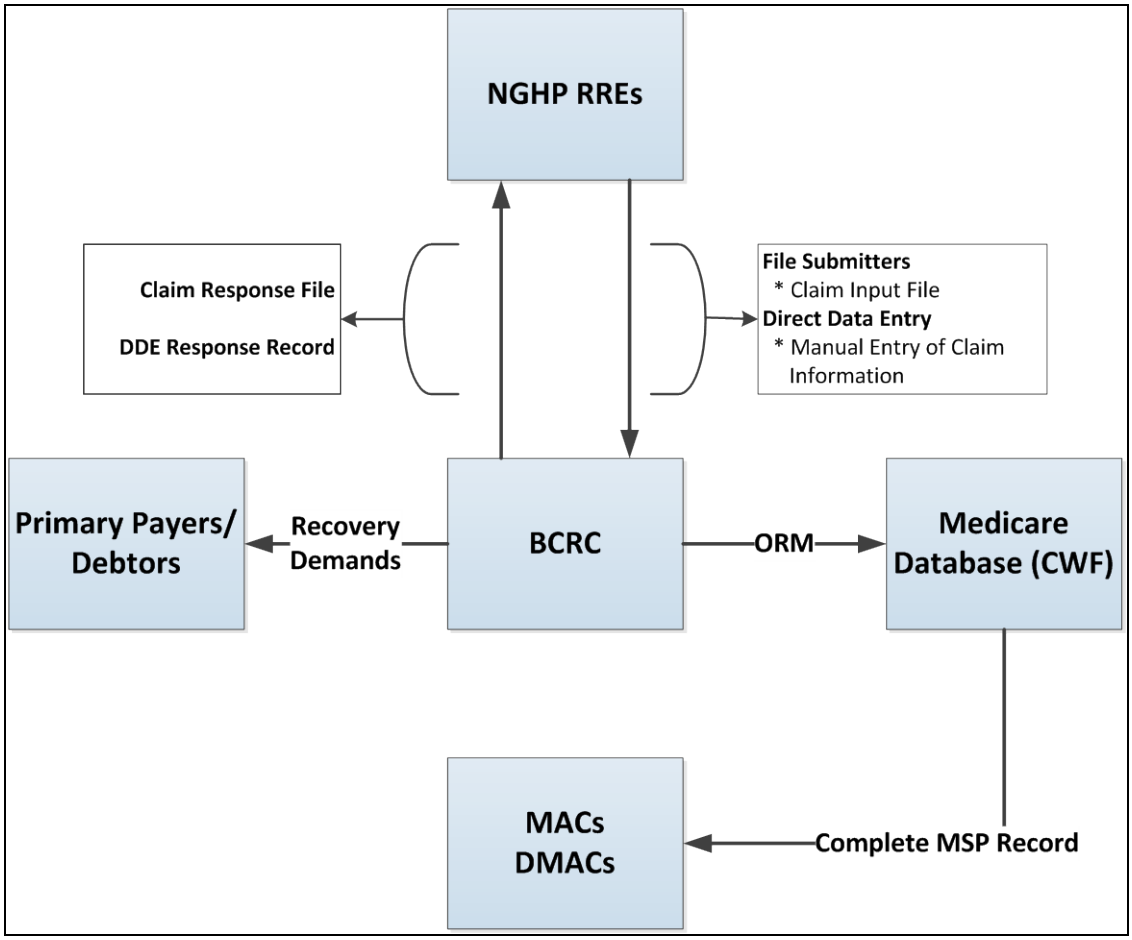
When the BCRC has cleared an RRE for "production" input file submissions, the RRE will submit claim information for all no-fault insurance, and workers' compensation claims involving a Medicare beneficiary as the injured party where the **TPOC Date** for the settlement, judgment, award, or other payment date is **October 1, 2010**, or subsequent, and which meet the reporting thresholds described in the NGHP User Guide Policy Guidance Chapter (Section 6.4). Information is also to be submitted for all liability insurance (including self-insurance) claims involving a Medicare beneficiary as the injured party where the **TPOC Date** for the settlement, judgment, award, or other payment date is **October 1, 2011**, or subsequent, and which meet the reporting thresholds described in the NGHP User Guide Policy Guidance Chapter (Section 6.4). In addition, RREs must submit information related to no-fault insurance, workers' compensation, and liability insurance (including self-insurance) claims for which **ongoing responsibility for medical** payments exists as of **January 1, 2010** and subsequent, regardless of the date of an initial acceptance of payment responsibility (see the Qualified Exception in the NGHP User Guide Policy Guidance Chapter (Section 6.3.2)).

Ongoing DDE and quarterly file submissions are to contain only new or changed claim information using add, delete, and update transactions.

Data Exchange Process

Figure 3-1 illustrates the Data Exchange process. A narrative description of this process directly follows the figure.

Figure 3-1: Data Exchange Process



- RREs that are file submitters electronically transmit their Claim Input File to the BCRC. RREs that are using DDE will manually enter and submit their claim information one claim report at a time using an interactive Web application on the Section 111 COBSW
- The BCRC processes the data in the *input file/DDE submission* by editing the incoming data and determining whether or not the submitted information identifies the injured party as a Medicare beneficiary.
- If the submitted claim information passes the BCRC edit process and is applicable to Medicare coverage, insurance information for Medicare beneficiaries derived from the input file is posted to other CMS databases (e.g., the Common Working File).
    - The BCRC helps protect the Medicare Trust Fund by identifying and recovering Medicare payments that should have been paid by another entity as the primary payer as part of a Non-Group Health Plan (NGHP) claim which includes, but is not limited to Liability Insurance (including Self-Insurance), No-Fault Insurance,

and Workers' Compensation.The Primary Payers/Debtors receive recovery demands advising them of the amount of money owed to the Medicare program.

- The Common Working File (CWF) is a Medicare application that maintains all Medicare beneficiary information and claim transactions. The CWF receives information regarding claims reported with ORM so that this information can be used by other Medicare contractors (Medicare Administrative Contractors (MACs) and Durable Medical Equipment Administrative Contractors (DMACs)) for claims processing to ensure Medicare pays secondary when appropriate.

- When the data processing by the BCRC is completed, or the prescribed time limit for sending a response has been reached, the BCRC electronically transmits a response file to RREs that are file submitters and a response on the DDE Claims Listing page for those RREs that are using DDE. The response will include information on any errors found, disposition codes that indicate the results of processing, and MSP information as prescribed by the response file format.
- RREs must take the appropriate action, if any, based on the response(s) received.

Detailed specifications for the Section 111 reporting process are provided in the documentation that follows.

The NGHP Data Files

A general description of each MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance and Workers' Compensation Data File Type is provided in Table 3-1: NGHP Data File Types. Detailed specifications for the Section 111 record layouts are presented in the NGHP User Guide Appendices Chapter.

Table 3-1: NGHP Data File Types

File Type	Description
Claim Input File	This is the data set transmitted from a MMSEA Section 111 RRE to the BCRC used to report applicable liability insurance (including self-insurance), no-fault insurance and workers' compensation claim information where the injured party is a Medicare beneficiary. This file is transmitted in a flat file format (there is no applicable HIPAA-compliant standard).
Claim Response File	This is the data set transmitted from the BCRC to the MMSEA Section 111 RRE after the information supplied in the RRE's Claim Input File has been processed. This file is transmitted in a flat file format.
TIN Reference File	The TIN Reference File consists of a listing of the RRE's federal tax identification numbers (TINs) reported on the Claim Input File records, and the business mailing addresses linked to the TIN and Office Code/Site ID combinations. This file is for purposes of both coordination of benefits and recovery. It is transmitted in a flat file format.

File Type	Description
TIN Reference Response File	This is the data set transmitted from the BCRC to the RRE after the information supplied in the RRE's TIN Reference File has been processed.
Query Input File	This is an *optional* query file that can be used by an RRE to determine whether an injured party/claimant is a Medicare beneficiary. This file is transmitted using the ANSI X12 270/271 Entitlement Query transaction set.
Query Response File	After the BCRC has processed a Query Input File it will return a Query Response File with information as to whether or not the data submitted identified an individual as a Medicare beneficiary. This file is transmitted using the ANSI X12 270/271 Entitlement Query transaction set.

Chapter 4: File Format

NOTE: This section pertains to those RREs choosing a file submission method, not to those using Direct Data Entry (DDE). For instructions on using DDE for claim submissions, please see Section 10.5.

4.1 General File Standards

Both the Claim Input and TIN Reference Files are transmitted in a flat, text, ASCII file format. The Connect:Direct file transmission method will convert files into EBCDIC. Query Files are transmitted using the ANSI X12 270/271 Entitlement Query transaction set. On request, the BCRC will supply each RRE free software to translate flat file formats to and from the X12 270/271. As described in Section Chapter 8 Query Files, the Query File formats are the flat file input and output to the translator software supplied by the BCRC. The remainder of this section assumes the RRE will use that software. If you are using your own X12 translator, the necessary mapping is documented in an X12 270/271 companion guide that can be downloaded from the NGHP page at the following link: http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Downloads/New-Downloads/NGHPInterfaceSpec50.pdf . Note that the BCRC will only accept the5010A1 version of the X12 270/271 (see Section 8.4 - Query Files and HEW Software Requirements). RREs will continue to be given at least 6 months advance notice for any future upgrades.

Mainframe and Windows PC/Server-based versions of the HEW software are available. Due to e-mail server security settings, the only way to obtain the Windows version of the HEW software is to download it from the Section 111 COBSW at http://www.section111.cms.hhs.gov. You may request a copy of the mainframe version from your EDI Representative or by contacting the EDI Department at 646-458-6740. The HEW software is maintained free of charge by the BCRC. No source code will be provided.

With the exception of the X12 270/271, all input files submitted for Section 111 must be fixed width, flat, text files. All records in the file must be the same length, as specified in the file layouts located in the NGHP User Guide Appendices Chapter. If the data submitted ends prior to the end of the specified record layout, the rest of the record must be completely filled or padded with spaces.

All data fields on the files are of a specified length and should be filled with the proper characters to match those lengths. No field delimiters, such as commas between fields, are to be used. Detailed record and field specifications are found in the NGHP User Guide Appendices Chapter. A carriage return/line feed (CRLF) character is in the byte following the end of each record layout defined in the NGHP User Guide Appendices Chapter (2221st byte of the line if the record is defined as 2220 bytes). When information is not supplied for a field, provide the default value per the specific field type (fill

numeric and numeric date fields filled with zeroes; alphabetic, alphanumeric and "Reserved for Future Use" fields filled with spaces).

Each input file format contains at least three record types.

- Header Record - each file begins with a *header* record. Header records identify the type of file being submitted, and will contain your Section 111 RRE ID. (You will receive your RRE ID on your profile report after your registration for Section 111 is processed.)
- Detail records - represents claim information when the injured party is a Medicare beneficiary, or query requests for individual people on the Query Input File.
- Trailer Record - each file always ends with a *trailer* record that marks the end of the file and contains summary information including counts of the detail records for validation purposes.

Each header record must have a corresponding trailer record. The file submission date supplied on the header record must match the date supplied on the corresponding file trailer record. Each trailer record must contain the proper count of detail records. **Do not include the header and trailer records in these counts.** If the trailer record contains invalid counts, your entire file will be rejected.

4.2 Data Format Standards

Table 4-1defines the formatting standard for each data type found in the Section 111 files, both input and response. **These standards apply unless otherwise noted in specific file layouts.**

Table 4-1: Data Type Formatting Standards

Data Type	Formatting Standard	Examples
Numeric	Zero through nine (0–9) Right justified. **Padded with leading zeroes.** Do not include decimal point. See individual field descriptions for any assumed decimal places. Default to all zeroes unless otherwise specified in the record layouts. **Note: the last two positions of dollar amount fields reflect cents. For example, in an 11 byte numeric field specified as a dollar amount, an amount of 10,000 (ten thousand) dollars and no cents must be submitted as "00001000000".**	Numeric (5): "12345" Numeric (5): "00045"

Data Type	Formatting Standard	Examples
Alphabetic	A through Z. Left justified. Non-populated bytes padded with spaces. Alphabetic characters sent in lower case will be converted and returned in upper case. Default to all spaces unless otherwise specified in the record layouts. Embedded hyphens (dashes), apostrophes and spaces will be accepted in alphabetic last name fields. First name fields may only contain letters and spaces.	Alpha (12): “TEST EXAMPLE” Alpha (12): “EXAMPLE” Alpha (12): “SMITH-JONES“ Alpha 12): “O’CONNOR”
Alphanumeric	A through Z (all alpha) + 0 through 9 (all numeric) + special characters: Comma (,) Ampersand (&) Space ( ) Hyphen/Dash (-) Period (.) Single quote (‘) Colon (:) Semicolon (;) Number (#) Forward slash (/) At sign (@) Left justified Non-populated bytes padded with spaces Alphabetic characters sent in lower case will be converted and returned in upper case. Default to all spaces unless otherwise specified in the record layouts. Parentheses () are not accepted.	Text (8): “AB55823D” Text (8): “XX299Y“ Text (18): “ADDRESS@DOMAIN.COM” Text (12): “800-555-1234” Text (12): “#34 “
Alphanumeric Plus Parens	Same as above but including Parentheses ()	“Department Name (DN)”
Numeric Date	Zero through nine (0 - 9) formatted as CCYYMMDD. No slashes or hyphens. Default to zeroes unless otherwise specified in the file layouts (no spaces are permitted).	A date of March 25, 2011 would be formatted as “20110325” Open ended date: “00000000”
Reserved for Future Use	Populate with spaces. Fields defined with this field type may not be used by the RRE for any purpose. They must contain spaces.	N/A

Chapter 5: File Submission Time Frames

This section pertains to those RREs choosing a file submission method, not to those using Direct Data Entry (DDE). RREs may submit files according to the specifications listed in Table 5-1. A more thorough explanation of these specifications directly follows this table. Note: RREs are assigned a *quarterly* file submission timeframe (a file submission "window"), during which they are to submit their production Claim Input Files. The submission timeframe is assigned at the completion of the registration process.

Table 5-1: File Submission Specifications

Type of File	File Name	Submission Frequency	RRE ID Status
Test	Query Input File Claim Input File TIN Reference File	Anytime, unlimited frequency	Test or Production
Production	Query Input File	Once per calendar month, on any day of the month	Test or Production
Production	TIN Reference File	Prior to, or with, the Claim Input File	Production
Production	Claim Input File	Quarterly, during RRE ID's 7-day file submission timeframe	Production

- **Test files (Query Input, Claim Input and TIN Reference)** may be submitted at any time with unlimited frequency by RRE IDs in test or production status. There is no file submission timeframe assigned to the RRE ID for test files. (See testing requirements in Section Chapter 9).
- **Production Query Input Files** may be sent as frequently as once per calendar month, on any day of the month, by RRE IDs in test or production status. There is no submission timeframe.
- **Production TIN Reference Files** must be submitted prior to, or with your *initial* production Claim Input File. After the *initial* TIN Reference File is successfully processed, the TIN Reference File is only required to be sent if you have changes or additions to make. Only new or changed TIN records need to be included on subsequent submissions.
- Subsequent TIN Reference Files may be sent as often as needed and at any time during a calendar quarter.
- There is no file submission timeframe associated with a separately submitted TIN Reference File.

- Many RREs choose to submit a current TIN Reference File with every Claim Input File submission.
- **Production Claim Input Files** must be submitted on a quarterly basis by RRE IDs in a production status during the RRE ID's 7-day file submission timeframe unless the RRE ID has nothing to report for a particular quarter. The file submission timeframe is assigned to the RRE ID on their profile report which is sent after the BCRC has processed their Section 111 registration and account setup.
- Your submission window timeframe is also displayed on the RRE Listing page after logging on to the Section 111 COBSW. Each 3-month calendar quarter has been divided into 12 submission periods, as shown in Table 5-2. For example, if you have been assigned to Group 7, you will submit your Claim Input and associated TIN Reference File from the 15th through the 21st calendar day of the second month of each calendar year quarter: February 15th and February 21st for the first quarter, May 15th and May 21st for the second quarter, August 15th and August 21st for the third quarter and November 15th and November 21st for the fourth quarter of each year.
- Under appropriate circumstances, Non-GHP RREs may submit multiple files within a single quarter. The primary purpose for the allowance of subsequent quarterly file submissions is to provide RREs with an avenue to more expediently post updates for records with ORM in situations where ORM has terminated. RREs will now have the ability to submit ORM Termination Dates in a more timely fashion via their standard electronic submission process. **The two limitations that apply to this are:**
  - A subsequent file submission will not be processed until the prior file submission has completed and a response file for that prior submission has been generated. RREs should not submit a subsequent file until the prior file's response file has been received. If a new Claim Input file is submitted before the prior file has completed processing the newly submitted file will be placed in a "System Hold" status. If that occurs, the subsequent file will be released from "System Hold" automatically once the prior file has completed processing.
  - **RREs will be limited to only one file submission** every fourteen days.
- **Please note**: Standard quarterly file submissions are still mandated during the NGHP RRE's assigned file submission period. RREs are under no obligation to submit more than one file per quarter.

Table 5-2: Quarterly Claim Input File Submission Time Frames

Dates/Files	1st Month	2nd Month	3rd Month
01 - 07	Group 1	Group 5	Group 9
08 - 14	Group 2	Group 6	Group 10
15 - 21	Group 3	Group 7	Group 11
22 - 28	Group 4	Group 8	Group 12

Chapter 6: Claim Input File

This section pertains to those RREs choosing a file submission method, and to DDE submitters. With the exception of information that pertains specifically to the physical creation and transmission of electronic files, DDE submitters must submit the same data elements and adhere to essentially the same Section 111 reporting requirements as file submitters. DDE submitters enter claim information manually on the Section 111 COBSW. File submitters transmit this same information in the form of an automated electronic file.

6.1 Overview

As a reminder: For purposes of NGHP data submissions, the term "**claim**" has a specific reference. It is used to signify the overall compensation claim for liability insurance (including self-insurance), no-fault insurance, or workers' compensation, rather than to a single (or disaggregated) claim for a particular medical service or item.

What is it? The Claim Input File is the data set transmitted from a MMSEA Section 111 RRE to the BCRC that is used to report liability insurance (including self-insurance), no-fault insurance, and workers' compensation claim information **where the injured party is a Medicare beneficiary** and medicals (i.e., claims for payment of health care services) are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals.

What should be reported? Claim information should be reported after ORM (Ongoing Responsibility for Medicals) has been assumed by the RRE or after a TPOC (Total Payment Obligation to Claimant) settlement, judgment, award, or other payment has occurred. Claim information is to be submitted for *no-fault insurance and workers' compensation* claims that are addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award, or other payment on or after **October 1, 2010** that meet the reporting thresholds described in Section 6.4. Claim information is to be submitted for *liability insurance (including self-insurance)* claims that are addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award, or other payment on or after **October 1, 2011** that meet the reporting thresholds described in Section 6.4. A TPOC single payment obligation is reported in total regardless of whether it is funded through a single payment, an annuity or a structure settlement.

RREs must also report claim information where ongoing responsibility for medical services (ORM) related to a no-fault, workers' compensation or liability claim was assumed by the RRE on or after **January 1, 2010**. In addition, claim information is to be transmitted for no-fault, workers' compensation and liability claims for which ORM exists on or through January 1, 2010, regardless of the date of an initial acceptance of payment responsibility (see the following sections in the NGHP User Guide Policy Guidance Chapter III: Section 6.3.2: Special Qualified Reporting Exception, Chapter 4

"MSP Overview," and Section 6.5.1 "What Claims Are Reportable/When Are Such Claims Reportable?" Also refer to the NGHP User Guide Appendices Chapter V for further guidance on the types of claims that must be reported).

How? This file submission is transmitted in a fixed-width, flat file format. The file layout is provided in NGHP User Guide Appendices Chapter V (Appendix A). Field descriptions in the NGHP User Guide Appendices Chapter apply to both file submission and information submitted via DDE.

When? The Claim Input File is submitted on a quarterly basis during the RRE's assigned file submission timeframe. Claim information can be submitted by DDE RREs on the COBSW at any time, but at least within 45 days of establishing a TPOC or assuming ORM.

Why? The BCRC will use this information to determine if the injured party reported can be identified by CMS as a Medicare beneficiary and whether the beneficiary's coverage under Medicare continued or commenced on or after the date of incident (DOI - as defined by CMS). See Section 6.1.1 (Matching Records to Medicare Beneficiaries) for more information on how the BCRC matches input records to its database of Medicare beneficiaries.

What happens with that information? If the claim information provided on the Claim Input File or submitted via DDE passes the BCRC edit process, it is then passed to other Medicare systems and databases including those used by the CMS BCRC and Medicare claims processing contractors. Concurrently, the BCRC will return a response file for each Claim Input File received. This response file will contain a response record corresponding to each input record, indicating the results of processing. The BCRC will begin creation of the response file as soon as all submitted records have finished processing, but no later than 45 days after file submission**.** Response files may take *up to 48 days* to be created and transmitted to the RRE. Responses are also produced for DDE claim submissions, with results displayed on the "Claim Listing" page of the Section 111 COBSW.

What must the RRE do after they submit? RREs must react to and take action on the information returned in the response file or displayed on the DDE Claim Listing page. For example, if a response record indicates that the Claim Input record was not accepted due to errors, then RREs that are file submitters must correct the record and resend it with their next quarterly file submission. DDE submitters must correct and resubmit erroneous claims on the Section 111 COBSW as soon as possible.

RRE Account Managers will receive e-mail notifications from the BCRC when a file has been received and when response files are available. File processing statuses and processing results for submitted Section 111 files will be displayed on the Section 111 COBSW on the File Listing and File Detail pages for the RRE ID. Users associated with the RRE ID will be able to see the following information:

- Date the file was received and processed by the BCRC;
- File status;
- Record counts for each completed file, such as the number of records received, including counts for additions, updates, and deletions; the number of records that

were matched to a Medicare beneficiary; the number of records in error; and a count of compliance flags posted by the BCRC.

Historical information on files submitted and processed remains on the Section 111 COBSW for a one-year period.

ORM: In the case of a settlement, judgment or award, or other payment without separate ongoing responsibility for medicals at any time, only one report record is required to be submitted per liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim where the injured party is a Medicare beneficiary. Records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by RRE, etc. An RRE is to report the assumption or termination of "ongoing responsibility for medicals" (ORM) situations along with the one-time reporting of payments where ongoing responsibility is not assumed.

When reporting ongoing responsibility for medicals, you are **not** to report individual payments for each medical item or service. You are also **not** to report a previously submitted and accepted record each quarter. However, when an RRE has accepted ongoing responsibility for medicals on a claim (as is the case with many workers' compensation and no-fault claims), the RRE will report **two** events: an initial (add) record to reflect the acceptance of ongoing payment responsibility, and a second (an update) record to provide the end date of ongoing payment responsibility (in the ORM Termination Date Field, 79).

ORM Indicator: When termination of ongoing responsibility for medicals is reported, the ORM Indicator in Field 78 *must* remain as 'Y' (for yes); do not change it to 'N'. The 'Y' indicates *current* ongoing responsibility for medicals only until a termination is reported. Once the termination date is reported, the 'Y' reflects the existence of ongoing responsibility for medicals *prior to* the termination date. Because reporting is done only on a quarterly basis, there may be some situations in which the RRE reports both the assumption of ongoing responsibility in the same record as the termination date for such responsibility.

RREs are **not** to submit a report on the Claim Input File every time a payment is made in situations involving ongoing payment responsibility. When reporting no-fault claim information, be sure to include the appropriate data in these report records for the No-Fault Insurance Limit (Field 61) when reporting the assumption of ORM and the Exhaust Date for the Dollar Limit for No-Fault Insurance (Field 62) when ORM is terminated as applicable. See Section 6.8 (Quarterly File Submissions) for more information on reporting ORM.

Matching to Medicare Beneficiaries: RREs must determine whether an injured party is a Medicare beneficiary. See Section Chapter 8 (: Query Files) for more information on the query process available for this purpose. RREs must submit the Medicare Health Insurance Claim Number (HICN) for the injured party (or the Social Security Number [SSN]) on all Claim Input File Detail Records. RREs are instructed to report only Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award, or other payment). If a reported individual is not a Medicare beneficiary, or CMS is unable to match a particular HICN or SSN based upon the submitted information, CMS will reject the record for that individual. The

Applied Disposition Code (Field 27) on the corresponding Claim Response File Detail Record will be returned with a value of '51' indicating that the individual was not matched to a Medicare beneficiary based on the submitted information. Complete response file processing is covered in Section Chapter 7 (: Claim Response File).

RREs with Multiple Lines of Business: An RRE may include liability insurance (including self-insurance), no-fault insurance, and workers' compensation claim records in a single file submission if it has responsibility for multiple lines of business. However, there is no requirement to do so. If separate files will be submitted by line of business, subsidiary, reporting agents or another reason, then the RRE must register and obtain a Section 111 RRE ID for each quarterly Claim Input File submission, as described in the Registration and Account Setup section in the NGHP User Guide Registration Procedures Chapter.

TIN Reference File: A TIN Reference File must be submitted prior to or with your initial Claim Input File. Subsequent Claim Input File submissions do not need to be accompanied by a TIN Reference File unless there are changes in the TIN reference File to submit. However, if you choose, you may submit a TIN Reference File with every quarterly Claim Input File submission.

File Structure: The file structure will be explained in subsequent sections.

For a high-level picture of what a TIN Reference File would look like, here is a sample TIN Reference File structure:

- Header Record for TIN Reference File for RRE ID
- TIN/Office Code 1 Combination
- TIN/Office Code 2 Combination
- Trailer Record for TIN Reference File for RRE ID

For a high-level picture of the associated Claim Input File, here is a sample Claim Input File structure:

- Header Record for Claim Input for RRE ID
- Detail Record for Claim/DCN 1
- Detail Record for Claim/DCN 2
- Auxiliary Record for Claim/DCN 2
- Detail Record for Claim/DCN 3
- Trailer Record for Claim Input for RRE ID

6.1.1 Matching Records to Medicare Beneficiaries

To determine whether an injured party is a Medicare beneficiary, the BCRC must match your data to Medicare's. This matching can be done using (as one data element) either an individual's Medicare Health Insurance Claim Number (HICN) or an individual's Social Security Number (SSN). You must send either a HICN or an SSN as part of the injured party's record in the Claim Input File or the Query Input File. The Medicare HICN is preferred. If an SSN is submitted and the individual's HICN is returned on a response

file, the RRE is required to use that HICN on all subsequent transactions involving the individual.

In order to determine if individuals are Medicare beneficiaries the BCRC uses:

- HICN (Field 4) (or SSN, Field 5)
- First initial of the first name (Field 7)
- First 6 characters of the last name (Field 6)
- Date of birth (DOB) (Field 10)
- Gender (Field 9)

First the BCRC must find an exact match on the HICN or SSN. Then at least three out of the four remaining data elements must be matched to the individual exactly.

If a match is found, you will always be returned the correct, current HICN. You must store this HICN on your internal files and are required to use it on future transactions. With a match, the BCRC will also supply updated values for the name, date of birth and gender in the "applied" fields of the response records based on the information stored for that beneficiary on Medicare's files.

Note: When using the query process, if an RRE submits a query transaction with a value of '0' for an "unknown gender" for an individual, the BCRC will change this value to a '1' to attempt to get a match. If the record is matched to a Medicare beneficiary, the Query Response File Record will be returned with a '01' disposition code. In this case, the RRE should use the updated values returned in the HICN, Name fields, DOB and Gender when the corresponding Claim Input File Detail Record is submitted. However, if this record is not matched to a Medicare beneficiary, the Query Response File Record will be returned with a '51' disposition code and the converted '1' in the Gender field. The RRE should NOT use the Gender value returned in this case. The RRE must validate the correct Gender and all other injured party information prior to submitting the Claim Input File Detail Record.

While HICNs may be changed at times (but only by the Social Security Administration [SSA]), the BCRC is able to crosswalk an old HICN to the new HICN. The BCRC will always return the most current HICN on response records, and RREs are to update their systems with that information and use it on subsequent record transmissions. However, updates and deletes sent under the original HICN/SSN will still be matched to the current HICN.

If an RRE submits **both** the SSN and HICN on a claim or query record, the system will **only use the HICN** for matching purposes, and the SSN will be ignored. The system will attempt to match the HICN to any current or previously assigned HICN for the individual, but if no match is found using the HICN the BCRC will not then make a second attempt to match using the SSN provided.

You should send the most recent, most accurate information you have in your system for name, date of birth and gender. The best source of this information is the beneficiary's Medicare Insurance Card. Medicare's files are updated by a feed from the Social Security Administration (SSA) so if a beneficiary updates his information with SSA, it will be fed to the BCRC and used in the matching process.

In most cases the Medicare HICN is constructed by SSA using an SSN. However, the SSN used in a HICN may not always be the SSN assigned to the Medicare beneficiary. In some cases the SSN used for the unique HICN may instead be the SSN of the beneficiary's spouse, followed by a suffix to make it unique. For example, suppose there is a married couple where only the husband worked outside the home. Suppose the husband's SSN is 111111111 and his spouse's SSN is 222222222. When both of these individuals turn age 65 and become covered by Medicare, SSA could assign the husband a HICN of 111111111A and the spouse a HICN of 111111111B. Suppose later, the husband dies. At some point after that, SSA might assign a new HICN to the spouse of 222222222A or 111111111D if she never worked outside the home. This is just one example of many possibilities. The important thing to remember is that every Medicare beneficiary receives a unique HICN assigned specifically to them. Even if it is based on another related individual's SSN, it will have a unique prefix or suffix. For Section 111 reporting, always report information for the actual injured party using that injured party's information (SSN, HICN, name, date of birth, gender). If that information is matched to a Medicare beneficiary, you will be returned the HICN for that individual and must use that HICN going forward.

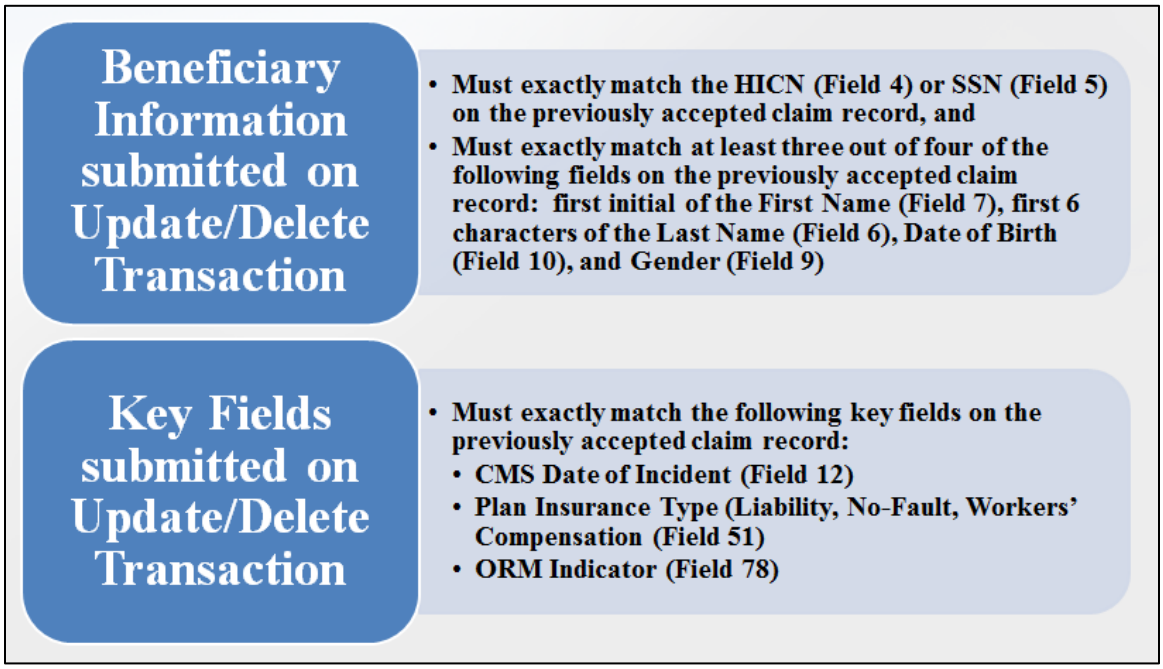
6.1.2 Matching Claim Records

Medicare stores information on claims submitted previously using certain fields that identify the beneficiary as well as the following key fields:

- CMS Date of Incident (Field 12)
- Plan Insurance Type (Liability, No-Fault, Workers' Compensation- Field 51)
- ORM Indicator (Field 78)

In order to successfully update or delete a previously submitted and accepted Claim Input File Detail Record, the BCRC must be able to match the beneficiary information and key fields that are submitted on the update/delete transaction to the corresponding information on the previously accepted claim record. Please see Figure 6-1.

Figure 6-1: Matching Criteria (Update/Delete)



The BCRC passes claim information on to several Medicare systems. One such system is the Common Working File (CWF), which is used by the Medicare claims payment process, among others. The BCRC provides the CWF information regarding claims reported with ORM to prevent Medicare from making an erroneous primary payment for a medical claim that should be paid by Workers' Compensation, No-Fault Insurance or Liability Insurance ORM. The key fields listed above are the key fields used by CWF. **All Non-Group Health Plan** claim records are passed to the BCRC for recovery consideration and the BCRC recognizes differing policy and claim numbers on the claim records it receives.

If one individual has different policy and claim numbers, RREs are to send separate records for each (if necessary). Medicare **does maintain information with policy and claim numbers submitted**. However, these are not considered key fields. Delete and update records should be submitted with the same policy and claim numbers as submitted on the original add record for the claim unless the policy and claim numbers associated to the claim were changed by the RRE after the initial claim report was made. In the case of a changed or corrected policy or claim number, on subsequent updates and deletes an RRE must submit the most current, accurate policy and claim number associated with the claim. A change in policy or claim number does not in and of itself trigger the need for an update, but updates to this information will be accepted. See the conditions for update and delete requirements specified in the Event Table found in Section 6.8.4. Event Table

6.2 Data Elements

Detailed record layouts and data element descriptions for the Claim Input File are in the NGHP User Guide Appendices Chapter (Appendix A). You must adhere to all requirements specified for each field, as documented in the record layout field

descriptions and associated error codes in the NGHP User Guide Appendices Chapter (Appendix F).

6.2.1 Header

The first record in the Claim Input File must be a *single header record*. This header record contains the record identifier of 'NGCH', the RRE ID associated with the file submission, a reporting file type of 'NGHPCLM', and an RRE-generated file submission date. The date on the header record must match the date included on the corresponding trailer record.

6.2.2 Detail Claim Record

The header record is followed by *detail claim records*, which constitute the bulk of the quarterly file submission. Each claim record contains a record identifier (value of 'NGCD'), an RRE-generated Document Control Number (DCN) which is unique for each record on the file, an action type (add, update or delete), information to identify the injured party/Medicare beneficiary, information about the incident, information concerning the policy, insurer or self-insured entity, information about the injured party's representative or attorney, settlement/payment information, and other claimant information in the reporting of an injured party who is deceased.

Each detail record on the Claim Input File must contain a unique DCN, which is generated by the RRE. This DCN is required so that an RRE can more easily track response records and match them with corresponding input records, quickly identifying and resolving any identified problems. The DCN can be any format of the RREs choosing as long as it is not more than 15 characters, as defined in the record layout. The DCN only needs to be unique within the current file being submitted. For those RREs using DDE, DCNs are automatically generated by the processing system.

Records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by claim number, etc. Consequently, it is possible that an RRE will submit more than one record for a particular individual in a particular quarter's Claim Input File. For example, if there is an automobile accident with both drivers insured by the same company and both drivers' polices are making payments to a particular beneficiary, there would be a record derived from the coverage under each policy. There could also be two records coming from coverage under a single automobile insurance policy if the coverage was for med pay or PIP (considered to be no-fault) assumption of ongoing responsibility for medicals (ORM) and/or exhaustion/termination amount, as well as a liability insurance (bodily injury coverage) settlement/judgment/award/other payment, in the same quarter.

Claimant Information is to be supplied on the Claim Input File Detail Record only in the case of a deceased Medicare beneficiary/injured party and the claimant is the beneficiary's estate or another individual/entity. However, RREs are not required to submit Claimant Information (Fields 84-98) or Claimant 1 Attorney/Other Representative Information (Fields 99 – 112) on the Claim Input File Detail Record even in the case of a deceased beneficiary. These fields are all **Optional.**

Note: Although "Claimant Information" and "Claimant Attorney/Other Representative Information" are no longer required even if the injured party is deceased, if entries are made in any of these fields, it will be edited for validity and completeness. Errors will be returned if submitted "Claimant Information" or "Claimant Attorney/Other Representative Information" is found to be invalid or incomplete. ***Be sure to populate Field 84, Claimant 1 Relationship with a space when not supplying Claimant 1 Information.***

6.2.3 Auxiliary Record

The Auxiliary Record is used to report information only if there is more than one "claimant" or if there is information related to additional Total Payment Obligation to Claimant (TPOC) amounts. It is only required if there are additional claimants to report for the associated Detail Claim Record and/or if there is more than one TPOC Amount to report. Do not include this record with the claim report unless one or both of these situations exists. (Remember that the "claimant" fields on the Claim Input File Detail Record (Fields 84 – 112) are only used if the injured party/ Medicare beneficiary is deceased and the claimant is the beneficiary's estate or another individual/entity.) Claimant 1 on the Detail Claim Record must be completed in order for information concerning additional claimants to be accepted. Additional claimants are reported only in the event of a deceased beneficiary (injured party) when another entity or individual has taken the Medicare beneficiary's place as the "Claimant" (Estate, Family, Other).

The record identifier for an Auxiliary Record is 'NGCE'. The DCN and injured party information must match that submitted on the associated detail record. Only one Auxiliary Record may be submitted per associated Detail Claim Record.

RREs are not required to submit Claimant [2, 3, and 4] Information (Fields 7-21, 36-53, and 65-79) or Claimant [2, 3, and 4] Attorney/Other Representative Information (Fields 22-35, 51-64, and 80-92) on the Claim Input File Auxiliary Record. These fields are all **Optional.**

Note: Although "Claimant Information" and "Claimant Attorney/Other Representative Information" are no longer required even if the injured party is deceased, if entries are made in any of these fields, it will be edited for validity and completeness. Errors will be returned if submitted "Claimant Information" or "Claimant Attorney/Other Representative Information" is found to be invalid or incomplete. ***Be sure to populate the Claimant Relationship fields with spaces when not supplying additional Claimant Information on the Auxiliary Record***.

Note: Once an Auxiliary Record has been submitted and accepted with a claim report, you must continue to send this record with any subsequent update record for the claim unless the information it contains no longer applies to the claim (the RRE wishes to remove information reported for Claimants 2-4 and TPOC 2-5 Fields). **To remove the information from the claim report that was previously sent and accepted on an auxiliary record, the RRE should re-submit the auxiliary record again with the corresponding detail record and fill in all fields with zeroes or spaces (as applicable); OR, they can simply re-submit the claim detail record and omit sending the corresponding auxiliary record on their next submission.**

6.2.4 Trailer

The last record in the file must be a trailer record defined with a record identifier of 'NGCT'. It must contain the RRE ID, reporting file type and file submission date that appears on the associated header record. It also contains a file record count of the total detail and auxiliary records contained in the file, for reconciliation purposes.

6.2.5 ICD-9 and ICD-10 Codes

All add and update records on Claim Input Files and as part of DDE submissions must include International Classification of Diseases, Ninth/Tenth Revision, Clinical Modification (ICD-9/ICD-10) diagnosis codes considered valid for purposes of Section 111 reporting in at least the first of the ICD Diagnosis Codes 1–19 beginning in Field 18.

These fields are used to provide a coded description of the alleged illness, injury, or incident claimed and/or released by the settlement, judgment, or award, or for which ORM is assumed. RREs may use diagnosis codes submitted on medical claim records they receive that are related to the claim, or derive ICD-9/ICD-10 Diagnosis Codes from the claim information the RRE has on file. Again, these codes *may be derived* by the RRE, and do not have to be a diagnoses specifically originating from a provider or supplier of medical services (e.g. physician, hospital, etc.) The ICD-9/ICD-10 codes are used by Medicare to identify claims Medicare may receive, related to the incident, for Medicare claims payment and recovery purposes. RREs are encouraged to supply as many related codes in the ICD Diagnosis Code 1-19 Fields as possible to ensure Medicare correctly identifies the applicable medical claims it receives. Field descriptions are provided in the record layout in the NGHP User Guide Appendices Chapter (Appendix A), which also provides more information concerning the requirements for these fields.

Certain codes are not valid for No-Fault insurance types (Plan Insurance Type is "D" in field 51), because they are not related to the accident, and may result in inappropriately denied claims. See Appendix J in Chapter V of this guide for a list of these codes.

Transition from ICD-9 to ICD-10 Diagnosis Codes

Beginning October 1, 2014, CMS will adopt the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) for diagnosis coding. ICD-10 codes are alphanumeric and contain 3 to 7 digits instead of the 3 to 5 digits used with ICD-9. The conversion from the 9th to the 10th Edition of ICD diagnosis codes requires changes to Section 111 reporting. **Effective April 1, 2015, RREs and their agents will be required to submit ICD-10 diagnosis codes on claim reports with a CMS DOI on or after 4/1/2015.**

In order to accommodate these changes, the Claim Input File Detail record has been modified.

- Positions 159-408 on the Claim Input File Detail Record have been redefined to manage these reporting requirements. Each current 5-byte diagnosis code field, including the Alleged Cause of Injury, Incident, or Illness has been expanded to 7 bytes by combining the 5 bytes of the ICD-9 diagnosis code field with the 2 bytes of filler that followed each of these fields in the record. ICD diagnosis codes will

continue to be reported in the same starting position, but the ending position has been increased by two bytes. These newly expanded fields have been renamed from "ICD-9 Diagnosis Code" to "ICD Diagnosis Code."

- A new one-byte ICD Indicator field has been added to identify the submitted diagnosis codes as all ICD-9 or all ICD-10. A value of a space or a "9" submitted in this field will indicate that the submitted diagnosis codes are all ICD-9 diagnosis codes. A value of "0" (zero) will indicate that the submitted diagnosis codes are all ICD-10 diagnosis codes.

Pre-Implementation Testing

As of October 1, 2013, RREs will have the opportunity to create and submit test Claim Input File Detail Records that include the ICD Indicator and ICD-10 diagnosis codes. Testing is optional, but recommended. It is the only way to ensure that an RRE can properly submit ICD-10 diagnosis codes and process corresponding response files. Reminder: RREs must transmit test files to the BCRC using the same transmission method as what was chosen for production files (HTTPS, SFTP, or Connect:Direct). For more information on the testing process, please refer to the *Testing the Section 111 Reporting Process* section in this NGHP User Guide.

As of October 1, 2013 the following requirements must be met for Claim Input File Detail Records submitted in **test** as of October 1, 2013. **These requirements must be met for all Claim Input File Detail Records submitted as of October 1, 2014**.

- The ICD Indicator (position 168) must be valid. The only values accepted in this field are "0" (zero), "9" or space. If an invalid value is submitted in this field, new error code CI31 will be returned.

  Note: Claims submitted with a CMS DOI on or after April 1, 2015 that contain an ICD indicator of "9" or space will be rejected with a CI31 error. *Since the system will not accept future dated DOIs, RREs will not be able to test this condition until 4/1/2015.*

- The diagnosis codes submitted on a Claim Input File Detail Record must correspond to the value submitted in the ICD Indicator field for that record. ***Although a file can contain records with both ICD-9 and ICD-10 codes, a single claim record can only contain either all ICD-9 or ICD-10 codes since there is only one ICD indicator per record***. If the ICD Indicator is a "9"or space, every diagnosis code submitted for that record must be an ICD-9 diagnosis code. If the ICD Indicator is a "0" (zero), every diagnosis code submitted for that record must be an ICD-10 diagnosis code.
- *If any invalid diagnosis code is submitted, the record will be rejected.* The record will be returned with an error associated to the field in which the invalid code was submitted, even if valid codes are supplied in one or more of any other ICD Diagnosis Code fields. Existing Error Codes CI03 and CI05-CI23 will be returned. ***Note: A diagnosis code will be considered to be invalid if the submitted code does not correspond to the value submitted in the ICD Indicator field.***
- If the optional Alleged Cause of Injury, Incident or Illness field is submitted on a record and the ICD Indicator is set to "9" or space (indicating that the record

includes all ICD-9 diagnosis codes), then the Alleged Cause of Injury, Incident or Illness field must begin with an “E” and must NOT be on the list of Excluded ICD-9 diagnosis codes found in the NGHP User Guide Appendices Chapter (Appendix I). If this requirement is not met, the record will be rejected with existing error CI03.

- If the optional Alleged Cause of Injury, Incident or Illness field is submitted on a record where the ICD Indicator is set to “0” (indicating that the record includes all ICD-10 diagnosis codes), then the Alleged Cause of Injury, Incident or Illness field: must begin with V, W, X, or Y and must NOT be on the list of Excluded ICD-10 diagnosis codes. If this requirement is not met, the record will be rejected with existing error CI03.
- An ICD-9 diagnosis code will be accepted as long as the code is valid (per the rules for Section 111) and the ICD Indicator is set to a “9” or a space. As of October 1, 2014, ICD-9 diagnosis codes will continue to be accepted on all add and update records submitted in production as long as the CMS DOI is prior to April 1, 2015. If the CMS DOI is October 1, 2014 or later and the record is submitted between October 1, 2014 and March 31, 2015, the response record will be returned with compliance flag “02”. To avoid receipt of this compliance flag, RREs are encouraged, but not required, to commence reporting of ICD-10 diagnosis codes on all new claim reports as of October 1, 2014. As of April 1, 2015, RREs are required to submit ICD-10 diagnosis codes on claims with a CMS DOI on or after April 1, 2015.

  Note: Since the system will not allow an RRE to submit a test Claim Input File Detail Record with a future-dated CMS DOI, this compliance flag will not be returned on test files submitted prior to October 1, 2014.
- An ICD-10 diagnosis code will be accepted in test as long as the code is valid (per the rules for Section 111) and the ICD Indicator is set to a 0.

Rules for Submitting ICD-9 and ICD-10 Diagnosis Codes

Each add or update record must include either all ICD-9 codes or all ICD-10 codes, but not a mixture of each. If a combination of codes is submitted, the record will reject. If the record includes all ICD-10 diagnosis codes, the ICD Indicator field (position 168 of the revised Claim Input File Detail Record) must be set to “0” (zero). If a value of space or “9” is submitted, the submitted diagnosis codes must all be ICD-9 codes.

Add Records

- ICD-9 Diagnosis Code Submissions
  - Will be accepted on claim reports with a CMS DOI prior to April 1, 2015.
  - Will not be accepted with a DOI on or after April 1, 2015. These records will be rejected.
  - Must have the ICD Indicator field (position 168 of the revised Claim Input File Detail Record) set to “9” or space.

  - Will receive compliance flag "02" on the corresponding response record for submissions with a CMS DOI of October 1, 2014 or later submitted between October 1, 2014 and March 31, 2015. These records will not be rejected.
- ICD-10 Diagnosis Code Submissions
  - Will be accepted on claim reports starting October 1, 2014.
  - Will not be accepted on production files submitted prior to October 1, 2014.
  - Are required on claim reports with a CMS Date of Incident of April 1, 2015 and subsequent.
  - Must have the ICD Indicator field (position 168 of the revised Claim Input File Detail Record) set to "0" (zero).
- RREs are encouraged to begin reporting ICD-10 codes on all new claim reports as of October 1, 2014.

Update Records

- After an initial add record has been submitted and accepted an RRE may submit an update record that includes all previously submitted ICD Diagnosis Codes that still apply to the claim report, along with any new codes the RRE needs to submit.
  - The update record must include either all ICD-9 codes or all ICD-10 codes, but not a mixture of each. If a combination of codes is submitted, the record will reject.
  - If the previously accepted claim report was submitted with ICD-9 diagnosis codes, any update record submitted for that claim report will continue to be accepted with those same ICD-9 codes in the future.
  - RRES will not be required to go back and crosswalk ICD-9s on previously accepted records to ICD-10s when sending an update to the previously accepted record.
- RREs may, but are not required to, change ICD-9 diagnosis codes to corresponding ICD-10 diagnosis codes on previously submitted and accepted records.

Valid ICD-9 Diagnosis Codes

With the implementation of ICD-10, please note that ICD-9 diagnosis codes will not be accepted on any Claim Input File Detail record with a CMS DOI of 4/1/2015 and subsequent.

Text and Excel files containing the list of valid ICD-9 diagnosis codes used for validating Section 111 files are available for download on the Section 111 COBSW at http://www.section111.cms.hhs.gov. RREs may obtain this list by clicking on the link found under the *Reference Materials* menu option. The files are updated each January.

Once an ICD-9 diagnosis code is accepted for Section 111 reporting, it will not be removed from the list of valid codes. It may continue to be submitted on subsequent update transactions (unless presently unforeseen updates are made to the list of excluded codes). ICD-9 codes are to be submitted with no decimal point.

If any invalid ICD-9 diagnosis code is submitted, the record will be rejected. The record will be returned with an error associated to the field in which the invalid code was submitted, even if valid codes are supplied in one or more of any other ICD Diagnosis Code fields. More specific requirements are given below.

The files of valid ICD-9 diagnosis codes used for Section 111 reporting were created using the following methodology. **RREs are advised to use the list of valid ICD-9 diagnosis codes posted to the Section 111 COBSW.**

CMS has published a list of valid ICD-9 diagnosis codes at: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html. Version 31 is the last ICD-9 file that will be provided by CMS since ICD-10 will be implemented on October 1, 2014. CMS will continue to maintain the ICD-9 code web site with the posted files.

These are the codes providers (physicians, hospitals, etc.) and suppliers must use when submitting claims to Medicare for payment. These codes form the basis of those used for Section 111 reporting, with some exceptions. The BCRC will consider any ICD-9 diagnosis code found in any of versions 25–31 that is posted to the web site above as valid, as long as that code does not appear on the list of *Excluded ICD-9 Diagnosis Codes* in the NGHP User Guide Appendices Chapter (Appendix I), and does not begin with the letter "V".

In summary, the term "valid ICD-9 diagnosis code" is identified as any ICD-9 code that:

- Exactly matches the first 5 bytes or characters of a record on any of the files incorporated into the BCRC Section 111 process;
- Exists in Versions 25–Version 31;
- Is not found on the list of exclusions in the NGHP User Guide Appendices Chapter (Appendix I); and,
- Does not begin with the letter "V".

As of this writing, the BCRC is using the following files to validate ICD-9 codes with the exceptions as noted above:

CMS30_DESC_LONG_DX 080612.txt (from Version 30)
CMS29_DESC_LONG_DX.101111.txt (from Version 29)
CMS28_DESC_LONG_DX.txt (from Version 28)
CMS27_DESC_SHORT_DX.txt (from Version 27)
V26 I-9 Diagnosis.txt (from Version 26)
I9diagnosesV25.txt (from Version 25)

To download a copy of these files:

- Go to http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html Download the following ".zip" files displayed on that page:
- Version 31 Full and Abbreviated Code Titles – Effective October 1, 2013 (Note: Version 31 does not include any ICD-9 diagnosis code updates).]

- Version 30 Full and Abbreviated Code Titles - Effective October 1, 2012 (05/16/2012: Corrections have been made to the full code descriptions for diagnosis codes 59800, 59801, 65261, and 65263.) [ZIP, 1001KB]
- Version 29 Full and Abbreviated Code Titles – Effective October 1, 2011
- Version 28 Full and Abbreviated Code Titles - Effective October 1, 2010
- Version 27 Abbreviated Code Titles - Effective October 1, 2009
- Version 26 Effective October 1, 2008 Version 25 Effective October 1, 2007
- Unzip the files and use:
- Version 30 (effective 10/1/2012): Any of the text or Excel files with "DX" in the name
- Version 29 (effective 1/1/2012): Any of the text or Excel files with "DX" in the name
- Version 28: Any of the text or Excel files with DX in the name
- Version 27: CMS27_DESC_SHORT_DX.txt
- Version 26: V26 I-9 Diagnosis.txt
- Version 25: I9diagnosesV25.txt

Note: Starting with Version 27, CMS also provides Microsoft Excel spreadsheets with the same list of valid diagnoses in the ".zip" files on this Web page. You may use the text files listed above or the Excel (".xls") files. They contain the same set of ICD-9 diagnosis codes. **Be sure to use the diagnosis files that include "DX" in the names, and not the procedure code files that include "SG" in the names.**

Again, RREs are advised to simply download the file of valid ICD-9 diagnosis codes used for Section 111 reporting from the Reference Materials menu option on the Section 111 COBSW at http://www.section111.cms.hhs.gov, rather than going through the process of creating their own version using the methodology described above. The ICD diagnosis code(s) reported starting in Field 18 are critical and must accurately describe the injury, incident or illness being claimed or released or for which ORM is assumed.

Valid ICD-10 Diagnosis Codes

Text and Excel files containing the list of valid ICD-10 diagnosis codes used for validating Section 111 files are available for download on the Section 111 COBSW at http://www.section111.cms.hhs.gov. RREs may obtain this list by clicking on the link found under the *Reference Materials* menu option. The files are updated each January. **RREs are advised to use the list of valid ICD-10 diagnosis codes posted to the Section 111 COBSW.**

Once an ICD-10 diagnosis code is accepted for Section 111 reporting, it will not be removed from the list of valid codes. It may continue to be submitted on subsequent update transactions (unless presently unforeseen updates are made to the list of excluded codes). ICD-10 codes are to be submitted with no decimal point.

If any invalid ICD-10 diagnosis code is submitted, the record will be rejected. The record will be returned with an error associated to the field in which the invalid code was submitted, even if valid codes are supplied in one or more of any other ICD diagnosis code fields. More specific requirements are given below.

CMS has published a list of valid ICD-10 diagnosis codes at: http://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs.html. These are the codes providers (physicians, hospitals, etc.) and suppliers must use when submitting claims to Medicare for payment with a CMS DOI of 4/1/2015 and subsequent. These codes form the basis of those used for Section 111 reporting, with some exceptions. CMS will consider any ICD-10 diagnosis code that is posted to the Website above as valid, as long as that code does not appear on the list of *Excluded ICD-9/ICD-10 Diagnosis Codes* in the NGHP User Guide Appendices Chapter (Appendix I), and does not begin with the letter "V," "W," "X," or "Y." CMS will add updated codes to this web page for subsequent years. The codes will be posted to the CMS website effective October 1, of the current year and will be incorporated into Section 111 processing as of January 1, of the following year.

In summary, the term "valid ICD-10 diagnosis code" is identified as any ICD-10 code that:

- Exactly matches a record on any of the files incorporated into the BCRC Section 111 process;
- Is not found on the list of exclusions in the NGHP User Guide Appendices Chapter (Appendix I); and,
- Does not begin with the letter "V," "W," "X," or "Y."

RREs are advised to download the file of valid ICD-10 diagnosis codes used for Section 111 reporting from the Reference Materials menu option on the Section 111 COBSW at http://www.section111.cms.hhs.gov. The ICD diagnosis code(s) reported starting in Field 18 are critical and must accurately describe the injury, incident, or illness being claimed or released or for which ORM is assumed.

Excluded ICD-9 and ICD-10 Diagnosis Codes

CMS has determined that certain available ICD-9/ICD-10 diagnosis codes as published do not provide enough information related to the cause and nature of an illness, incident, or injury to be adequate for Section 111 reporting. Such codes are therefore excluded from use in Section 111 claim reports. A list of these excluded codes is provided in Appendix I (in the NGHP User Guide Appendices Chapter), as the list of "Excluded ICD-9/ICD-10 Diagnosis Codes". These codes will NOT be accepted in the Alleged Cause of Injury, Incident, or Illness (Field 15) or in the ICD Diagnosis Codes beginning in Field 18.

In addition, all ICD-9 diagnosis codes beginning with the letter 'V' are considered invalid for Section 111 reporting. They are not listed singly on the exclusion list in the NGHP User Guide Appendices Chapter (Appendix I). No ICD-9 'V' Codes will be accepted for Section 111 reporting.

Furthermore, all ICD-10 diagnosis codes beginning with the letter "V," "W," "X," or "Y" are considered invalid for Section 111 reporting. They are not listed singly on the exclusion list in the NGHP User Guide Appendices Chapter (Appendix I). No ICD-10 "V," "W," "X," or "Y" codes will be accepted for Section 111 reporting.

The list of Excluded ICD-9 Diagnosis Codes found in the NGHP User Guide Appendices Chapter (Appendix I), may be downloaded from the Section 111 COBSW at http://www.section111.cms.hhs.gov by clicking on the link found under the Reference Materials menu option.

Summary of Requirements

- When there is a **TPOC** settlement, judgment, award, or other payment, RREs are to submit ICD-9/ICD-10 codes to reflect **all the alleged illnesses/injuries claimed and/or released**. Where **ORM** is reported, RREs are to submit ICD-9/ICD-10 codes for **all alleged injuries/illnesses for which the RRE has assumed ORM.**
- If, due to a subsequent ruling by CMS, an ICD-9/ICD-10 diagnosis code previously submitted no longer applies to the claim, RREs may send an update transaction without that particular ICD-9/ICD-10 diagnosis code, but must include all ICD-9/ICD-10 diagnosis codes that still apply.
- CMS encourages RREs to supply as many valid ICD-9/ICD-10 Diagnosis Codes as possible as that will lead to more accurate coordination of benefits, including claims payments and recoveries, when applicable.
- ICD-9/ICD-10 codes are to be submitted with no decimal point.
- Codes must be left justified and any remaining unused bytes filled with spaces to the right.
- Leading and trailing zeroes must be included only if they appear that way on the list of valid ICD-9/ICD-10 diagnosis codes (see below). Do not add leading or trailing zeroes just to fill the 5 positions of the field on the file layout.
- Valid ICD-9 diagnosis codes can be 3, 4 and 5 digits long—and no partial codes may be submitted. In other words, you may not submit only the first 3 digits of a 4-digit code, etc.
- Valid ICD-10 diagnosis codes can be 3 to 7 digits long—and no partial codes may be submitted.
- The downloadable list of ICD-9 and ICD-10 codes considered valid by CMS for Section 111 reporting are posted under the Reference Materials menu option of the Section 111 COBSW at http://www.section111.cms.hhs.gov. A submitted ICD-9 diagnosis code must ***exactly*** match the first 5 bytes/characters of a record on this list. A submitted ICD-10 diagnosis code must ***exactly*** match the first 7 bytes/characters of a record on this list.
- ICD diagnosis code edits are not applied to delete transactions, but are applied to add and update transactions.
- The **Alleged Cause of Illness/Injury (Field 15) is an optional field. If an ICD-9 diagnosis code is supplied, it must begin with an "E" (be an "E code")** and be on the list of valid ICD-9 codes for Section 111 reporting. In addition, the E code supplied must ***NOT*** be on the list of Excluded ICD-9 Diagnosis Codes provided in the NGHP User Guide Appendices Chapter (Appendix I). **If an ICD-10 diagnosis code is supplied, it must begin with "V," "W," "X," or "Y"** and must be on the list of valid ICD-10 codes for Section 111 reporting. In addition, the "V," "W," "X," or "Y" code supplied must ***NOT*** be on the list of Excluded ICD-10 Diagnosis Codes

provided in the NGHP User Guide Appendices Chapter (Appendix I). (See Section 0 (Special Default Diagnosis Code for Liability – NOINJ Code) for a special default code that may be used under only very limited circumstances.)

- At least one valid ICD-9/ICD-10 diagnosis code must be provided on all add and update records, entered in Field 18. Additional valid ICD-9/ICD-10 diagnosis codes (numbers 2 through19) are optional. But remember that RREs must provide as many as possible to adequately describe the injury/illness associated with the TPOC and/or ORM reported, as specified above.
- If more than one ICD-9/ICD-10 Diagnosis Code is supplied, all must be valid. If even one code submitted is invalid, the entire record will be rejected. The associated error code for the field in error will be included with the rejected file.
- Any unused ICD Diagnosis Code fields are to be filled with spaces.
- If any of these requirements are not met, the record will be rejected and an 'SP' disposition code and associated error code(s) will be returned on the corresponding Claim Response File Detail Record. For example, if two diagnosis codes are submitted and one is valid but the other is not, the applicable error code will be posted to the response record and the **entire record will be rejected** with an "SP" disposition code.
- After an initial add record has been submitted and accepted an RRE may add or remove ICD-9/ICD-10 diagnosis codes on subsequent update records. Update records should include all previously submitted ICD-9/ICD-10 diagnosis codes that still apply to the claim report, along with any new codes the RRE needs to submit.

More information related to ICD-9-CM codes and coding may be found at: http://www.cdc.gov/nchs/icd/icd9cm.htm. More information related to ICD-10-CM codes and coding may be found at: http://www.cdc.gov/nchs/icd/icd10cm.htm. In addition, RREs and reporting agents may find it helpful to do an Internet search on ICD codes, where many sources of information regarding ICD-9/ICD-10 diagnosis codes may be found, including online and downloadable search lists, and free software to assist with deriving codes applicable to specific injuries.

Special Default Diagnosis Code for Liability – NOINJ Code

This section provides information related to a default code that may be used under **extremely limited and specific circumstances** when reporting liability insurance (including self-insurance).

As documented in the NGHP User Guide Policy Guidance Chapter (Section 6.5.1 - What Claims Are Reportable/When Are Such Claims Reportable) and elsewhere in this guide:

"Information is to be reported for claims related to liability insurance (including self-insurance), no-fault insurance, and workers' compensation where the injured party is (or was) a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment **has the effect of releasing medicals***."*

There are certain, very limited liability situations where a settlement, judgment, award, or other payment releases medicals or has the effect of releasing medicals, but the type of alleged incident typically has no associated medical care and the Medicare

beneficiary/Injured Party has not alleged a situation involving medical care or a physical or mental injury. This is frequently the situation with a claim for loss of consortium, an errors or omissions liability insurance claim, a directors and officers liability insurance claim, or a claim resulting from a wrongful action related to employment status action is alleged.

Current instructions require the RRE to report claim information in these circumstances. However, in these very limited circumstances, when the claim report does **not** reflect ongoing responsibility for medicals (ORM) and the insurance type is liability, a value of "**NOINJ**" may be submitted in Field 18 (ICD Diagnosis Code 1).

When submitting the "**NOINJ**" value in Field 18, all of the rest of the diagnosis fields must be left blank and Field 15 (Alleged Cause of Injury, Incident, or Illness must be submitted with the value "NOINJ" or all spaces. All other required fields must be submitted on the claim report.

Important Considerations:

- The default code of 'NOINJ' may not be submitted on claim reports reflecting ORM. If a Claim Input File Detail Record is submitted with Y in the ORM Indicator (Field 78) and either the Alleged Cause of Injury, Incident, Illness (Field 15) or any ICD Diagnosis Codes 1-19 (starting at Field 18) contain 'NOINJ', the record will be rejected.
- The default code of 'NOINJ' may only be used when reporting liability insurance (including self-insurance) claim reports with L in the Plan Insurance Type (Field 51). If the Plan Insurance Type submitted is not L, the record will be rejected.
- 'NOINJ' will only be accepted in Fields 15 and 18 on the Claim Input File Detail Record. If 'NOINJ' is submitted in any of the ICD-9 Diagnosis Codes 2-19 starting in Field 19, the record will be rejected.
- If 'NOINJ' is submitted in Field 15 then 'NOINJ' must be submitted in Field 18, otherwise the record will be rejected.
- If 'NOINJ' is submitted in Field 18, then 'NOINJ' (or all spaces) must be submitted in Field 15 otherwise the record will be rejected.
- If 'NOINJ' is submitted in Field 18 then all remaining ICD-9 Diagnosis Code 2-19 (Fields 19-36) must be filled with spaces. If Fields 19-36 contain values other than spaces, the record will be rejected.
- If an 'NOINJ' code is incorrectly or inappropriately used, the record will be rejected with the CI25 error code.
- CMS will closely monitor the use of the 'NOINJ' default code by RREs to insure it is used appropriately. RREs using this code erroneously are at risk of non-compliance with Section 111 reporting requirements.

6.2.6 Foreign Addresses

Contact information that is outside the United States may not be provided in any address or telephone number field on the Claim Input File. (Guam, Puerto Rico, and the US Virgin Islands are considered inside the US.) Foreign address fields for RRE use are

available on the TIN Reference File (see Section 6.3 and the NGHP User Guide Appendices Chapter (Appendix B)). On the Claim Input File Detail (and Auxiliary) Records, the RRE must supply a domestic, US address and telephone number for Claimant and Representative fields, if possible. If none is available, then supply a value of 'FC' in the associated State Code field and default all other fields to spaces or zeroes as specified in the record layouts in the NGHP User Guide Appendices Chapter (Appendix A). If US contact information is not supplied for a Claimant or Representative, then the RRE may be contacted directly to supply additional information. It is recommended that an RRE make every effort to supply US contact information in order to avoid further questions regarding contact address information.

6.3 TIN Reference File

A Tax Identification Number (TIN) is submitted in Field 52 of each Claim Detail Record. It is an IRS-provided tax identification code number assigned to the RRE. This code number may also be known as the RRE's federal employer identification number (FEIN or EIN). For those who are self-employed, their business TIN may be an Employer Identification Number (EIN) or a personal Social Security Number (SSN).

For an RRE not based in the United States and without a valid IRS-assigned TIN or EIN, the Section 111-required TIN may be a fake (or pseudo-TIN) created by the RRE during the Section 111 COBSW registration process, using the format of 9999xxxxx where 'xxxxx' is any number of the RRE's choosing (see the NGHP User Guide Registration Procedures Chapter (Section 4.2.6 - Foreign RRE Registration). CMS encourages foreign entities (RREs that have no IRS-assigned TIN and/or US mailing address) to apply for a U.S. federal TIN by completing the Internal Revenue Service (IRS) SS-4 Application and then using that number to register and report, if possible. Note that entities in Guam, Puerto Rico, and the US Virgin Islands are considered within the US, have US addresses, and have IRS-assigned TINs.

The TIN in field 52 of the Claim Input File must match what was submitted in your TIN Reference File. All claims should be reported with the RRE TIN associated with the entity that currently has payment responsibility for the claim. This will mean that, depending on the circumstances, you might submit either the same or different TINs in Field 72 and in the TIN Reference File than you provided when you registered for your RRE ID. As described later, updates may be submitted to change the TIN associated with a previously reported claim, if needed.

Additional TINs for injured parties, other claimants, attorneys, or representatives are submitted on the Claim Detail Record, but only the RRE TINs submitted in Field 52 are to be included on the TIN Reference File. For RRE (Plan) TIN and Office Code (Site ID) combinations reported in Fields 52 and 53 of your Claim Input File Detail Records, you must have submitted a TIN Reference File with those codes.

The TIN Reference File is submitted prior to or with the Claim Input File – doing so makes it unnecessary to repeat the RRE name and address information associated with each TIN on every Claim Input Record. The TIN, name and mailing address submitted on the TIN Reference File Detail Record should be those associated to the TIN and address

to which healthcare claim insurance coordination of benefits information and notifications related to Medicare's recovery efforts, if necessary, should be directed.

An RRE may use more than one TIN for Section 111 claim reporting. For example, an insurer may have claims operations defined for various regions of the country or by line of business. Because they are separate business operations, each could have its own TIN. In such case, each TIN may be associated with a distinct name and mailing address.

To allow for further flexibility, CMS has added an optional field called the Office Code (or Site ID) as Field 53 of the Claim Detail Record. This is an RRE-defined, non-zero, 9-digit number that can be used when the RRE has only one TIN but wishes to associate claims and the corresponding mailing address for the RRE to different offices or sites. If you do not need this distinction, the Office Code/Site ID must be filled with nine spaces on the Claim Input File Detail Record and corresponding TIN Reference File Record.

NOTE: If you choose to use the Office Code field, it must be submitted as a non-zero 9-digit number right justified and padded with zeroes ('123456789' or '000000001'). If you choose not to use it, the Office Code must be filled with spaces.

For example, an RRE may use only one TIN ('123456789') but have two office codes; '000000001' for workers' compensation claims and '000000002' for commercial liability claims. Two records will be reported on the TIN Reference File. One record will be submitted with TIN of '123456789' and Office Code of '000000001' and a second record submitted with the same TIN of '123456789' but Office Code of '000000002'. Different mailing addresses may be submitted on the TIN Reference File Detail Record for each of these combinations. In this example, the RRE would submit '123456789' in Field 52 of each Claim Detail Record, '000000001' in Field 53 of each workers' compensation Claim Detail Record, and '000000002' in Field 53 of each commercial liability Claim Detail Record.

Foreign RREs with no US address must submit the value 'FC' in the TIN/Office Code State (Field 9) and supply the international address of the RRE in the Foreign RRE Address Lines 1-4 (Fields 12-15). Since there are numerous differences in the format of international addresses, the RRE may provide the address using these fields in a "free form" manner of their choosing, as long as at least the Foreign Address Line 1 (Field 12) is supplied. Components of the address (e.g., street, city) should be separated by spaces or commas. Each of these alphanumeric fields is 32 bytes.

For all RRE reporters: The TIN Reference File may be submitted with your Claim Input File as a logically separated file within the same physical file, or as a completely separate physical file. It has its own header and trailer records. It must be sent prior to or at the same time as your first Claim Input File. Note that TIN and TIN address information is required when entering claim information on the Section 111 COBSW using DDE.

The TIN Reference File must contain only one record per unique TIN and Office Code combination. Again, if you do not need to use it, put spaces in the Office Code field to distinguish separate locations and mailing addresses.

Any TIN/Office Code combination submitted in Fields 52 and 53 on a Claim Detail Record must be included on a corresponding record in the TIN Reference File in order for the Claim Input File Detail Record to be processed.

As of October, 2011, a submitted TIN Reference File will generate a corresponding TIN Response File. Errors on TIN Reference File records will result in the rejection of subsequently processed Claim Input File Detail Records that have matching RRE TIN/Office Codes (Section 6.3.3). The TIN Reference File layout and field descriptions can be found in the NGHP User Guide Appendices Chapter (Appendix B).

You do not need to send a TIN Reference File with every Claim Input File submission. After the initial TIN Reference File is successfully processed, you only need to resend it if you have changes or additions to make. Subsequent Claim Input Files do not need to be accompanied by a TIN Reference File unless changes to previously submitted TIN/Office Code information must be submitted or new TIN/Office Code combinations have been added. Only new or changed TIN records need to be included on subsequent submissions. Even so, many RREs choose to submit a full TIN Reference File with each Claim Input File submission. Remember that all TINs in each TIN Reference File submitted will be verified, so it is imperative that the TIN information you provide is accurate.

6.3.1 Submission of TPA information via the TIN Reference File

As of December 20, 2011, RREs can submit third party administrator (TPA) information using existing Section 111 TIN Reference File fields. Submission of this information via Section 111 will provide CMS and the BCRC the necessary notification that the TPA is representing the RRE and eliminate the need for the RRE to submit a separate communication to the BCRC on the RRE's letterhead to that effect. This is a temporary workaround until specific TPA-related fields can be added to the Section 111 TIN Reference File for this purpose.

To submit TPA information on the Section 111 NGHP TIN Reference File and indicate that the TPA is representing the RRE for claims submitted under the same TIN/Office Code combination:

- Submit the RRE's IRS-assigned tax identification number (TIN) in Field 3
- Submit the applicable Office Code/Site ID in Field 4
- Submit the RRE's name in Field 5
- Submit the TPA's address in Fields 6 and 8-11
- Submit the TPA's name in Field 7 prefaced by "C/O" or "ATTN"
- Submit all other TIN Reference File fields as specified in the file layouts in the NGHP User Guide Appendices Chapter (Appendix B).

Submission of TPA information on the TIN Reference File is **optional**. If an RRE is not using a TPA or an RRE does not wish to direct recovery-related correspondence to their TPA, the RRE should submit its own address on the TIN Reference File.

Submission of TPA information on the TIN Reference File serves as notice to CMS that the TPA is representing the RRE with respect to a claim involving a Medicare beneficiary. No separate correspondence to the BCRC is required to authorize the TPA to act on the RRE's behalf.

If an RRE submits its TPA's address on the Section 111 NGHP TIN Reference File using this workaround, all correspondence related to a recovery case will only be sent by the

BCRC to the TPA. The RRE will not receive a copy at this time. It is up to the RRE and its TPA to agree on a means of sharing this information with each other as appropriate. The RRE still retains ultimate responsibility for adhering to Section 111 mandatory reporting requirements and all other pertinent MSP regulations.

Note: As noted above, any addresses submitted on the TIN Reference File are used by CMS in subsequent business processes. This subsequent activity includes Medicare claims payment processing, and recovery activity performed by the BCRC. The submitted TIN address(es) may be shared with providers and suppliers who submit medical claims to Medicare to assist them in directing their claims to the proper primary payer. The addresses are also used by the BCRC to direct demand package mailings and other recovery-related notifications. RREs must be prepared to receive such information at the addresses provided on the TIN Reference File and to make sure it is directed to the proper RRE resources for proper handling.

6.3.2 TIN Validation

CMS uses the following procedures to process and manage TIN Codes.

- On a Claim Input File Detail Record, a TIN/Office Code combination in Fields 52 and 53 must match a TIN/Office Code combination included on a current or previously submitted TIN Reference File Detail Record. (The Office Code field can be left blank if it is not used.)
- All RRE TINs submitted in Field 52 must be valid IRS-assigned tax IDs (except for foreign RRE pseudo-TINs). Only the TIN will be used in this validation. We don't also match on an associated IRS-assigned name and address.
- If you receive a compliance error on a TIN you believe is valid, please contact your EDI Representative. Upon receipt of the appropriate documentation, your EDI Representative will mark the TIN as valid and it will be accepted on subsequent file submissions.
- No validation is done on RRE-assigned pseudo-TINs submitted for foreign RREs other than to check for a 9-digit number beginning with '9999'.

6.3.3 Address Validation and TIN Reference Response File

As of October 1, 2011

Basic Field Validation

- If an RRE submits a TIN Reference File at the same time as their Claim Input File, the BCRC will process the TIN Reference File first. It will process the Claim Input File after the TIN Reference File processing is complete. RREs may also submit a TIN Reference File alone (without submission of a Claim Input File). In such case the system will process the TIN file in the BCRC's next scheduled batch cycle. There is no defined file submission timeframe associated with a separately submitted TIN Reference File.
- On all TIN Reference Files submitted, basic field validations will be performed according to the field descriptions in the TIN Reference File layouts in the NGHP User Guide Appendices Chapter (Appendix B).

- Each RRE TIN will be validated to ensure it is a valid IRS-assigned tax ID. Only the TIN will be used in this validation process. In this step, CMS does not require that any name and address submitted with the TIN necessarily has to match the name and address associated with that TIN by the IRS. (But see “Address Validation”, below.)
- If an error is found on an input TIN Reference File Detail Record during the basic field validation step, the TIN record will be rejected and returned on the new TIN Reference Response File. The response file will include a ‘TN’ disposition code and error codes specific to the errors identified (See the TIN Response File Error Codes table in the NGHP User Guide Appendices Chapter (Appendix F)).
- As with other Section 111 file processing, when reports of certain severe errors are generated for TIN Reference Files, notification is sent to RREs via e-mail alerts. “Severe errors” include missing header or trailer records, incorrectly formatted header and trailer records or an invalid record count on the trailer. RREs notified of a severe error must contact their assigned EDI Representative and resubmit a corrected TIN Reference File, as instructed.

Address Validation

In this step, mailing addresses associated with TINs have already been validated.

- TIN Reference File records that pass the basic field validation edits will be further processed by the BCRC using a postal software address analysis tool. This tool will be used to validate and improve the standardization of mailing addresses.
- Non-foreign addresses will be reformatted into the standardized format recommended by the U. S. Postal Service (USPS), so that they can be matched against another database of valid, deliverable addresses. This process will involve such changes as correcting misspellings, changing the order of the individual components of the primary address line(s), and applying standard postal abbreviations, such as RD for “Road”.
- After the address is standardized, it will be matched to the postal database. This matching will include Delivery Point Validation (DPV). When a match to a deliverable address is confirmed, the address is considered valid.
- If a standardized address received by CMS is matched to one that is considered an undeliverable address, such as a vacant lot, the address will be considered invalid.
- The general “return codes” provided by the postal software address analysis tool will be translated into more specific descriptive error codes that will indicate why the address failed to be validated. These descriptive error codes are included in the TIN Response File Error Codes table in the NGHP User Guide Appendices Chapter (Appendix F).
- Address validation will be applied to the TIN/Office Code Mailing Address submitted in a TIN Reference File Detail Record in Fields 6 – 11, where the TIN/Office Code State (Field 9) is not equal to ‘FC’ (foreign).
- Foreign RRE Addresses, submitted in Fields 12 – 15 on TIN Reference File Detail Records where the State code in Field 9 equals ‘FC’, will *not* be validated in this step. Only the basic field validation steps will apply to the Foreign RRE Address.

TIN Reference Response File

- TIN Reference Response Files will start with a header record, followed by all TIN Reference File Detail Records, and end with a trailer record containing the Detail Record count. Each record is a fixed length of 1000 bytes. The file layout is shown in the NGHP User Guide Appendices Chapter (Appendix D).
- The TIN Reference Response File Detail Record will contain the submitted TIN/Office Code, a disposition code, ten error code fields, the submitted mailing address, applied mailing address, any submitted foreign RRE address, and an indicator to show whether the system applied changes to the mailing address fields.
- If a TIN Reference File Detail Record **fails** the TIN and/or TIN address validation, it will be rejected. In such case a corresponding TIN Reference Response File Detail Record will be returned with:
- A value of 'TN' in the TIN Disp Code (Field 22)
- Associated errors in the TIN Error 1-10 (Fields 23 - 32), as documented in the TIN Response File Error Codes table in the NGHP User Guide Appendices Chapter (Appendix F)
- TIN Reference File TIN, Office Code, name and mailing address in the Submitted TIN, Submitted Office Code/Site ID, Submitted TIN/Office Code Mailing Name and Address (Fields 3 - 11)
- Spaces in the Applied TIN/Office Code Mailing Address (Fields 12 - 17)
- Spaces in the TIN/Office Code Address Change Flag (Field 33)
- If a TIN Reference File Detail Record **passes** the TIN and TIN address validation, it will be accepted and a TIN Reference Response File Detail Record returned with:
- A value of '01' in the TIN Disp Code (Field 22)
- Spaces in the TIN Error 1-10 (Fields 23 - 32)
- TIN Reference File TIN, Office Code, name and mailing address in the Submitted TIN, Submitted Office Code/Site ID, Submitted TIN/Office Code Mailing Name and Address (Fields 3 - 11)
- Addresses the BCRC will use for subsequent processing in the corresponding Applied TIN/Office Code Mailing Address (Fields 12 - 17)
- If the Applied TIN/Office Code Mailing Address (Fields 12 - 17) is different from the Submitted TIN/Office Code Mailing Address (Fields 6 – 11), the TIN/Office Code Address Change Flag (Field 33) will be set to 'Y'. If they are the same, Field 33 will be set to 'N'.
- If there was a TIN Reference File Detail Record previously submitted that matches the new TIN Reference File Detail Record being processed, the new record will overlay the prior record on the COB database and the new record will be used for subsequent Claim Input File processing, regardless of the TIN Disp (disposition) Code returned. New but erroneous TIN records can replace previously existing TIN records that were valid, and vice versa. **Errors on TIN Reference File records will result in the rejection of subsequently processed Claim Input File Detail Records that have matching RRE TIN/Office Codes.** TIN records returned with errors must

be corrected and resubmitted in order for the corresponding Claim Input File Detail Records to process correctly.

- The system will take approximately 3 to 7 business days to process a TIN Reference File and create the TIN Reference Response File. If an RRE submits a TIN Reference File with its Claim Input File, the system will process and produce the TIN Reference Response File first. RREs may also submit a TIN Reference File without submission of a Claim Input File and the system will proceed with processing the TIN file in the next scheduled batch cycle.
- TIN Reference Response Files will be created for both test and production TIN Reference File submissions.
- RREs are encouraged to update their internal systems with the applied address fields returned.
- RREs are encouraged to pre-validate RRE addresses using postal software or online tools available on the USPS Website pages, such as http://zip4.usps.com/zip4/welcome.jsp.

Processing TINs on the Claim Input File

- The TIN and Office Code/Site ID (Claim Input File Fields 52 and 53) will be matched to the COB database table of valid, **accepted** TIN Reference File records submitted by the RRE.
- If a match is found, the TIN/Office Code information will be used in subsequent processing of claim information by Medicare and also be passed to the BCRC.
- If a match is not found to a valid TIN record, the Claim Input File Detail Record will be **rejected** and returned on the Claim Response File with a 'SP' disposition code and a TN99 error code, indicating that a valid TIN/Office Code record could not be found. This error will not provide information as to why the TIN record was rejected. **RREs will have to refer to the errors identified and returned on their TIN Reference Response Files** to determine what caused the matching TIN record to be rejected. An RRE will then need to resubmit corrected TIN Reference File records, and also to resubmit the corresponding Claim Input File Detail Records that were rejected, either in their next file submission or as instructed by their EDI Representative.

Direct Data Entry (DDE) TIN and TIN Address Validation

Although NGHP DDE reporters do not submit TIN Reference Files, they do submit the same TIN information online. The Section 111 COBSW does some basic editing of the TIN and associated address and will continue to do so.

- All TIN edits applied to TIN Reference File records will be applied, in the batch process, to TIN information submitted via DDE after the claim has been submitted.
- Checks to ensure the TIN is a valid, IRS-assigned TIN (except for a foreign RRE pseudo-TIN) and to validate addresses will only be performed in batch.
- If a TIN error is found during batch processing, the claim will be marked complete but an 'SP' disposition will be returned. The associated TN errors will be displayed on the Claim Confirmation page and must be corrected by editing the invalid fields. Once corrected, the claim report must be resubmitted for processing.

- Refer to the TIN Response File Error Codes table in the NGHP User Guide Appendices Chapter (Appendix F) for a list of possible TIN errors that could be returned for a claim submitted via DDE.
- TIN information from DDE submissions will be added to the COB database TIN table and transmitted to the BCRC as is done for TIN Reference File processing.
- RREs are encouraged to pre-validate RRE addresses using postal software or online tools available on the USPS website pages, such as http://zip4.usps.com/zip4/welcome.jsp.

6.4 Total Payment Obligation to the Claimant (TPOC) Reporting

The TPOC Amount refers to the dollar amount of a settlement, judgment, award, or other payment in addition to or apart from ORM. A TPOC generally reflects a "one-time" or "lump sum" settlement, judgment, award, or other payment intended to resolve or partially resolve a claim. It is the dollar amount of the total payment obligation to, or on behalf of the injured party in connection with the settlement, judgment, award, or other payment. Individual reimbursements paid for specific medical claims submitted to an RRE, paid due the RRE's ORM for the claim, **do not** constitute separate TPOC Amounts. The TPOC Date is not necessarily the payment date or check issue date. The TPOC Date is the date the payment obligation was established. This is the date the obligation is signed if there is a written agreement, unless court approval is required. If court approval is required, it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement, it is the date the payment (or first payment if there will be multiple payments) is issued. Please refer to the definition of the TPOC Date and TPOC Amount in Fields 80 and 81 of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter (Appendix A).

6.4.1 TPOC Mandatory Reporting Thresholds

CMS has revised the mandatory reporting thresholds and implementation timeline for all liability insurance (including self-insurance) and workers' compensation TPOC settlements, judgments, awards, or other payments for Section 111 TPOC reporting. See Table 6-1 for a TPOC reporting requirements summary,

Table 6-2 for the mandatory TPOC thresholds for liability insurance (including self-insurance) and for the mandatory TPOC thresholds for workers' compensation.

RREs must adhere to these requirements when determining what claim information should be submitted on initial and subsequent quarterly update Claim Input Files and DDE submissions. These thresholds are solely for the required reporting responsibilities for purposes of 42 U.S.C. 1395y(b)(8) (Section 111 MSP reporting requirements for liability insurance (including self-insurance), no-fault insurance, and workers' compensation).

These thresholds are not exceptions; they do not act as a "safe harbor" for any other obligation or responsibility of any individual or entity with respect to the Medicare Secondary Payer provisions. CMS reserves the right to change these thresholds and will provide appropriate advance notification of any changes.

Note: All RREs (except for those using DDE), must report during each quarterly submission window. Please see Section Chapter 5 (: File Submission Time Frames) for more information. DDE submitters are required to report within 45 calendar days of the TPOC date.

Table 6-1: TPOC Reporting Requirements Summary

Insurance Type	Reportable TPOC Dates	Reportable Amounts	Threshold Applicable
Liability insurance (including self-insurance)	October 1, 2010 & subsequent	Any amount	No
Workers' Compensation	October 1, 2011 & subsequent	Cumulative TPOC Amount that exceeds threshold	Yes
No-Fault	October 1, 2010 & subsequent	Cumulative TPOC Amount that exceeds threshold	Yes

Meeting the Mandatory TPOC Reporting Threshold

- Where there are multiple TPOCs reported by the same RRE on the same record, the combined TPOC Amounts must be considered in determining whether or not the reporting threshold is met. However, multiple TPOCs must be reported in separate TPOC fields as described in the Section 6.6.
- For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the threshold applies to the total of these two figures.
- To determine which threshold date range the TPOC falls into, the RRE will compare the most recent (or only) TPOC Date to the threshold date ranges. If the cumulative TPOC Amount associated with the claim is greater than the threshold amount for the threshold date range, the claim record must be reported.

6.4.2 No-Fault Insurance TPOCs

- RREs are required to report all no-fault insurance TPOCs with dates of October 1, 2010 and subsequent.
- RREs may, but are not required to, include no-fault TPOCs with dates prior to October 1, 2010.
- There is no de minimis dollar threshold for reporting no-fault TPOCs.

6.5 Liability Insurance (including Self-Insurance) TPOCs

- RREs are required to report TPOC Dates of October 1, 2011 and subsequent.
- RREs may, but are not required to, include TPOCs with dates prior to October 1, 2011.

- RREs are required to report liability insurance (including self-insurance) TPOCs **only** if the cumulative TPOC Amount **exceeds** the reporting threshold for the most recent TPOC Date.
- The BCRC will total all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.
- RREs **may** submit TPOCs that are less than or equal to the TPOC dollar threshold on an add record only if the claim **has ORM**.
- The TPOC reporting thresholds do not apply to these records. If submitted, the claim report will not reject with the CJ07 error.
- RREs will not be penalized for submitting claim reports with TPOCs that are under threshold.

6.5.1 Mandatory TPOC Thresholds for Liability Insurance (including Self-Insurance)

CMS has revised the Implementation Timeline and TPOC Dollar Thresholds for **certain** liability insurance (including self-insurance) (Plan Insurance Type = 'L') TPOC settlements, judgments, awards, or other payments. The reporting requirements are summarized in Table 6-2.

- If the most recent TPOC Date is on or between October 1, 2011 and March 31, 2012, and the cumulative TPOC Amount is greater than $100,000, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning January 1, 2012.
- For this date range, TPOCs greater than $5,000 through $100,000 may be reported, but there is no requirement to do so.
- If an add record is submitted for this date range with a total TPOC Amount less than or equal to $5,000, the claim report will reject with a CJ07 error.
- If the most recent TPOC Date is on or between April 1, 2012 and June 30, 2012, and the cumulative TPOC Amount is greater than $50,000, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning July 1, 2012.
- For this date range, TPOCs greater than $5,000 through $50,000 may be reported, but there is no requirement to do so.
- If an add record is submitted for this date range with a total TPOC Amount less than or equal to $5,000, the claim report will reject with a CJ07 error.
- If the most recent TPOC Date is on or between July 1, 2012 and September 30, 2012, and the cumulative TPOC Amount is greater than $25,000, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning October 1, 2012.
- For this date range, TPOCs greater than $5,000 through $25,000 may be reported, but there is no requirement to do so.
- If an add record is submitted for this date range with a total TPOC Amount less than or equal to $5,000, the claim report will reject with a CJ07 error.

- If the most recent TPOC Date is on or between October 1, 2012 and September 30, 2013, and the cumulative TPOC Amount is greater than $5,000, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning January 1, 2013.
- For this date range, TPOCs greater than $300 through $5,000 may be reported, but there is no requirement to do so.
- If an add record is submitted for this date range with a total TPOC Amount less than or equal to $300, the claim report will reject with a CJ07 error.
- If the most recent TPOC Date is on or between October 1, 2013 and September 30, 2014, and the cumulative TPOC Amount is greater than $2,000, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning January 1, 2014.
- For this date range, TPOCs greater than $300 through $2,000 may be reported, but there is no requirement to do so.
- If an add record is submitted for this date range with a total TPOC Amount less than or equal to $300, the claim report will reject with a CJ07 error.
- If the most recent TPOC Date is on or after October 1, 2014, and the cumulative TPOC Amount is greater than $300, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning January 1, 2015.
- If an add record is submitted for this date range with a total TPOC Amount less than or equal to $300, the claim report will reject with a CJ07 error.

Table 6-2: Mandatory Thresholds for Liability Insurance (including self-insurance) TPOC Settlements, Judgments, Awards or Other Payments

Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over $100,000	October 1, 2011	January 1, 2012
TPOCs over $50,000	April 1, 2012	July 1, 2012
TPOCs over $25,000	July 1, 2012	October 1, 2012
TPOCs over $5,000	October 1, 2012	January 1, 2013
TPOCs over $2,000	October 1, 2013	January 1, 2014
TPOCs over $300	October 1, 2014	January 1, 2015

6.5.2 Workers' Compensation TPOCs

- RREs are required to report TPOCs with dates of October 1, 2010 and subsequent.
- RREs may, but are not required to, include TPOCs with dates prior to October 1, 2010.
- RREs are required to report workers' compensation TPOCs **only** if the cumulative TPOC Amount **exceeds** the reporting threshold for the most recent TPOC Date.

- RREs **may** submit TPOCs that are less than or equal to the TPOC dollar threshold on an add record only if the claim **has ORM**.
- The TPOC reporting thresholds do not apply to these records. If submitted, the claim report will not reject with the CJ07 error.
- RREs will not be penalized for submitting claim reports with TPOCs that are under threshold.
- The BCRC will total all TPOC Amounts reported on the claim record when determining if the claim meets the reporting threshold.

Mandatory TPOC Thresholds for Workers' Compensation

CMS has revised the Timeline and TPOC Dollar Thresholds for Workers' Compensation (Plan Insurance Type = 'E') TPOC settlements, judgments, awards, or other payments. The reporting requirements are summarized in Table 6-3.

- If the most recent TPOC Date is on or between October 1, 2010 and September 30, 2013, and the cumulative TPOC Amount is greater than $5,000, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning January 1, 2011.
- Beginning January 1, 2013, TPOCs greater than $300 through $5,000 may be reported, but there is no requirement to do so.
- Beginning January 1, 2013, if an add record is submitted for this date range with a total TPOC Amount less than or equal to $300, the claim report will reject with a CJ07 error.
- If the most recent TPOC Date is on or between October 1, 2013 and September 30, 2014, and the cumulative TPOC Amount is greater than $2,000, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning January 1, 2014.
- For this date range, TPOCs greater than $300 through $2,000 may be reported, but there is no requirement to do so.
- If an add record is submitted for this date range with a total TPOC Amount less than or equal to $300, the claim report will reject with a CJ07 error.
- If the most recent TPOC Date is on or after October 1, 2014, and the cumulative TPOC Amount is greater than $300, the TPOC(s) must be reported no later than the end of the RRE's submission timeframe in the quarter beginning January 1, 2015.
- If an add record is submitted for this date range with a total TPOC Amount less than or equal to $300, the claim report will reject with a CJ07 error.

Table 6-3: Mandatory TPOC Thresholds for Workers; Compensation Summary

Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over $5,000	October 1, 2010	January 1, 2011
TPOCs over $2,000	October 1, 2013	January 1, 2014
TPOCs over $300	October 1, 2014	January 1, 2015

6.6 Reporting Multiple TPOCs

This section provides information on how RREs will report multiple TPOC Dates and Amounts on the Section 111 Claim Input File for Section 111 reporting. For example, if an RRE negotiates **separate, different settlements at different times** for a liability claim, each settlement amount is to be reported and maintained in separate fields.

The following examples illustrate situations where a TPOC should ***NOT*** be reported in multiple TPOC fields:

- **Single TPOC Example 1:** A settlement was established on 5/16/2011 for $10,000 that includes two components: attorney fees and costs borne by the beneficiary. One check was made out to the attorney for $1,500 and another check was made out to the beneficiary for the remaining $8,500.
- Do **not** report these amounts as two separate TPOCs.
- Do combine the amounts from both checks and report the sum as a single TPOC on the Claim Input File Detail Record.
  - Submit 20110516 in the TPOC Date 1 (Field 80) and submit 00001000000 in the TPOC Amount 1 (Field 81).
  - Do not submit any information in the TPOC fields on the Auxiliary Record.
- **Single TPOC Example 2:** A settlement was established on 8/11/2011 for $12,500 that was set up as installment payments to be paid in increments of $500 each month.
  - Do **not** report each $500 payment as a separate TPOC.
  - Do report this is as a single TPOC on the Claim Input File Detail Record
    - Submit 20110811 in the TPOC Date 1 (Field 80) and submit 00001250000 entered in the TPOC Amount 1 (Field 81)
  - Do not submit any information in the TPOC fields on the Auxiliary Record.

Before submitting multiple TPOC Amounts, remember that a TPOC is a single total payment obligation reported **in total** regardless of whether it is funded through a single payment, an annuity, or a structured settlement.

When reporting multiple TPOCs, each TPOC should reflect a separate, different settlement, judgment, award or other payment usually established at different times. As such, the dates in the TPOC Date fields are usually not identical.

- **Multiple TPOC Example:** A medical malpractice case is settled for a single injured party in which two practitioners (two defendants) are involved, and both are covered by the same medical malpractice insurance policy. Two separate settlements were reached under the same policy, one for each defendant. One settlement was established on 5/3/2011 for $5,000 and the other settlement was established on 5/10/2011 for $10,000.
- Report each settlement as a separate TPOC:
  - Submit one settlement on the Claim Input File Detail Record (e.g., submit 20110503 in the TPOC Date 1 (Field 80) and submit 00000500000 entered in the TPOC Amount 1 (Field 81)
  - Submit the additional settlement on the Claim Input File Auxiliary Record (e.g., submit 20110510 in the first TPOC Date (Field 93) and submit 00001000000 entered in the first TPOC Amount (Field 94)

If multiple checks for a single settlement are issued on the same date, do **NOT** report each check as a separate settlement (i.e., as multiple TPOCs). Instead, combine the amounts and enter that sum in the first TPOC Amount field. The following are examples of single settlements:

- Annuity payments
- Structured settlement
- Installment payments

For Section 111 reporting there are five sets of TPOC fields available – one set on the Claim Input File Detail Record, and four sets on the Claim Input File *Auxiliary* Record. Each of these sets of fields includes the associated TPOC Date, TPOC Amount, and Funding Delayed Beyond TPOC Start Date for each separate TPOC associated with a claim report. Please see the field descriptions in the file layouts in the NGHP User Guide Appendices Chapter (Appendix A) for the Detail and Auxiliary Records. TPOC fields on the Claim Input File Auxiliary Record only need to be used if the RRE has more than one, distinct, TPOC to report for a claim. Information for reporting using add, delete and update transactions can be found in other sections of this Guide. Please note: The date submitted in the Funding Delayed Beyond TPOC Start Date fields should never be the same as what is reported in the TPOC Date fields.

TPOC fields are “positional”, in the sense that the first settlement/judgment/award/other payment TPOC Amount should be reported on the Detail Record in Fields 80-82, the second settlement/judgment/award/other payment TPOC Amount should be placed in the first available TPOC Date and Amount on the Auxiliary Record starting at Field 93, and so on. Then, all subsequent reports regarding the claim should maintain the position/field the TPOC was previously reported in (e.g., if TPOC Date 2 and TPOC Amount 2 were previously reported with incorrect data, the corrected data for these fields would be placed in the TPOC Date 2 and Amount fields on the update transaction).

In the Claim Input File, the Auxiliary Record must always directly follow the corresponding Detail Record for the claim report. The Detail Record is always required for a claim report on the Claim Input File. The Auxiliary Record is only included if needed.

Once an RRE has submitted an Auxiliary Record and it has been accepted by the BCRC, the RRE must continue to include the Auxiliary Record with all subsequent update transactions for that claim unless there are no additional claimants to report and the second through fifth TPOC Amounts are subsequently zeroed out (TPOC 2-5 amounts reported previously but subsequently appropriately removed by the RRE).

Table 6-4 and Table 6-5 illustrate how to submit TPOCs on initial and subsequent claim reports. Directly following each of these tables is supporting text that explains each row in the table.

Table 6-4: Submitting TPOCs on an Initial Claim Report

Submission	Number of TPOCs	Action Type Field 3	TPOC Reported in	TPOC Date and Amount Reported in Field(s)
Initial	1	0 (Add)	Claim Input File Detail Record	TPOC in Fields 80 & 81
Initial	More than 1	0 (Add)	• Claim Input File Detail Record • Claim Input File Auxiliary Record	• 1st TPOC in Fields 80 & 81 • 2nd & subsequent TPOCs beginning in Field 93

Submitting TPOCs on Initial Claim Submissions:

- **To report *only one* TPOC Amount on an initial claim report**, submit an add transaction with a ‘0’ in the Action Type (Field 3) of the Claim Input File Detail Record, and place the TPOC Date and Amount in Fields 80 and 81 of the Claim Input File Detail Record. Do not include an Auxiliary Record.
- **To report *more than one* TPOC Amount on an initial claim report**, submit an add transaction with a ‘0’ in the Action Type of the Claim Input File Detail Record. Place the first TPOC Date and Amount in Fields 80 and 81 of the Claim Input File Detail Record, and place the second and any subsequent TPOC Dates and Amounts in the corresponding TPOC fields on the Claim Input File Auxiliary Record.

Table 6-5: Submitting TPOCs on a Subsequent Claim Report

Submission	Number of TPOCs	Action Type Field 3	TPOC Reported in	TPOC Date and Amount Reported in Field(s)
Subsequent	1	2 (update)	Claim Input File Detail Record	Fields 80 & 81
Subsequent	2 (1 previously reported; 1 being added)	2 (update)	• Claim Input File Detail Record • Claim Input File Auxiliary Record	• 1st (previously reported) TPOC in Fields 80 & 81 • 2nd (new) TPOC in Field 93 & 94
Subsequent	3 (2 previously reported, 1 being added)	2 (update)	• Claim Input File Detail Record • Claim Input File Auxiliary Record	• 1st (previously reported) TPOC in Fields 80 & 81 • 2nd (previously reported) TPOC in Field 93 & 94 • 3rd (new) TPOC in Field 96 & 97
Subsequent	More than 5 (5 previously reported, 1 or more being added)	2 (update)	• Claim Input File Detail Record • Claim Input File Auxiliary Record	• 1st (previously reported) TPOC in Fields 80 & 81 • The 2nd through 4th (previously reported) TPOCs should be reported beginning in Field 93 & 94. • The 5th (previously reported) & all new TPOCs should be added together and this total should be reported in TPOC Amount 5. The most recent TPOC Date should be reported in TPOC Date 5.

Submitting TPOCs on Subsequent Claim Submissions

- **To report a *new first* TPOC Amount on a subsequent claim report (record already exists with ORM information only)**, submit an update transaction with a '2' in the Action Type of the Claim Input File Detail Record, and place the TPOC Date and Amount in Fields 80 and 81.
- **To report a *new, additional second* TPOC Date and Amount after the first TPOC Amount has been reported,** submit an update transaction with '2' in the Action Type of the Claim Input File Detail Record, and place the previously reported first TPOC Date and Amount in Fields 80 and 81 of the Claim Input File Detail Record. Then include an Auxiliary Record, and place the new, additional second TPOC Date and Amount in Fields 93 and 94 on the Auxiliary Record.
- **To report a *new, additional third* TPOC Date and Amount after a previous claim submission**, submit an update transaction with '2' in the Action Type of the Detail Record, place the previously reported first TPOC Date and Amount in Fields 80 and

81 of the Detail Record. Then include an Auxiliary Record and place the second previously reported TPOC Date and Amount in Fields 93 and 94 on the Auxiliary Record. Then place the new, additional third TPOC Date and Amount in Fields 96 and 97 on the Auxiliary Record. To add subsequent TPOCs, follow the same procedure.

- **To report *new additional* TPOCs for a single claim, after a previous claim submission containing 5 TPOCs,** submit an update transaction with '2' in the Action Type of the Detail Record. Place the first TPOC Date and Amount in Fields 80 and 81 of the Detail Record. The second through 4th TPOCs should be reported beginning in Field 93 & 94. Add the sixth and subsequent TPOC Amounts to the amount reported in TPOC Amount 5 on the Auxiliary Record, put the most recent TPOC Date in TPOC Date 5.
- This necessary circumstance will be *very* rare. Remember: you are NOT to report every payment related to individual medical services, procedures and supplies – if you have assumed responsibility to pay such charges directly you should be reporting ORM. If you have a TPOC settlement, judgment, award, or other payment which includes a direct payment to a provider, physician, or other supplier on behalf of a beneficiary, you should report such payment(s) as part of the total TPOC amount.
- Remember that the total TPOC Amount is reported after settlement, judgment or award, or other payment, not individual installment payments if these were made as part of the servicing of a TPOC.

Table 6-6 illustrates how to correct or remove TPOC information. Directly following this table is supporting text that explains each row in the table.

Table 6-6: Correcting or Removing TPOCs

Required Result	Action Type (Field 3)	TPOC Date and Amount Reported in Fields
Correct a previously submitted TPOC	2	• Corrected TPOC Amount and/or Date in the same field previously reported. • All other TPOCs reported previously should be placed in their original locations
Remove a previously submitted TPOC	2	• Place zeroes in the erroneous TPOC Amount and Date in the same field previously reported • All other TPOCs reported previously should be placed in their original locations
Remove TPOCs 2-5	2	• 1st TPOC Date and Amount in the same field previously reported (i.e. fields 80 and 81 on the Claim Input File Detail Record) • If there are no additional claimants reported on the Auxiliary Record, do not submit the Claim Input File Auxiliary Record, or submit it with all zeroes or spaces as applicable.

Required Result	Action Type (Field 3)	TPOC Date and Amount Reported in Fields
Remove all TPOCs with no ORM on any Claim Records that were submitted in error	1	Place all values previously submitted in the same field previously reported.

Correcting or Removing TPOCs

- **To *correct a previously submitted TPOC* Amount or Date,** submit an update transaction with a value of '2' in the Action Type on the Claim Input File Detail Record and place the *corrected* TPOC Amount and/or Date in the same field it was reported in previously. All other TPOCs reported previously for the claim should be reported with their original values and in their original locations on the Claim Input File Detail or Auxiliary Records, as applicable.
- **To *remove an erroneous TPOC* reported on a prior submission** (in essence, deleting that one TPOC but keeping any others), you will submit an update transaction with a value of '2' in the Action Type on the Claim Input File Detail Record. You will place zeroes in the TPOC Date and Amount in the same fields in which they were reported previously on the Claim Input File Detail (or Auxiliary) Record. Subsequent submissions for the claim report should continue to preserve the positional nature of these fields – the removed TPOC should continue to be reported with zeroes on any subsequent report for the claim.
- **To *remove or zero out all TPOCs 2 – 5* on the Auxiliary Record (where no additional claimants were previously reported on the auxiliary record),** resubmitting the Claim Input File Detail Record as an update, without including the Auxiliary Record, will have the same effect as submitting the Auxiliary Record with zeroes in the TPOC fields. Then, if you have nothing else to report on the Auxiliary Record, subsequent updates do not need to include that record.
- **To *remove all previously reported TPOCs* on a previously accepted Claim Input File Detail Record with no ORM (ORM Indicator = 'N'),** resubmit the Claim Input File Detail Record as a delete. In this case, the previously accepted record should never have been sent (i.e., the RRE submitted it in error, there was no settlement, judgment, award, or other payment [including assumption of ORM]). Do not submit an update record with no ORM and no TPOC as this will result in the receipt of the CJ07 error. **Note**: As a reminder, if ORM ends, you must submit ORM Indicator is 'Y' and the applicable ORM Termination Date to indicate that.

Please Note: If you are unsure how to correctly submit TPOC information, contact your EDI Representative for assistance.

6.7 Initial File Submission

This section describes the requirements for your initial file submission. The initial file submission is the first Section 111 Claim Input File you will submit on or about your production "live" date, after data exchange testing has been successfully completed.

Instructions for necessary retroactive reporting are described below (see “File Submission Example 3B”, and following).

The information in this section also applies to DDE submitters, Remember, however, that for DDE submitters, information to be reported is submitted on a claim by claim basis through the Section 111 COBSW rather than via an aggregated electronic file.

To begin reporting for Section 111, you must create and send a file that contains information for all claims *where the injured party is or was a Medicare beneficiary*, ***and where medicals are claimed and/or released (or the settlement, judgment, award, or other payment had the effect of releasing medicals).***

A TPOC (or “Total Payment Obligation to the Claimant”) single payment obligation is reported in total regardless of how payment is made—as a single payment, an annuity, or a structured settlement—and the TPOC amount is determined without regard to the “ongoing responsibility for medicals” (or ORM) if the RRE has assumed ORM.

The subject claims are those which are addressed/resolved (or partially addressed/resolved) through either (1) a no-fault insurance or workers’ compensation settlement, judgment, award, or other payment with a TPOC Date on or after October 1, 2010, or (2) through a liability insurance (including self-insurance) settlement, judgment, award, or other payment with a TPOC Date on or after October 1, 2011, regardless of the date for your first file submission, whether assigned or made via DDE. Claim reports with earlier TPOC Dates will be accepted but are not required.

In other words, for claims only involving payment due to a TPOC settlement, judgment or award, or other payment, you only need to submit a Section 111 report if the settlement, judgment, award, or other payment date is on or after October 1, 2010 (no-fault and workers’ compensation), or on or after October 1, 2011 (liability). See the Claim Input File Detail Record Layout in the NGHP User Guide Appendices Chapter (Appendix A), Field 80, for an explanation of how to determine the TPOC Date.

You must also report on claims for which the RRE has ORM (ongoing responsibility for medicals) as of January 1, 2010 and subsequent, *even if* the assumption of responsibility occurred prior to January 1, 2010. Where the assumption of ongoing responsibility for medicals occurred prior to January 1, 2010, and continued on or through January 1, 2010, reporting is required. In addition, ORM that was in effect on or after January 1, 2010 must be reported even if ORM was terminated prior to your initial reporting date.

See Section 6.4, Section 6.5 and Section 6.9 for specific exceptions related to Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, or workers’ compensation. See 6.4 for Reporting Threshold requirements.

The following table provides a set of examples related to your initial Section 111 submission. However, it is not intended as an all-inclusive list of reporting requirements.

Table 6-7: Initial File Submission Examples

No.	Situation	Additional Facts	Section 111 Report	Rationale
1A	A Medicare beneficiary is injured by slipping and falling in a retail store. The owner of the store is covered by a general liability policy. A one-time payment is made to the Medicare beneficiary and the insurer has no ongoing obligation for additional medical payments for the beneficiary.	The beneficiary files a claim with the insurer of the liability policy. A settlement is signed by both parties on June 3, 2011; there is no court involvement.	No report of settlement for Section 111	The liability insurance "Total Payment Obligation to the Claimant" (TPOC) Date is prior to October 1, 2011. See Field 80 on the Input File Detail Record for further information on the TPOC Date. Remember that TPOC information/date is reportable without regard to responsibility/lack of responsibility for ongoing medicals.
1B	Same basic facts as 1A	The beneficiary sues. A settlement for $10,000 is signed by both parties on June 3, 2011. However, the settlement requires court approval, which is not obtained until October 10, 2011.	Report settlement for Section111	The liability "Total Payment Obligation to the Claimant" (TPOC) Date is on or after October 1, 2011 and the TPOC Amount meets the reporting threshold for the TPOC Date timeframe (greater than $5000). See Field 80 and 81 on the Claim Input File Detail Record layout for further information on the TPOC Date and Amount. Remember that the TPOC date/information is reportable without regard to responsibility/lack of responsibility for ongoing medicals.

No.	Situation	Additional Facts	Section 111 Report	Rationale
2A	A Medicare beneficiary is injured on the job on February 15, 2009, and files a workers' compensation claim. Workers' compensation assumes responsibility (including a requirement to pay pending investigation) for the associated medicals.	The claim is still open; workers' compensation continues to have responsibility for the medicals on and after January 1, 2010. There is no settlement, judgment, award, or other payment aside from the assumption of responsibility for medicals.	Report ongoing responsibility for medicals for Section 111	The RRE has assumed ongoing responsibility for medicals (ORM). The ORM exists as of January 1, 2010, or later. See Section 6.9 for exceptions and information regarding termination of workers' compensation ORM.
2B.	Same basic facts as 2A	There was a judgment or award for $50,000 by the WC court issued on June 23, 2010. This judgment or award left the medicals open.	Report the Section111 ORM. You are not required to report the judgment or award. (However, if a workers' compensation TPOC amount established prior to 10/1/2010 is reported along with an ORM, the TPOC will not be rejected.)	See 2A for why the ongoing responsibility for medicals is reported. The workers' compensation settlement, judgment, award, or other payment, which was separate from the ongoing responsibility for medicals, is not required to be reported because the applicable TPOC date is prior to October 1, 2010.

No.	Situation	Additional Facts	Section 111 Report	Rationale
3A	A Medicare beneficiary is injured in an automobile accident on September 15, 2009. The beneficiary files a claim with the other driver's insurer (or with his own if it is a no-fault state). The insurer opens a claim and assumes responsibility for ongoing medicals associated with the claim under the "med pay" portion of the policy (which has a cap of $5,000) and is no-fault insurance as defined by CMS. The med pay cap is reached as of December 15, 2009.		Do not report the ORM under Section 111.	ORM terminated prior to January 1, 2010.
3B	Same basic facts as 3A	The beneficiary's medicals exceed the cap and/or he/she has other alleged damages. The insurer settles with the beneficiary for $50,000 under the liability (bodily injury) component of the policy on October 3, 2011.	Do not report ORM under Section 111. Do report the $50,000 liability TPOC	No-fault insurance ORM terminated prior to January 1, 2010. The liability TPOC date is on or after October 1, 2011 and exceeds the reporting threshold.
3C	Same basic facts as 3A/3B **except that state law requires life-time medicals.**	Same additional facts as 3B	Report both the no-fault ORM and the liability settlement on separate claim reports, by insurance type.	No-fault ORM continued in effect January 1, 2010. The liability TPOC date was on or after October 1, 2011 and exceeded the reporting threshold.

Your initial Claim Input File must contain "retroactive" reporting for:

- All no-fault insurance and workers' compensation TPOC amounts meeting the reporting thresholds described in Section 6.4 with TPOC dates on or after October 1, 2010

- All liability insurance (including self-insurance) TPOC amounts meeting the reporting thresholds described in Section 6.4 with TPOC dates on or after October 1, 2011
- All ongoing responsibility for medicals (ORM) for no-fault insurance, workers' compensation and liability insurance (including self-insurance) that you assumed on or after January 1, 2010
- All reports of ORM that you initially assumed prior to January 1, 2010, and that continued at least through January 1, 2010.

All records on your initial file will be "add" records and have a value of zero ('0') in the Action Type (Field 3).

Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation RREs were to submit their initial production Section 111 Claim Input File during the **first calendar quarter (January - March) of 2011** during their assigned submission time slot, unless the RRE had no applicable claim information to report. For RREs that selected the DDE option, reporting commenced on July 11, 2011 (See Section 10.5). When you register for Section 111 reporting and select a file submission method, you will be assigned a 7-day window for your quarterly file submission. Your required production live date is the first day of your first quarterly submission time slot and your initial Claim Input File must be received inside that 7 day window. Those RREs registering for DDE will be in production reporting status immediately after completing the registration process and must begin production reporting of applicable claims on the Section 111 COBSW, including the retroactive reporting described above.

You must submit a TIN Reference File prior to or with your initial Claim Input File submission.

6.8 Quarterly File Submissions

The information in this section also applies to DDE submitters, Remember, however, that for DDE, information to be reported is submitted on a claim by claim basis through the Section 111 COBSW rather than via an aggregated electronic file.

"Add" and "Update" Records:

For File submitters: Once your initial quarterly Claim Input File has been submitted, your subsequent, quarterly Claim Input File submissions must include records for any new claims where the injured party is a Medicare beneficiary as "add" records. These will reflect settlements, judgments, awards, or other payments (including assumption of ORM) since the last file submission.

Your file may also contain "update" records for previously submitted claims, if critical claim information that will affect Medicare claims payment or recovery processes needs to be corrected or changed. See 6.8.4 (Event Table) for information about what will trigger an update record submission.

Claim records submitted in error:

If a record was submitted and accepted by the BCRC with a '01' or '02' disposition code in a previous file submission, but that claim record should never should have been sent—the RRE submitted it in error (e.g., there was no settlement, judgment, award, or other payment [including assumption of ORM]) – then you must submit a "delete" record on your next quarterly Claim Input File to remove that erroneous claim information from Medicare systems and databases.

Quarterly update files must also include the resubmission of any records found in error on the previous file, with the necessary corrections made. Since the original claim record was not accepted by the BCRC, corrected records are to be sent with the same action type given on the original record. **Note: RREs may now submit multiple files in a single quarter. Please see 6.8 for more information.**

Response File Processing:

Response file processing will be discussed in detail, in Section Chapter 7 (: Claim Response File) of this guide, but please note that a record is considered accepted by the BCRC if the corresponding response record is returned with a disposition code of '01' or '02'.

Individual NOT a Medicare Beneficiary:

If an individual was not a Medicare beneficiary at the time responsibility for ongoing medicals was assumed for that individual, the RRE must monitor the status of that person and report when he or she becomes a Medicare beneficiary, unless responsibility for ongoing medicals has terminated before Medicare program participation is established. The Query File can be used to monitor for an injured party's Medicare coverage (See Section Chapter 8 (: Query Files.)

New TINs or Office Codes:

If you are reporting any *new* TINs or Office Codes on your Claim Input File, be sure to also submit a TIN Reference File with records for each new TIN/Office Code combination, either prior to or along with the quarterly Claim Input File submission that includes the new TIN/Office Code information.

No new information to report during quarterly submission:

If you have no new information to supply on a quarterly update file, you **may, but are not required,** to submit an "empty" Claim Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count. When submitting an empty file, no TIN Reference File is required. But if one is submitted it will be accepted and processed. Note that for empty Claim Input Files no Claim Response File is generated.

See also, Sections 6.8, 6.9 and 6.10 for specific exceptions related to Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, or workers' compensation. See Section 6.4 for Reporting Threshold requirements.

6.8.1 Add

An "add" is a record submitted to the BCRC for a new claim, one that was either not previously submitted, or that was submitted but not accepted with a '01 or '02'

disposition code. An add transaction could be for a new claim settled since your last quarterly report, a claim resubmitted due to errors with the original submission, or a claim where the RRE had earlier assumed ongoing responsibility for medicals and the injured party has now become covered by Medicare.

An “add” record or transaction is identified by a placing a ‘0’ (zero) in the Action Type (Field 3) of a Claim Detail Record.

Example 1: An RRE has been submitting production Section 111 Claim Input Files and has received and processed the last quarter’s responses from the BCRC. A liability insurance claim not previously submitted has a settlement, judgment, award, or other payment. The RRE will submit the information for the new claim as an add record on its next quarterly file submission.

Example 2: An RRE has been submitting production Section 111 Claim Input Files and has received and processed the last quarter’s responses from the BCRC. A claim on the RRE’s previous quarter’s file submitted as an add record included significant errors and received an ‘SP’ disposition code, with the errors listed on the response record. The RRE corrects the claim and resubmits it as an add record on its next quarterly file submission.

Example 3: An RRE has been submitting production Section 111 Claim Input Files and has received and processed the last quarter’s responses from the BCRC. Subsequently, the RRE determines (through its own ongoing monitoring procedures) that an injured party on a claim where the RRE has ongoing responsibility for medicals (ORM) under Section 111 has become covered by Medicare. The RRE submits the claim for this individual as an add record on its next quarterly file submission.

6.8.2 Delete

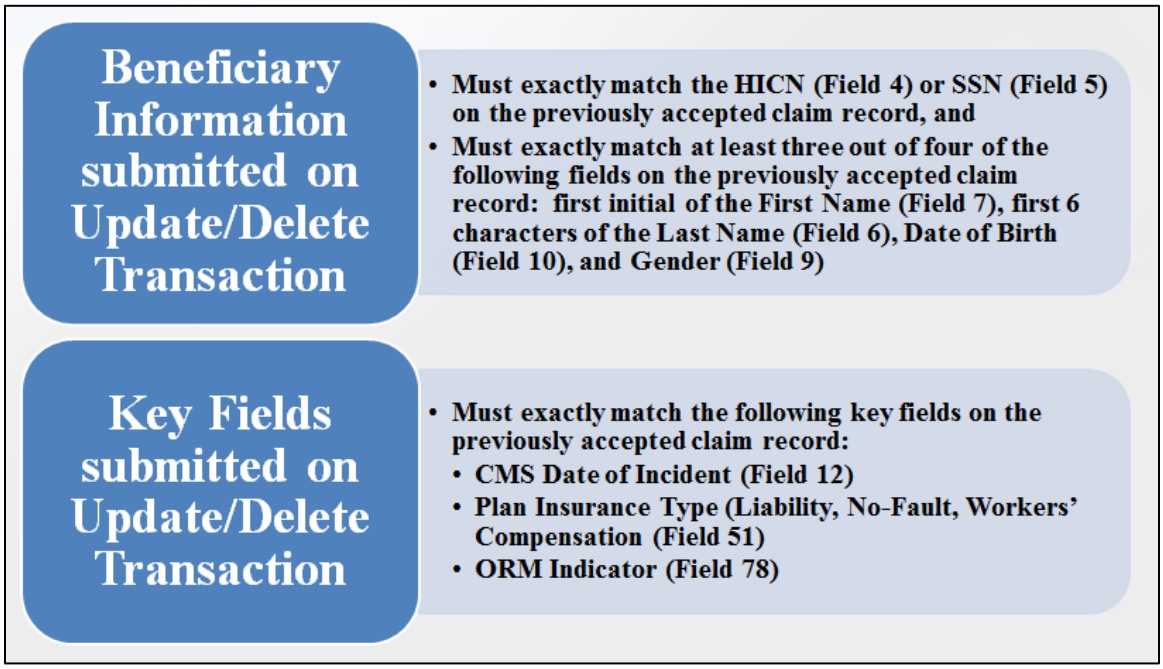
A “delete” record or transaction is identified by placing a ‘1’ in the Action Type (Field 3) of a Claim Detail Record.

A delete transaction is sent to remove reporting information previously sent to the BCRC. Records accepted by the BCRC receive a ‘01’ or ‘02’ disposition code in the Claim Response File you receive from the BCRC. If an add transaction did not result in the generation of one of these two disposition codes, there’s no need to delete it even if it was previously sent in error – there is no need to send a delete record for a record for which you previously received a ‘03’.

Delete transactions should be needed only under rare circumstances. But if you discover a severe error affecting many records on a Section 111 file transmitted to the BCRC, please immediately contact your EDI Representative to discuss the steps that should be taken to correct it.

In order to successfully delete a previously submitted and accepted Claim Input File Detail Record, the BCRC must be able to match the beneficiary information and key fields submitted on the delete transaction to the corresponding information on the previously accepted claim record. Please see Figure 6-2.

Figure 6-2: Matching Criteria (Delete)



Deleting Erroneous Record Submissions

Record deleting actions are used in two situations. First: if the original record should never have been sent in the first place.

Example: A claim record was submitted for a liability claim with a settlement, judgment, award, or other payment on an RRE's previous quarterly file submission and was accepted with a '02' disposition code. Subsequently the RRE discovers an internal system error and realizes that this claim did not in fact have a settlement, judgment, award, or other payment. On its next Claim Input File, the RRE sends a delete record for the claim, with the values for the key fields listed above, all other claim information submitted previously on the add record, and places a '1' in the Action Type. The BCRC accepts the record, deletes the claim information from internal Medicare files and returns a '01' disposition code for the delete record.

Correcting Key Fields – Delete/Add

The second situation in which a record should be deleted is when you need to correct a previously submitted and accepted key field. In this situation, the RRE must send a delete record with the key information that matches the *previously accepted* add record, followed by a *new add record with the changed information*. This operation is often referred to as the "delete/add" process.

Only perform a delete/add to correct the following previously submitted fields:

- CMS Date of Incident (Field 12)
- Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51)
- ORM Indicator (Field 78)

Do not perform a delete/add to correct or change any other fields. Simply submit an update transaction to correct non-key fields as described in Section 6.8.3 and noted in the Event Table in Section 6.8.4.

NOTE 1: RREs only need to correct the HICN or SSN in cases where an **incorrect person** was submitted and accepted on the input record. HICNs may be changed by the Social Security Administration at times but the BCRC is able to crosswalk the old HICN to the new HICN. Therefore in those instances where the correct person was previously submitted but the person's HICN changes at a later date, the RRE does **not** need to correct the record - updates may continue to be sent under the originally submitted HICN. However, note that in such cases the BCRC will always return the most current HICN on response records, and we encourage RREs to update their systems with the current HICN and use it on subsequent record transmissions. The new HICN may be used on all subsequent transactions without the RRE performing the "delete/add" procedure.

NOTE 2: If a record was previously submitted and accepted with only a SSN, and the RRE obtains the HICN on the response file, the RRE should **not** send a "Delete" and "Add" just to update the beneficiary's information with the newly-identified HICN. The beneficiary's record has already been stored by the BCRC under both the SSN and HICN. However, on subsequent transactions records must be submitted with the individual's HICN.

Example: A record for a liability insurance claim with a settlement, judgment, award, or other payment was submitted on a RRE's previous quarterly file submission and was accepted with a '01' disposition code. Subsequently, the RRE changes the CMS date of incident (DOI) in its internal system.

On its next Claim Input File, the RRE sends a *delete* record for that claim, with the originally submitted values for the key fields listed above, all other claim information originally submitted, and places a '1' in the Action Type. In the same Claim Input File, the RRE sends an *add* record for the claim with the changed information, including the new DOI, and puts a '0' in the Action Type. The BCRC processes both records and on the response file returns a record for each with the applicable disposition code. The original record will be deleted from the BCRC system and the updated record with the new DOI supplied will be added.

6.8.3 Update

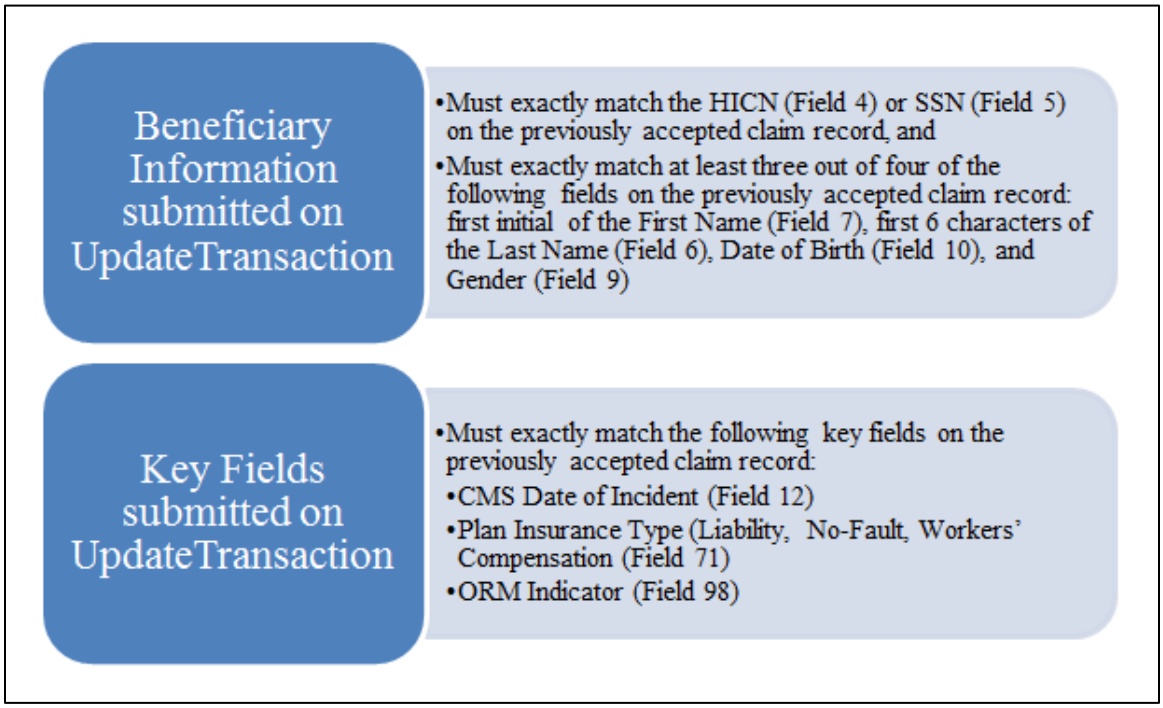
An "update" record or transaction is identified by placing a '2' in the Action Type (Field 3).

An update transaction (Action Type '2') is sent when you need to change information on a record previously submitted and accepted by the BCRC for which you received an '01' or '02' disposition code in your Claim Response File. An update transaction (Action

Type '2') is also sent when you need to submit a new, additional TPOC Amount and Date. See the section on Multiple TPOCs in this guide.

In order to successfully update a previously submitted and accepted Claim Input File Detail Record, the BCRC must be able to match the beneficiary information and key fields submitted on the update transaction to the corresponding information on the previously accepted claim record. Please see Figure 6-3.

Figure 6-3: Matching Criteria (Update)



Update records are submitted under three circumstances.

- When an RRE needs to send the ORM Termination Date to indicate that the responsibility for ongoing medicals has ended (this may be a simple termination or it might be associated with the reporting of a settlement, judgment, award, or other payment TPOC amount/date).
- When a report of ongoing responsibility for medicals has already been submitted and accepted and there is a separate settlement, judgment, award, or other payment TPOC amount/date but the RRE continues to retain ongoing responsibility for medicals.
- To change information critical for use by Medicare in its claims payment and recovery processes.

See the Event Table in Section 6.8.4 for additional information.

If you need to update one of the key fields identified above, follow the "delete-add" process described in the previous section. See the Event Table for additional information.

If you need to update one of these other fields, send an update transaction:

- ICD-9 Diagnosis Codes 1-19 (starting at Field 18 on the Detail Record)

- TIN (Field 52 of the Detail Record)
- TPOC Date1 (Field 80 of the Detail Record)
- TPOC Date 2 -5 (Fields 93, 96, 99, 102 of the Auxiliary Record)
- TPOC Amount 1 (Field 81 of the Detail Record)
- TPOC Amount 2 – 5 (Fields 94, 97, 100, 103 of the Auxiliary Record)
- Claimant 1 Information (Fields 84 – 95 of the Detail Record)
- ORM Termination Date (Field 79)

Updated information for all other fields will be accepted if submitted but changes to other fields do not trigger the update requirement. You may send an update to change other information but it is not required.

Note: If a previous claim report included an Auxiliary Record (additional claimant information or additional TPOCs) you must submit all subsequent updates with an Auxiliary Record - unless the update is, in effect, removing that information from the report (the information on the Auxiliary Record is no longer is applicable to the claim and the RRE is, in effect, removing all of it). Remember that if a previously reported Auxiliary Record is not included on a subsequent update report, the BCRC will assume that the previous information reported on the Auxiliary Record no longer applies to the claim report.

Example 1: An initial claim record was previously submitted by an RRE and accepted by the BCRC for a workers' compensation claim where the RRE assumed ongoing responsibility for medicals (the ORM Indicator Field 78 was submitted with a 'Y'). The RRE's ongoing responsibility for medicals subsequently terminated. In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a '2' in the Action Type (Field 3) and an ORM Termination Date (Field 79) reflecting when the RRE's ongoing responsibility for medicals ended. All other data elements are submitted as they were on the original report, including a 'Y' in the ORM Indicator. Note that an update record is sent to report the ORM Termination Date, not a delete transaction. Also note that the ORM Indicator should be reported with a value of 'Y' on the update record.

Example 2: An initial claim record was previously submitted by an RRE and accepted by the BCRC for a no-fault claim where the RRE assumed ongoing responsibility for medicals (the ORM Indicator Field 78 was submitted with a 'Y'). The no-fault limit of the policy applicable to the claim was provided in the No-Fault Insurance Limit (Field 61). Subsequently, the no-fault limit was reached and the RRE's ongoing responsibility for medicals ended. In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a '2' in the Action Type (Field 3), an ORM Termination Date (Field 79) reflecting when the RRE's ongoing responsibility for medicals ended, and the date the no-fault limit was reached in the Exhaust Date for Dollar Limit for No-Fault Insurance (Field 62). All other data elements are submitted as they were on the original report - including a 'Y' in the ORM indicator.

Example 3: A claim record was previously submitted by the RRE and accepted by the BCRC for a liability insurance claim with a settlement, judgment, award, or other payment information in TPOC Date 1 (Field 80) and TPOC Amount 1 (Field 81). Subsequently, the RRE corrects the TPOC Date 1 (Field 80) in its claim system since an

incorrect date was entered initially. In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a '2' in the Action Type (Field 3) and the corrected TPOC Date 1 (Field 80). All other data elements are submitted as they were on the original report.

Example 4: A claim record was previously submitted by the RRE and accepted by the BCRC for a liability insurance claim with a settlement, judgment, award, or other payment TPOC. The Claim Detail Record submitted reflected ongoing responsibility for medicals (ORM Indicator = 'Y') and included a TPOC Date 1 and TPOC Amount 1 (Fields 80 and 81). Subsequently, an additional settlement, judgment, award, or other payment TPOC is reached with respect to the same claim record. In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a '2' in the Action Type (Field 3) the same amounts submitted previously in TPOC Date 1 and TPOC Amount 1 on the detail record. The new, additional TPOC date and amount in TPOC Date 2 and TPOC Amount 2 (Fields 93 and 94) is sent on an Auxiliary Record immediately following the Detail Record. All other data elements are submitted as they were on the original report, including a 'Y' in the ORM Indicator on the detail record.

6.8.4 Event Table

Table 6-8: Event Table is to be used by RREs and their agents to help determine when, and how, to send records on the Claim Input File.

RRE Action reflects Claim Input File record submissions to be included in the next quarterly Section 111 filing after the Event occurs. Please see the Claim Input File record layouts in Appendix A for the requirements for each specific field; this Event Table describes the record submission requirements in only general terms.

No report is made for liability insurance (including self-insurance), no-fault insurance, or workers' compensation claims in which the injured party is a Medicare beneficiary until there is a settlement, judgment, award, or other payment (either ORM or TPOC, or both).

The phrase "previously reported and accepted" means that a claim record was previously submitted and the BCRC sent back a disposition code of '01' or '02' on the corresponding Claim Response File Detail Record. See also the definition of Total Payment Obligation to Claimant (TPOC) Amount and Date in Fields 80 and 81 of the Claim Input File Detail Record in Appendix A - it also applies to the TPOC Date and Amount fields on the Auxiliary Record.

Only perform a delete/add transaction to correct the following previously submitted fields:

- **CMS Date of Incident (Field 12)**
- **Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51)**
- **ORM Indicator (Field 78)**

Do not perform a delete/add transaction to correct or change any other fields. Simply submit an update transaction to correct non-key fields as described in Section 6.8.3 and noted in the Table 6-8 below.

NOTE: RREs only need to correct the HICN or SSN in cases where an **incorrect person** was submitted and accepted on the input record. HICNs may be changed by the Social Security Administration at times but the BCRC is able to crosswalk the old HICN to the new HICN. Therefore in those instances where the correct person was previously submitted but the person's HICN changes at a later date, the RRE does **not** need to correct the record - updates may continue to be sent under the originally submitted HICN. However, note that in such cases the BCRC will always return the most current HICN on response records, and we encourage RREs to update their systems with the current HICN and use it on subsequent record transmissions. The new HICN may be used on all subsequent transactions without the RRE performing the "delete/add" procedure.

Table 6-8: Event Table

Event	RRE Action
Single Report – No ORM • Claim with settlement, judgment, award, or other payment TPOC date on or after **10/1/2010 (no-fault or workers' compensation) or 10/1/2011 (liability insurance including self-insurance**). • Total TPOC Amount reaches/meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 6.4). TPOCs with earlier dates may be included at the RREs discretion. • No ORM	Send Add Record: • '0' (add) in the Action Type • 'N' in the ORM Indicator • TPOC Dates and Amounts

Event	RRE Action
Initial Report – with ORM and TPOC (**same** insurance type, same injuries) • Claim with settlement, judgment, award, or other payment TPOC date on or **after 10/1/2010 (no-fault or workers' compensation) or 10/1/2011 (liability insurance including self-insurance**). • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 6.4). TPOCs with earlier dates may be included at the RREs discretion. NOTE: Total TPOC Amount may be less than the threshold, at the RREs discretion, since ORM is being reported in this case. • RRE has or had ORM on or after **1/1/2010** and meets the Workers' Compensation reporting threshold for ORM if applicable (that is, the ORM does not meet one or more of the specified criteria for it to be excluded from reporting). • Both ORM and TPOC are for the same insurance type and apply to all injuries reported.	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • TPOC Dates and Amounts
Initial Report – with ORM and TPOC (**same** insurance type, ORM for one injury, TPOC and no ORM for another injury) Two (or more) injuries claimed/alleged on the same claim under the same insurance type. • RRE assumes ORM for one (or more) alleged injury, but not all injuries claimed/alleged. • RRE settles with a TPOC settlement, judgment, award, or other payment for other alleged injuries claimed and/or released, not covered by ORM. • ORM and TPOC meet the reporting thresholds documented in Section 6.4. • Both ORM and TPOC are for the **same** insurance type, policy, and claim number but for different injuries.	Send Two Add Records First Add Record for ORM: • '0' (add) in the Action Type • ICD-9 Diagnosis Code(s) describing all alleged injuries/illnesses for which ORM was assumed • 'Y' in the ORM Indicator • No TPOC Dates and Amounts • Second Add Record for TPOC: • '0' (add) in the Action Type • ICD-9 Diagnosis Code(s) describing all alleged injuries claimed and/or released related to the TPOC • 'N' in the ORM Indicator • TPOC Dates and Amounts Both records may be sent in the same file submission in any order.

Event	RRE Action
Initial Report – with ORM and TPOC (**different** insurance types) • Claim with settlement, judgment, award, or other payment TPOC date on or **after 10/1/2010 (no-fault or workers' compensation) or 10/1/2011 (liability insurance including self-insurance**). • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 6.4). TPOCs with earlier dates may be included at the RREs discretion. • RRE has or had ORM on or after 1/1/2010 and meets the Workers' Compensation reporting threshold for ORM if applicable (that is, the ORM does not meet one or more of the specified criteria for it to be excluded from reporting). • ORM and TPOC are for **different** insurance types (Example: an automobile accident where for the same injured party ORM is covered under the no-fault coverage of the policy and TPOC is covered under the bodily injury/liability coverage on the same policy).	Send **Two** Add Records: ORM Record • '0' (add) in the Action Type • 'Y' in the ORM Indicator • No TPOC Date(s) or Amount(s) • Applicable Plan Insurance Type (i.e. 'D' for No-Fault) • TPOC Record • '0' (add) in the Action Type • 'N' in the ORM Indicator • TPOC Date(s) and Amount(s) • Applicable Plan Insurance Type (e.g., 'L' for Liability) Both records can have the same Injured Party information, Date of Incident, Policy Number, Claim Number, etc., as applicable
Initial Report – with ORM, no TPOC • Claim with no settlement, judgment, award, or other payment TPOC but the RRE has or had ORM on or after **1/1/2010** and meets the Workers' Compensation reporting threshold for ORM if applicable	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • Zeroes in TPOC Date and Amount
Termination of ORM – No TPOC • Claim with ORM previously reported and accepted by the BCRC • ORM ends and there is no settlement, judgment, award, or other payment TPOC Amount.	Send Update Record: • '2' (update) in the Action Type • **'Y' in the ORM Indicator** • Zeroes in TPOC Date and Amount • Date ORM ended in ORM Termination Date field • Include Auxiliary Record if previously submitted and information on it still applies

Event	RRE Action
Termination of ORM – With TPOC • Claim with ORM previously reported and accepted by the BCRC • ORM is ended and there is also a settlement, judgment, award, or other payment TPOC Amount for the same injuries • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 6.4). TPOCs with earlier dates may be included at the RREs discretion. Total TPOC Amount may be less than the threshold at the RREs discretion.	Send Update Record: • '2' (update) in the Action Type • **'Y' in the ORM Indicator** • TPOC Date and Amount • Date ORM ended in ORM Termination Date • Include Auxiliary Record if previously submitted and information on it still applies
Initial Report and ORM Termination in One Report – No TPOC • Claim with no settlement, judgment, award, or payment TPOC amount • With ORM assumed on or after **1/1/2010** and meets the Workers' Compensation reporting threshold for ORM if applicable • Claim **not** previously reported and accepted • ORM has ended prior to the initial report of the ORM	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • Zeroes in TPOC Date and Amount • Date ORM ended in ORM Termination Date

Event	RRE Action
Initial Report and ORM Termination in One Report – With TPOC (same insurance type, same injuries) • Claim with settlement, judgment, award, or other payment TPOC amount • With ORM assumed on or after **1/1/2010** and meets the Workers' Compensation reporting threshold for ORM if applicable • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 6.4). TPOCs with earlier may be included at the RREs discretion. Total TPOC Amount may be less than the threshold at the RREs discretion. • Both ORM and TPOC are for the same insurance type and injuries. • Claim **not** previously reported and accepted • ORM has ended prior to initial report but on or after **1/1/2010**. (ORM could have ended because no-fault benefits were exhausted or termination in connection with the TPOC, etc.)	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • TPOC Date and Amount • Date ORM ended in ORM Termination Date

Key Field Change (Correction) – Delete/Add Transaction
• Claim record was previously reported and accepted
• One or more of the following **Key** fields was changed after the initial claim record was submitted and accepted:
  • CMS Date of Incident (Field 12)
  • Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51)
  • ORM Indicator (Field 78)
	Send a Delete Followed by an Add
	1) Send Delete Record:
	  • '1' (delete) in the Action Type
	  • All other fields with matching values sent on the original record
	2) Send Add Record:
	  • '0' (add) in the Action Type
	  • Corrected/updated information for all other fields
	  • Include Auxiliary Record if previously submitted and information on it still applies
	  • All other information previously submitted and updated, as required

Event	RRE Action

Changed Information (other than Key Field information)
• Claim previously submitted and accepted
• One or more of the following fields has changed after the initial claim record was submitted and accepted:
  • ICD-9 Diagnosis Codes 1-19
  • TIN (Field 52)
  • TPOC Dates 1 - 5
  • TPOC Amounts 1 - 5
  • Claimant 1 Information (Fields 84 - 95)
  • ORM Termination Date (Field 79)
	Send Update Record:
	• '2' (update) in the Action Type
	• Include Auxiliary Record if previously submitted and information on it still applies
	• Changed values for
	  • ICD-9 Diagnosis Codes 1-19
	  • TIN (Field 52)
	  • TPOC Dates 1 - 5
	  • TPOC Amounts 1 – 5
	  • Claimant 1 Information (Fields 84 - 95)
	• Same values previously reported for
	  • Injured Party SSN/HICN (Fields 4/5)
	  • CMS Date of Incident (Field 12)
	  • Plan Insurance Type (Field 51)
	  • ORM Indicator and Termination Date (Fields 78 and 79)
	  • Same or updated information for all other fields

Delete/Cancel Prior Record Submission • Claim record was previously reported and accepted • Record was submitted in error – it should not have been sent due to an RRE system problem or other issue	Send Delete Record • '1' (delete) in the Action Type • All other fields with matching values sent on the original record
Record Rejected with Errors Submitted claim record returned with an 'SP' disposition code in the corresponding response file record (not accepted, rejected by the BCRC due to errors)	Correct errors Send record with previously submitted Action Type (Add, Update or Delete)
Record in Process at BCRC Submitted claim record returned with a '50' disposition code in the corresponding response file record (still being processed by the BCRC)	Resubmit same record with most current claim information
Ongoing Monitoring – Injured Party Becomes Covered by Medicare • Claim record previously submitted and rejected by the BCRC with a '51' or '03' disposition code • RRE continues to have ORM • Injured party becomes covered by Medicare	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • TPOC Dates and Amounts as applicable

Event	RRE Action
Reporting Additional TPOC Amounts • Claim record was previously reported and accepted (including a TPOC amount) • With or without ORM • An **additional** settlement, judgment, award, or other payment TPOC is reached with respect to the same Section 111 claim record. For example, if a claim to an insurer includes both no-fault insurance (as defined by CMS) and liability insurance, TPOCs associated with the no-fault and liability insurance would be reported on separate add records with different Plan Insurance Types (Liability, No-Fault, Workers' Compensation) in Field 51. Note that this instruction only applies where there are multiple TPOCs for the same record, for the same insurance type, policy, claim number, etc.	Send Update Record • '2' in the Action Type • New/additional TPOC Date and Amount in the next available set of TPOC fields on the Auxiliary Record (not cumulative amount but rather the amount of the additional TPOC) • Same values previously reported for • Injured Party SSN/HICN (Fields 4/5) • CMS Date of Incident (Field 12) • Plan Insurance Type (Field 51) • ORM Indicator and Termination Date (Fields 78 and 79) • Same or updated information for all other fields • See the Section 6.5 on Reporting Multiple TPOCs for more information

ORM Reopens or Change in ORM Termination Date
• Claim previously submitted and accepted with ORM Indicator (Field 78) = 'Y', non-zero ORM Termination Date (Field 79)
• RRE reopens or reassumes ORM or otherwise changes ORM Termination Date
	Send Update Record
	• '2' in the Action Type
	• Same values previously reported for
	  • Injured Party SSN/HICN (Fields 4/5)
	  • CMS Date of Incident (Field 12)
	  • Plan Insurance Type (Field 51)
	  • 'Y' in ORM Indicator (Field 78)
	• Zeroes in the ORM Termination Date (Field 79) if no ORM Termination Date established (to "reopen" the ORM on the record) or submit new/corrected date in ORM Termination Date. An ORM Termination Date in the future may be submitted if known and firmly established.
	• Same or updated information for all other fields

Event	RRE Action

ORM Ends for One Injury, Continues for Another
• Claim previously submitted and accepted with ORM Indicator (Field 78) = 'Y', non-zero ORM Termination Date (Field 99), multiple ICD-9 Diagnosis Codes reflecting ORM assumed for multiple injuries
• RRE's ORM subsequently ends for one or more injuries but ORM continues on the claim for one or more other injuries
	Send Update Record
	• '2' in the Action Type
	• Same values previously reported for
	  • Injured Party SSN/HICN (Fields 4/5)
	  • CMS Date of Incident (Field 12)
	  • Plan Insurance Type (Field 51)
	  • 'Y' in ORM Indicator (Field 78)
	• Zeroes in the ORM Termination Date (Field 79)
	• ICD-9 Diagnosis Codes reflecting injuries for which the RRE continues to have ORM (No ICD-9 Diagnosis Codes related to injuries for which ORM ended)
	• Be sure to submit a valid value, not spaces, in ICD-9 Diagnosis Code 1 (Field 18)
	• Same or updated information for all other fields
	• **Note:** Submit ORM Termination Date on subsequent update only when ORM ends for **all** alleged injuries for which the RRE assumed ORM

6.8.5 Claim Input File Reporting Do's and Don'ts

Here are some helpful reminders for RREs to be successful in submitting Section 111 claim information.

Disposition Code '51'

- RREs will receive this disposition code on their response file if the information submitted to identify a beneficiary is not matched to the information CMS has on file for Medicare beneficiaries. The BCRC must find an exact match on the Health Insurance Claim Number (HICN) or Social Security Number (SSN). Then at least three out of four of the following fields must be matched exactly: first initial of the First Name, first 6 characters of the Last Name, Date of Birth (DOB), and Gender. Please note: The matching process depends on the quality of the data submitted.
- If a disposition code of '51' is received, the RRE must validate all the information submitted in the injured party information fields.
- The RRE must check to ensure that data entered in these fields was both correct *and correctly submitted*.
  - Example: On a Claim Input File Detail Record, the RRE submits correct beneficiary information. However, the RRE submits the Last Name in the First Name field and submits the First Name in the Last Name field. When this record is processed by the BCRC, a match will not be found on Medicare's records. Although the BCRC will find an exact match on the HICN, only two of the remaining four data elements (Date of Birth and Gender) exactly match Medicare's records. The response record will be returned with a disposition code '51'. The RRE must then check the data submitted in the injured party fields to

ensure that it was both correct and correctly submitted. The RRE must make the appropriate corrections and resubmit the claim report on their next scheduled file submission.

- RREs are advised to obtain a valid Gender from the injured party or the query process prior to submitting claim reports to help ensure they receive a match.
- When using the query process, please be aware that when an RRE submits a query transaction with a '0' (unknown) in the Gender field, the system will change this value to '1' to attempt to get a match. If this record is not matched to a Medicare beneficiary, the Query Response File Record is returned with a disposition code of '51' and the converted '1' in the Gender field. The RRE should NOT use the Gender value returned in this case. The RRE must validate the correct Gender and all other injured party information prior to submitting the Claim Input File Detail Record.
- If the RRE has ensured that the data was submitted correctly and the claim does not have ORM, the record does not have to be resubmitted, unless subsequent TPOC payments are made.
- If the RRE has ensured that the data was submitted correctly, and the claim has ORM, the RRE must monitor the status of the injured party in order to determine if/when the injured party becomes covered by Medicare. Monitoring of the injured party must continue as long as the ORM remains open. When the individual becomes covered by Medicare, the RRE must submit a Claim Detail Record.
- If the ORM terminates and is not subject to reopening or otherwise subject to further request for payment, monitoring of such individuals may cease. One final query or claim report should be submitted after an ORM Termination Date has been reached, to ensure the RRE obtains the most up-to-date information on the individual before they stop checking.

Delete Transactions

Delete transactions should only be submitted to:

- Remove an entire record that was created in error (delete record), or
- To **correct** a key field (i.e., CMS Date of Incident (Field 12), Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51), ORM Indicator (Field 78)). In this case, delete the transaction and then add the correction. Do not perform a delete/add to correct or change any other fields. Simply submit an update transaction to correct non-key fields.

RRE Address Validation

- RREs are encouraged to pre-validate insurer/TPA addresses using postal verification software or online tools available on the USPS website pages such as http://zip4.usps.com/zip4/welcome.jsp. RREs should try to use standard abbreviations and attempt to limit data submitted in these fields and adhere to USPS standards. The address validation enhancements in place will "scrub" addresses submitted on the TIN Reference File using USPS standards, and we recommend that RREs also attempt to meet these standards, to improve results. Although NGHP DDE reporters

do not submit TIN Reference Files, they do submit the same TIN information online. It is recommended that DDE reporters also pre-validate RRE addresses.

Reporting ICD-9 Diagnosis Codes

- Be sure to submit ICD-9 Diagnosis Codes (starting in Field 18) that exactly match the first 5 positions of a code on the list of valid ICD-9s (See Section 6.2.5 - ICD-9-CM and ICD-10-CM Codes). *Partial codes are not accepted*.
- Retain leading and trailing zeroes but do not add leading or trailing zeroes if they are not shown for the code in the list of valid ICD-9s.
- *Do not include the decimal point*, but be sure to include any digits that may follow the decimal point. For example, ICD-9 diagnosis code 038.42 should be submitted as 03842. Records with any of these invalid entries will be rejected with the errors C105-C1023, depending on the fields in error.

Reporting ORM Information

- As soon as ongoing responsibility for medicals (ORM) is established, report the ORM as an add record (ORM Indicator set to 'Y'). Do not wait until the ORM has terminated before reporting the existence of ORM. If there is no established end date, a value of all zeroes must be entered in the ORM Termination Date.
- To terminate the ORM record, submit an update record with the ORM Termination Date and a 'Y' in the ORM Indicator field. Remember, if the claim ever involved ORM, it should be reported with a 'Y' in the ORM Indicator, even after ORM has terminated. Do not send a delete transaction when the RRE's ORM ends.
- When no-fault limits are reached and ORM is terminated on a no-fault insurance claim report (Plan Insurance Type 'D'), be sure to submit an ORM Termination Date (Field 79) in addition to the Exhaust Date for Dollar Limit for No-Fault Insurance (Field 62). Failure to submit an ORM Termination Date may result in improper denial of medical claims submitted to Medicare after no-fault limits are reached.

ORM Indicator/TPOC Threshold

- Add records submitted with 'N' in the ORM Indicator (Field 78) must contain TPOC Amounts that exceed the applicable reporting thresholds. There is no TPOC threshold applied to no-fault claims. However, there is no circumstance under which an RRE would submit 'N' in the ORM Indicator and no TPOC information. This will result in rejection of the record with the CJ07 error. Information is to be reported ***after*** the RRE assumes ORM or ***after*** there is a TPOC settlement, judgment, award, or other payment.

Reporting the Self-Insured Type

- The value in the Self Insured Type (Field 45) must correspond to the value in the Self Insured Indicator (Field 44). The Self Insured Type must be 'I' (Individual) or 'O' (Other than Individual) if the Self Insured Indicator is 'Y' (Yes). The Self Insured Type must be blank if the Self Insured Indicator is 'N' (No) or blank. Records submitted incorrectly will be rejected with a CS02 error.

Reporting the Plan Insurance Type

- Values in the Plan Insurance Type (Field 51) must correspond with the Self Insured Indicator (Field 44). If the Plan Insurance Type is 'E' (Workers' Compensation) or 'L' (Liability), the Self Insured Indicator must equal 'Y' (Yes) or 'N' (No). If the Plan Insurance Type is 'D' (No-Fault), the Self Insured Indicator must equal 'N' or blank.
- Note: If you are a liability insurer (self-insurer) that is administered as a no-fault plan, the Plan Insurance Type must be entered as 'L' (Liability).
- Please ensure that the Plan Insurance Type is entered correctly when the RRE is assuming ORM. Analysis of early files has identified numerous records where an RRE is mistakenly reporting Liability with an ORM indicator of "Y". Assuming ORM in Liability cases is not a common occurrence. While there are instances where this may be correct, RREs should review their information to be certain they have provided the correct Plan Insurance Type/ORM indicator combination.

Reporting the Policy Number

- The Policy Number (Field 54) is a required data element. In the case of self-insurance where the RRE has no policy number associated with the claim, this field must be filled with all zeroes - it may not be left blank. Records submitted with all blanks in the Policy Number field will be rejected with the error CP04.

6.9 Ongoing Responsibility for Medicals (ORM) - When and What to Report

The following section reviews the requirements for reporting the assumption or establishment of ORM for no-fault insurance, liability insurance (including self-insurance), and workers' compensation. Information regarding an RRE's reporting for the assumption of ORM has been presented in other sections of the NGHP User Guide. This section provides additional policy information. Please see Table 6-9 for a summarized view of the ORM reporting requirements for no-fault, liability insurance (including self-insurance), and workers' compensation.

The reference to "ongoing" is not related to "ongoing reporting" or repeated reporting of claims under Section 111, but rather to the RRE's responsibility to pay, on an ongoing basis, for the injured party's (Medicare beneficiary's) medicals associated with the claim. This often applies to no-fault and workers' compensation claims, but may occur in some circumstances with liability insurance (including self-insurance).

The trigger for reporting ORM is the assumption of ORM by the RRE – when the RRE has made a determination to assume responsibility for ORM, or is otherwise required to

assume ORM – not when (or after) the first payment for medicals under ORM has actually been made. Medical payments do not actually have to be paid for ORM reporting to be required.

If an RRE has assumed ORM, the RRE is reimbursing a provider, or the injured party, for specific medical procedures, treatment, services, or devices (doctor's visit, surgery, ambulance transport, etc.). These medicals are often being paid by the RRE as they are submitted by a provider or injured party. Payments like these are NOT reported individually under Section 111 *as TPOCs (see Section 6.4 for more information on TPOCs)*. Even when ORM payments are aggregated and paid to a provider or injured party in a single payment, this aggregation does not constitute a TPOC just because it was paid in a "lump sum". For example, an injured party might incur medical expenses in excess of no-fault insurance (such as automobile Personal Injury Protection (PIP) or Med Pay) shortly after an automobile accident. The RRE may reimburse the provider of these medical services or injured party via one payment since the no-fault limit was already reached, but the payment still reflects ORM, *not* a TPOC settlement, judgment or award.

The dollar amounts for ORM are not reported, just the fact that ORM exists or existed. When ORM ends (a no-fault limit is reached, or the RRE otherwise no longer has ORM, etc.) the RRE reports an ORM Termination Date. If there was no TPOC settlement, judgment, award, or other payment related to the claim (an actual settlement for medicals and/or lost wages, etc.), **you do not need to report a TPOC Amount on the claim with ORM.** You can just submit the ORM Termination Date.

Reporting for ORM is not a guarantee by the RRE that ongoing medicals will be paid indefinitely or through a particular date; it is simply a report reflecting the responsibility currently assumed. Ongoing responsibility for medicals (including a termination date, where applicable) is to be reported without regard to whether there has also been a separate settlement, judgment, award, or other payment outside of the payment responsibility for ongoing medicals.

It is critical to report ORM claims with information regarding the cause and nature of the illness, injury, or incident associated with the claim. Medicare uses the information submitted in the Alleged Cause of Injury, Incident or Illness (Field 15) and the ICD-9 Diagnosis Codes (starting in Field 18) to determine what specific medical services claims, if submitted to Medicare, should be paid first by the RRE and considered only for secondary payment by Medicare. The ICD-9 codes provided in these fields must provide enough information for Medicare to identify medical claims related to the underlying Injury, Incident or Illness claim reported by the RRE.

6.9.1 ORM Additional Technical Requirements - When and What to Report

For claims where the liability insurance (including self-insurance), no-fault insurance, or workers' compensation RRE has assumed ongoing responsibility for medicals – ORM - associated with the claim, **two** reports under Section 111 are required. The first report is when the RRE assumes ORM. The second is when ORM terminates. In the first report the RRE provides basic information about the claim, including a 'Y' in the ORM Indicator, and the no-fault insurance policy limit (if applicable). In the second report, the

RRE provides the ORM Termination Date (date when ongoing responsibility for medicals has ended) and, if a no-fault case, the date the no-fault policy limit was exhausted (if applicable). The first report will be an add record and the second report will be an update record. The second report will also have a 'Y' in the ORM Indicator.

The RRE does not provide a TPOC Date and TPOC Amount on either ORM report unless there was a settlement, judgment, award, or other payment TPOC amount in addition to the ORM.

NOTE: In situations where the injured party is a Medicare beneficiary, there has been a settlement, judgment, award, or other payment, and the RRE has not assumed ORM, only **one** Section 111 claim report is required after the Total Payment Obligation to Claimant (TPOC) date. The TPOC Date is the date the obligation was established. Please see the description of these fields in the Claim Input File Detail and Auxiliary Record layouts, and the additional explanation in the NGHP User Guide Policy Guidance Chapter (Section 2 - Introduction and Important Terms). The RRE provides the TPOC Date (as defined in Field 80 of the Claim Input File Detail Record) and the TPOC Amount (as defined in Field 81 of the Claim Input File Detail Record) when such a settlement, judgment, award, or other payment occurs. The field descriptions in the record layout explain how to calculate the TPOC Date and TPOC Amount. Note that there is one set of TPOC fields provided on the Detail Record and four more sets of TPOC fields provided on the Auxiliary Record to allow for reporting of multiple TPOC settlements, judgments, awards, or other payments. See also Section 6.4 Reporting Thresholds and Section 6.5 Reporting Multiple TPOCs for more information on TPOC reporting requirements.

If ORM is started and ended within the same calendar quarter or prior to the current reporting quarter before the initial report of ORM was made, all the reporting may be done on one record. Example: In January, a workers' compensation claim is opened for an injured employee who is a Medicare beneficiary. The injury is relatively minor, and the ORM terminates in March. Depending upon its specific quarterly submission date, the RRE may only need to report the claim once after the claim is closed and ORM has ended. This record would include a "Y" in the ORM Indicator and an ORM Termination Date. This scenario of reporting both the assumption of ORM and termination of ORM on one add record may also occur if no-fault insurance policy limits are reached shortly after or on the date of incident. A TPOC Date and Amount would also be included in this single report if there was also a separate settlement, judgment, award, or other payment outside of the termination of the ORM.

A value of 'Y' in the ORM Indicator means that the claim includes or included ORM. CMS's key for claims processing actions is knowing an RRE reported ORM. **The ORM Indicator is not an on/off switch. Once "on" (a value of "Y"), it stays "on".** To turn ORM "off" as of a certain date, the RRE sends an ORM Termination Date on an update record, but leaves the ORM Indicator set to 'Y". This will indicate that the RRE had ORM from the date of the incident through the ORM Termination date. Zeroes in the ORM Termination Date indicate that there is yet no established end date for the ORM.

For claims with ORM, an RRE does NOT make a Section 111 report each time it pays for a medical service for the injured party. The actual amounts paid for specific medical services under the assumption of ORM are not reported. It is only the assumption of

coverage that is reported, the fact that ORM has been assumed for a particular claim for a particular period of time.

RREs are NOT to report the same, unchanging ORM claim information each quarter. Once the first report is made and they get back a positive response that the record was accepted they do not need to report again until the ORM has terminated, or there is separate TPOC information to be reported, or another event occurs that triggers the need for an update (see the Event Table in Section 6.8.4).

In most cases ORM reporting will require two Section 111 reports – one to add the report of ORM, and another to report the termination of ORM. Note: there are two exceptions to the need for two claim reports for ORM. The first is when assumption and termination of ORM are reported in the same record. The second is when the RRE needs to update or delete previously submitted information and correct records due to a change in important information sent on the prior record. Please refer to the Event Table in Section 6.8.4 to determine what would trigger an additional update or delete. Example: The RRE reported an incorrect diagnosis for the description of the injury. Since this could have a material effect on Medicare's claims processing and/or recovery efforts, the RRE will need to submit an *update record* to correct that error. Remember that a delete transaction would be sent only if the original record was entirely in error and that record needs to be completely removed from Medicare's databases/systems.

With respect to ORM, a determination that a case is "closed" or otherwise inactive does not automatically equate to a report terminating the ORM. If the ORM is subject to reopening or otherwise subject to a further request for payment, the record submitted for ORM should remain open. (Medicare beneficiaries have a continuing obligation to apply for all no-fault or workers' compensation benefits to which they are entitled.) Similarly, if a file would otherwise be "closed" due to a "return to work" and no additional anticipated medicals, a report terminating the ORM should not be submitted as long as the ORM is subject to reopening or otherwise subject to an additional request for payment. For certain states which require a workers' compensation or no-fault claim be left open for medicals indefinitely, this second type of report may never be submitted. In addition, ***RREs are not to submit an expected, anticipated, or contingent ORM Termination Date. ORM Termination Dates should only be submitted when the termination of ORM is certain. Future-dated ORM Termination Dates can be dated no more than 6 months after the file submission date (the ORM Termination Date cannot be more than 6 months greater than the file submission date).***

Note: There is a limited "Special Exception" regarding reporting termination of ORM:

- Assumption of ORM typically occurs with respect to no-fault insurance (as defined by CMS—see Record Layout descriptor for CMS's definition) or workers' compensation. Because this may involve all levels of injury, the above rule could result in the continuation of open ORM records even where, as a practical matter, there is no possibility of associated future treatment. An example might be a relatively minor fully healed flesh wound that occurred in a State where workers' compensation requires life-time medicals. To address this situation, RREs may submit a termination date for ORM if they have a signed statement from the injured

individual's treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or otherwise subject to a claim for further payment.

- If, in fact, there is a subsequent reopening of the claim and further ORM, the RRE must report this as an update record with zeroes or a new date in the ORM Termination Date (Field 79).

CMS uses information regarding ORM for both claims processing and potential recoveries. Providers, physicians, and other suppliers are to bill primary payers such as liability insurance (including self-insurance), no–fault insurance, and workers' compensation prior to billing Medicare, although Medicare may pay conditionally if "prompt payment' as defined by CMS rules is not made by the liability insurance (including self-insurance), no-fault insurance, or workers' compensation coverage. Conditional payments are subject to recovery if primary payment responsibility is subsequently established.

If the individual was not a Medicare beneficiary at the time ORM was assumed, the RRE must monitor the status of that individual and report when that individual becomes a Medicare beneficiary, unless the RRE's ORM has terminated before the individual becomes a Medicare beneficiary. (However, monitoring of such individuals may cease before they become a Medicare beneficiary if the standard for ORM termination set forth in "'Special Exception' regarding reporting termination of ORM" above is met.)

Where payment is made pending investigation, the RRE must report this as an assumption of ongoing responsibility for medicals. If ORM terminates upon completion of the investigation, the termination of ORM must be reported.

See Section 6.5.2 for thresholds related to exemptions for reporting workers' compensation claims with ORM.

NOTE: Originally, the BCRC was unable to accept an ORM Termination Date (Field 79) less than 30 days after the CMS Date of Incident (Field 12). RREs were instructed to default the ORM Termination Date to accommodate this limitation. This is no longer necessary. RREs should provide the actual ORM Termination Date as defined in the field description in the NGHP User Guide Appendices Chapter (Appendix A). RREs are not required to go back and change/correct records reported previously with the "default" ORM termination dates.

Self-Reporting ORM Outside the Section 111 Reporting Process is NOT Required

With the implementation of Section 111 Mandatory Insurer Reporting, a "self-report" for certain ongoing responsibility for medicals (ORM) is no longer needed:

- RREs must report ORM through the Section 111 reporting process at their next submission window (or during the subsequent window if taking advantage of an applicable grace period).
- RREs should no longer "self-report" to the BCRC the exhaustion of benefits.
- RREs must report the termination or exhaustion of ORM through the Section 111 reporting process.

Making an Immediate Report of ORM Termination

Since CMS uses reports of ORM in the Medicare claims adjudication process, it is imperative that any ORM Terminations be reported promptly. See Section 6.10 and Section 6.9 for related timely ORM reporting requirements.

If an RRE wishes to make an immediate report of ORM Termination *prior to* its next quarterly file submission, a representative from the RRE may contact the BCRC Call Center and report an ORM Termination Date for a single claim report previously submitted and accepted via a Section 111 Claim Input File. However, the RRE must also submit the report of ORM Termination on its next quarterly Claim Input File submission.

Do not make this report of ORM Termination to your EDI Representative. The BCRC Call Center may be contacted Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired. RREs using the DDE option do not need to contact the BCRC Call Center. They may update a claim originally entered via DDE with an ORM Termination Date at any time by using the Section 111 COBSW.

Note: RRE self-reports do not eliminate the RRE's Section 111 reporting obligations. Where an RRE self-reports an ORM termination date, the RRE must still report the termination through the Section 111 reporting process.

6.9.2 Ongoing Responsibility for Medicals (ORM) Reporting Summary

No-Fault Insurance ORM

No-fault insurance ORM that existed or exists on or after January 1, 2010 must be reported.

Liability Insurance ORM

Liability Insurance (including Self-Insurance) ORM that existed or exists on or after January 1, 2010 must be reported.

Workers' Compensation ORM

Workers' Compensation ORM that existed or exists on or after January 1, 2010 must be reported. However, workers' compensation ORM claims are excluded from reporting indefinitely if they meet *ALL* of the following criteria.

Workers' Compensation (Plan Insurance Type "E") ORM exclusion:

- The claim is for "medicals only;"
- The associated "lost time" is no more than the number of days permitted by the applicable workers' compensation law for "medicals only" (or 7 calendar days if applicable law has no such limit);
- All payment(s) has/have been made directly to the medical provider; AND
- Total payment for medicals does not exceed $750.00

Note: Once a workers' compensation ORM claim is excluded from reporting, it does not need to be reported unless the circumstances change such that it no longer meets the exclusion criteria listed. In other words, the claim does not need to be reported unless

something other than medicals is included, there is more lost time, a payment is made to someone other than a provider, and/or payments for medicals exceed $750.

This exclusion does not act as a "safe harbor" for any other obligation or responsibility of any individual or entity with respect to the Medicare Secondary Payer provisions.

Table 6-9: ORM Reporting Requirements Summary

Insurance Type	Reportable ORM Dates
No-Fault ORM	Existed or exists on or after 1/1/2010
Liability insurance (including self-insurance) ORM	Existed or exists on or after 1/1/2010
Workers' Compensation ORM	Existed or exists on or after 1/1/2010

6.10 Special Qualified Reporting Exception for ORM Assumed Prior to January 1, 2010, Where Such ORM Continues as of January 1, 2010

The general rule is that aside from the "'Special Exception' regarding reporting termination of ORM", a report terminating the ORM should not be submitted as long as the ORM is subject to reopening or otherwise subject to an additional request for payment.

QUALIFIED EXCEPTION: However, for ORM assumed prior to January 1, 2010, if the claim was actively closed or removed from current claims records prior to January 1, 2010, the RRE is not required to identify and report that ORM under the requirement for reporting ORM assumed prior to January 1, 2010.

If such a claim is later subject to reopening with further ORM, it must be reported with full information, including the original Date of Incident (DOI), as defined by CMS. Thus, when looking back through claims history to create your initial Claim Input File report to include claims with ORM that was assumed prior to January 1, 2010, the RRE needs only look back to the status of claims as of January 1, 2010. If the claim was removed from the RRE's current/active claim file prior to January 1, 2010, it does not need to be reported unless it is reopened. However, RREs may report ORM on claims they consider closed prior to January 1, 2010 at their discretion. "Older" ORM claims will not be rejected.

Table 6-10 includes some illustrative examples of how to report ORM assumed prior to January 1, 2010.

Table 6-10: Qualified Exception Examples: ORM Assumed Prior to January 1, 2010

Claim Example	Reporting Requirement
RRE assumed ORM March 5, 2009 and is still making payments for medicals as of 1/1/2010.	Report this claim since payment for medicals continues as of January 1, 2010. The claim is on the active claim file as of January 1, 2010 and subsequent.
RRE assumed ORM March 5, 2009, is not making payments as of January 1, 2010 but didn't consider the claim "closed" until after January 1, 2010. As of January 1, 2010 and subsequent, the claim is still "technically" open and ORM continues, but the RRE hasn't made a payment since August of 2009. The RRE considers this claim actively closed and removed it from their file of current open/active claims **on February 15, 2010.**	Report this claim since the claim was not actively closed or removed from current claim records until ***after*** January 1, 2010. The claim was on the active claim file as of January 1, 2010.
RRE assumed ORM March 5, 2009, is not making payments as of January 1, 2010 and considered the claim "closed" prior to January 1, 2010. As of January 1, 2010 and subsequent, the claim is still "technically" open and ORM continues, but the RRE hasn't made a payment since August of 2009. The RRE considers this claim actively closed and removed it from their file of current open/active claims **on October 1, 2009.**	Do not report this claim since it was actively closed or removed from current claims records prior to January 1, 2010. The claim was not on the active claim file as of January 1, 2010.

6.11 Additional Requirements

Note: This information concerns both those RREs choosing a file submission method and DDE submitters. With the exception of information that pertains specifically to the physical creation and transmission of electronic files, DDE submitters must submit the same data elements and adhere to essentially the same Section 111 reporting requirements as file submitters. DDE submitters enter claim information manually on the Section 111 COBSW. File submitters transmit this same information in the form of an automated electronic file.

6.11.1 Technical Requirements

- Individual reimbursements paid for specific medical claims submitted to an RRE, paid through the RRE's ORM for the claim do not constitute separate TPOC amounts. The TPOC Date is not necessarily the payment date or check issue date. Instead, the TPOC Date is the date the payment obligation was established. This is the date the obligation is signed if there is a written agreement unless court approval is required. If court approval is required it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement it is the date the payment (or first payment if there will be multiple payments) is issued. Please refer to the definition of the TPOC Date and TPOC Amount in Fields 80 and 81 of the Claim

Input File Detail Record in the NGHP User Guide Appendices Chapter (Appendix A).

- Claim Input Files must include properly formatted header, detail and trailer records, as defined in the file layouts provided in this User Guide.
- Claim Input Files must be submitted on a quarterly basis, four times a year, unless an RRE has nothing to report in a particular quarterly reporting period.
- Claim Input Files must be submitted within the RRE's assigned, 7-day submission period each quarter. This file submission time slot will be assigned after successful registration for Section 111 reporting.
- Claim Input Files submitted within 14 calendar days before the start of a quarterly submission period are considered early submissions for that quarter. The file will be held until the start of the submission period.
- RREs must register on the Section 111 COB Secure Web site (COBSW) and complete testing prior to submission of production Claim Input Files. After the registration has been processed by the BCRC, the RRE will receive an e-mail with a profile report. The profile report will contain information submitted during registration for verification purposes, the assigned 7-day file submission time slot, and the assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). The last page of the profile report must be signed by the RRE's Authorized Representative and returned to the BCRC before testing can begin. Once testing requirements have been passed, the RRE ID status will be updated by the BCRC to "production" and production Claim Input File submission may commence.

  NOTE: Entities who are RREs for purposes of the Section 111 liability insurance (including self-insurance), no-fault insurance, or workers' compensation are not required to register if they will have nothing to report. For example, if an entity is self-insured (as defined by CMS) solely for the deductible portion of a liability insurance policy but it always pays any such deductible to its insurer, who then pays the claim, it may not have anything to report.

  Some entities may not register initially because they have no expectation of having claims to report. However, they **must** register in time to *allow a full quarter for testing* if they find they have a reasonable expectation that they will soon have to report.
- RREs will be assigned a Section 111 RRE ID during registration, which is to be used on all submitted files.
- Except for DDE RREs, Claim Input File testing is required before an RRE ID can be set to a production status and production files submitted. See Section Chapter 9.
- Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation RREs that elected to use one of the file submission methods were required to commence production Section 111 Claim Input File reporting during the **first calendar quarter (January - March) of 2011** in their assigned submission time slot. RREs with only liability insurance (including self-insurance) TPOCs to report must commence production Section 111 Claim Input File reporting during the first calendar quarter (January – March) of 2012 in their assigned submission time slot.

- RREs that have elected the DDE reporting option were required to commence reporting on the Section 111 COBSW effective July 11, 2011. DDE claim record submissions are required within 45 calendar days of the TPOC Date of a reportable TPOC Amount, or within 45 calendar days of assuming ORM. An ORM Termination Date submission must be made via DDE within 45 calendar days of the ORM Termination Date. RREs using the DDE option must complete their Section 111 registration on the COBSW. There is no file submission testing performed for DDE.
- Foreign RREs (RREs that have no IRS-assigned TIN and/or US mailing address) must register using the COBSW and commence production reporting as specified above.
- Group Health Plan (GHP) file submissions for Section 111 may not be mixed with liability, no-fault, and workers' compensation (Non-Group Health Plan) Claim Input File submissions.
- An RRE (or agent) may not mix data originating from multiple RRE IDs in a single input file from the sending RRE (or agent). Each RRE ID with quarterly data to report must submit a separate unique Section 111 input file. Only one input file may be submitted by an RRE ID per quarter, unless instructed otherwise by the RRE's EDI Representative. In cases of exceptional circumstances – such as when one RRE absorbs the operations of another RRE – obtain and follow the direction of the surviving RRE's EDI Representative.
- All reporting is to be through electronic file exchanges or Direct Data Entry (DDE) as described in this User Guide and the Section 111 COBSW User Guide.
- Files may be submitted via the Section 111 COBSW user interface using Hypertext Transfer Protocol over Secure Socket Layer (HTTPS) or the Section 111 SFTP server via Secure File Transfer Protocol (SFTP). As an alternative, RREs with large amounts of data may submit via Connect:Direct (formerly known as NDM) via the CMSNet. RREs with very few claim reports to make per year may choose to submit claim information using the DDE method on the Section 111 COBSW. See Section 10.5 for details.
- RREs must implement a process in their claims review procedures to determine whether an injured party is a Medicare beneficiary. RREs must submit either the Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN) for the injured party on all Section 111 Claim Input File Detail Records. RREs are only to report information about Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award, or other payment). If an individual you report on cannot be identified as a Medicare beneficiary based upon the information submitted, CMS will reject the record for that individual. The Applied Disposition Code (Field 27) on the corresponding Claim Response File Detail Record will be returned with a value of '51' indicating that the individual was not matched to a Medicare beneficiary based on the submitted information.
- It is not acceptable for an RRE to send information on every claim record without first attempting to establish the injured party's Medicare status. CMS will monitor ongoing Claim Input File submissions to make sure that RREs have implemented a

procedure to reasonably identify an injured party as a Medicare beneficiary, and are not simply submitting their entire set of claims to satisfy Section 111 reporting requirements. Please refer to the description of the query process elsewhere in this guide.

- RREs must store any Medicare Health Insurance Claim Number (HICN) returned on response files in their internal systems. RREs are required to use these HICNs on future transactions. An individual's SSN may be submitted initially if the RRE does not have an individual's HICN, but once a HICN is returned for that individual it must be used going forward on all subsequent record submissions. The HICN is CMS's identifier for all Medicare beneficiaries and is the "gold standard" ID data element for matching purposes. RREs are encouraged to obtain HICNs from those injured parties who are Medicare beneficiaries (the HICN is printed on the Medicare Card) and use them, rather than SSNs, whenever possible.
- A TIN Reference File must be submitted prior to or with the initial Claim Input File containing records for each plan TIN submitted in Field 52 of Claim Input File Detail Records. All Plan TIN and Office Code/Site ID Codes submitted in Fields 52 and 53 of the Claim Input File Detail Records must have a *corresponding TIN/Office Code combination* on the TIN Reference File. Subsequent Claim Input Files do not need to be accompanied by a TIN Reference File, unless 1) changes to previously submitted TIN/Office Code information must be submitted, or 2) new TIN/Office Code combinations have been added.
- Quarterly Claim Input Files must include records for any new claims involving a Medicare beneficiary, reflecting settlement, judgment, award, or other payment since the last file submission.
- However, if the settlement, judgment, award, or other payment is within 45 days prior to the start of the RRE's 7-day file submission time slot, the RRE may submit that claim on the next quarterly file. This grace period allows the RRE time to internally process the newly addressed/resolved (or partially addressed/resolved) claim information prior to a Section 111 reporting submission. For example, if there is a reportable TPOC with a TPOC Date of May 1, 2011, and the RRE's file submission period for the second calendar quarter of 2011 is June 1-7, 2011, then the RRE may delay reporting that TPOC claim until its third calendar quarter file submission (September 1-7, 2011). On the other hand, if this TPOC Date is April 1, 2011, the RRE must include this claim in the second calendar quarter file submission, during June 1-7, 2011. Records not received on time will be processed, but marked as late, and will be accounted for in subsequent compliance tracking. A code indicating a late submission was received will be placed in the first available Compliance Flag field (Fields 38 – 47) of the corresponding Claim Response File Detail Record. See Section 7.4 for more information on timeliness and compliance flags.
- All subsequent quarterly update files must include pertinent updates/corrections/deletions to any previously submitted records - see the instructions in Table 6-8.
- Quarterly update files must include the resubmission of all records found to be in error on the previous file, with corrections made.

- If you have no new information to supply on a quarterly update file, you **may (but are not required to)** submit an "empty" Claim Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count. No Claim Response File is returned for empty files. When submitting an empty file, no TIN Reference File is required. If one submitted, however, it will be accepted and processed.
- E-mail notifications will be sent to the RRE's Account Manager after a file has been received by the BCRC and when a response file has been transmitted or is available for download. Using the Section 111 COBSW, all users with login IDs associated to the RRE ID may monitor the status of submitted files.
- Each Detail Record on the Claim Input File must contain a unique Document Control Number (DCN) developed and generated by the RRE. This DCN is required so that response records can be matched to input records and any problems more easily identified and resolved. The DCN can be any format of the RRE's choosing as long as it is not more than 15 alpha-numeric characters (as defined in the record layout). Most of CMS's current data exchange partners use some form of a Julian date and a counter as their DCN. The DCN only needs to be unique within a single file. The same DCN does not need to be maintained and submitted on subsequent update or delete records. A new DCN may be generated for the claim report each time it is submitted in subsequent files. For RREs using the DDE option, DCNs are automatically generated by the system.
- The BCRC will create the Claim Response File directly after all input records have completed processing, or by no later than 45 days after the Claim Input File receipt date if some records are still being processed. RREs can expect to receive Claim Response Files within 48 days of their Claim Input File receipt date.

Chapter 7: Claim Response File

In general, this information concerns both those RREs choosing a file submission method, and DDE submitters. But for DDE submitters, remember that response information is returned by the BCRC on a claim by claim basis and displayed on the Section 111 COBSW. File submitters receive this same information in the form of an automated electronic file.

For Section 111 reporting, file submitters send a completed Claim Input File to the COBC. If it is successfully transmitted without severe errors, in return the BCRC will send you a Claim Response File. The Claim Response File specifications are in the NGHP User Guide Appendices Chapter V (Appendix C).

If the BCRC can match the injured party identified by the RRE to a Medicare beneficiary, based upon the information submitted on the input record, the response record will always contain the Medicare HICN for that individual. You *must* save the HICN returned for Medicare the beneficiary and use it on any subsequent Claim Input File records for that beneficiary. The HICN is CMS's official beneficiary identifier, and is always the preferred data element for use in matching your information to Medicare beneficiaries.

The response file will be returned to you within 48 days of receipt of your input file using the same method you used to send your input file (HTTPS, SFTP, or Connect:Direct). The response file contains a header record, followed by a file of detail records corresponding to each record you submitted on your input file, followed by a trailer record that contains a count of the detail records being returned to you. This count does not include the header and trailer records.

The detail response record contains "supplied" data, those which the RRE had submitted on the corresponding input record. It also contains "applied" data, field values derived from information on Medicare's general and MSP files

The Claim Response File Detail Records contain:

- The same DCN submitted on the corresponding Claim Input File Detail Record (Submitted DCN Field 2)
- The information the RRE supplied on the input record for the injured party and for the RRE TIN/Office Code:
- Submitted Action Type (Field 3)
- Injured Party HICN (Field 4)
- Submitted Injured Party SSN (Field 5)
- Submitted Injured Party Last Name (Field 6)
- Submitted Injured Party First Name (Field 7)
- Submitted Injured Party Middle Initial (Field 8)
- Submitted Injured Party Gender (Field 9)

- Submitted Injured Party DOB (Field 10)
- Submitted Plan TIN (Field 11)
- Submitted Plan Office Code/Site ID (Field 12)
- Submitted Policy Number (Field 13)
- Submitted Claim Number (Field 14)
- Applied information for the injured party if identified as a Medicare beneficiary, and fields that indicate when and why Medicare is secondary to the other insurance reported on the input record (disposition of '01' and '02'):
- Applied Injured Party HICN (Field 16)
- Applied Injured Party Last Name (Field 18)
- Applied Injured Party First Name (Field 19)
- Applied Injured Party Middle Initial (Field 20)
- Applied Injured Party Gender (Field 21)
- Applied Injured Party DOB (Field 22)
- Applied MSP Effective Date (Field 23)
- Applied MSP Termination Date (Field 24)
- Applied MSP Type Indicator (Field 25)

  You should (but are not required to) use the Applied Injured Party Name, Gender and DOB fields to update your internal system and submit these values on any subsequent transactions for that Medicare beneficiary. You must use the Applied Injured Party HICN to update your internal system and submit this HICN on any subsequent transactions for the injured party/Medicare beneficiary.
- An Applied Disposition Code (Field 27) that indicates the results of processing
- Error codes indicating why the record was rejected for errors (Fields 28 – 37)
- Compliance Flags (Fields 38 – 47) indicating that there were fields that were not reported according to Section 111 requirements or that the record was not submitted on a timely basis.

You must develop processing to appropriately react to the response file. Your own processing of the response file you receive must be finished before submission of your next quarterly Claim Input File.

Disposition codes, Claim Input/Response File error codes, TIN Reference Input/Response File error codes, and compliance flag codes are documented in the NGHP User Guide Appendices Chapter (Appendix F).

7.1 Disposition Codes

The Applied Disposition Code is Field 27 on the Claim Response File Detail Record. Disposition code values are listed in the NGHP User Guide Appendices Chapter (Appendix F) along with the actions (if any) the RRE must take upon receipt of each disposition code.

Every Claim Input File Detail Record will receive a disposition code on the corresponding Claim Response File Detail Record. Records without any errors – those returned with a '01', '02' or '03' disposition code because the injured party was identified as a Medicare beneficiary – only need to be resubmitted under certain circumstances, as specified below. Records that are rejected due to errors receive an 'SP' disposition code and must be corrected and resubmitted. Records concerning an injured party who could not identified as a Medicare beneficiary receive a '51' disposition code. Finally, in the rare case of records that have not finished processing by the time the response file to you is generated, a disposition code of '50' will be returned. Any records with this disposition code must be resubmitted in your next quarterly file submission.

After examining the Disposition Codes received, RREs must take the following actions.

- **'SP' Disposition Code – Record in Error**

  Records returned with an 'SP' disposition code failed BCRC edits due to errors in submitted data. These records **must be corrected and resent on your next quarterly submission,** unless otherwise specified in the error code description. The associated error codes will be placed in Fields 28 - 37. The edits performed and associated error codes are documented in the NGHP User Guide Appendices Chapter (Appendix F).

  Note: RREs should not submit a record known to be missing required data elements. Submitting a record known to be in error will not make the RRE more compliant or serve any other purpose. Prior to submitting claim information, the RRE should obtain all required information, correct all known errors, and then submit the claim record.

- **'51' Disposition Code – Injured Party Not Identified as a Medicare Beneficiary**

  Records returned with a '51' disposition code were not matched to a Medicare beneficiary.

  - RREs must validate the injured party information used for matching (HICN/SSN, name, date of birth, and gender) to make sure it was correctly gathered, entered and submitted in the proper fields.
  - As long as you confirm that the injured party information you originally submitted was completely correct, and the claim does NOT represent ongoing responsibility for medicals (no ORM), you do not have to submit this claim again for Section 111 reporting unless or until subsequent TPOC payments are made.
  - ***If the claim represents ongoing responsibility for medicals (ORM), you must continue to monitor the Medicare status of the injured party*** as long as the responsibility for ORM remains open – if or when the injured party becomes covered by Medicare, Medicare may be a secondary payer. (Your monitoring process might include ongoing communication with the injured party, use of the Section 111 Query process described in Chapter 8: Query Files and/or use of the Beneficiary Lookup feature on the Section 111 COBSW.) When the RRE determines the injured party does become covered by Medicare, the record must be resubmitted on the next submission of the Claim Input File.

    However, your monitoring of such individuals may stop before they become Medicare beneficiaries if the ORM terminates and is not subject to reopening

or otherwise subject to further request for payment **or** if the standard for ORM termination set forth in Section 6.9 regarding reporting termination of ORM is met. In such event, one final query or claim report should be submitted after an ORM Termination Date has been reached.

- **'01' Disposition Code – Record Accepted for Individual Identified as a Medicare Beneficiary there is ORM**

  Records accepted with a '01' disposition code were accepted by the BCRC as claims where the **RRE has indicated ongoing responsibility for medicals**. The claim record does not need to be reported again until the ongoing responsibility for medicals ends or updates are needed for material fields as described in previous sections (see the Event Table in Section 6.8.4). The response record will be returned with:

  - Applied MSP Effective and Termination Dates and MSP Type Indicator
  - Applied Injured Party HICN, Name, DOB, Gender
  - No error codes
  - Any applicable compliance flags.

- **'02' Disposition Code – Record Accepted for Individual Identified as a Medicare Beneficiary and No ORM**

  Records accepted with a '02' disposition code were accepted by the BCRC as claims where the injured party is a Medicare beneficiary during the time between the CMS Date of Incident and TPOC Date and the **RRE has indicated NO ongoing responsibility for medicals(No ORM)**. The claim record does not need to be reported again unless updates are needed for material fields as described in previous sections (see the Event Table). The response record will be returned with:

  - Applied Injured Party HICN, Name, DOB, Gender
  - No error codes
  - Any applicable compliance flags.

- **'03' Disposition Code – Record for Individual Matched to a Medicare Beneficiary but Outside Medicare Coverage Period**

  Records returned with a '03' disposition code were found to be error-free and the injured party submitted was matched to a Medicare beneficiary, but the Medicare coverage dates for the beneficiary are outside the time frame that is between the date of incident, and TPOC Date or the date ORM ended, as applicable. For example, the individual may have once been covered by Medicare, but Medicare's coverage ended prior to the CMS Date of Incident (DOI). Or, the individual's Medicare coverage was not effective until after the TPOC Date or after the ORM Termination Date. In other words, the beneficiary's Medicare participation does not or did not overlap the applicable coverage time reflected on the submitted claim.

The response record will be returned with:

- Applied Injured Party HICN, Name, DOB, Gender
- No error codes
- No compliance flags.

As long as you confirm that the injured party information you originally submitted was completely correct, and the claim does NOT represent ongoing responsibility for medicals (no ORM), you do not have to submit this claim again for Section 111 reporting unless or until a subsequent TPOC amount is established at a later date.

If the claim represents ongoing responsibility for medicals (ORM), you must continue to monitor the Medicare status of the injured party as long as the responsibility for ORM remains open – if or when the injured party becomes covered by Medicare, Medicare may be a secondary payer. Your monitoring process might include ongoing communication with the injured party, and/or resubmission of the claim record on subsequent quarterly Claim Input Files. Since the injured party has already been identified as being covered by Medicare at one time, a query record will not provide any further information as to when Medicare coverage is activated again. The RRE will continue to receive a disposition code of '03' on the corresponding response file record until the injured party's Medicare coverage is re-activated and overlaps the period of time reported on the claim between the CMS Date of Incident and ORM Termination Date (which could be open-ended – all zeroes).

However, your monitoring of such individuals may stop before they become Medicare beneficiaries if the ORM terminates and is not subject to reopening or otherwise subject to further request for payment **or** if the standard for ORM termination set forth in Section 6.9 regarding reporting termination of ORM is met. In such event, one final claim report should be submitted after an ORM Termination Date has been reached.

When resubmitting claim reports that previously were returned with a '03' disposition code, provide the most current claim information you have available at the time of resubmission.

- **'50' Disposition Code – Record Still in Process at the BCRC**
  - A record returned with a disposition code '50' indicates that the BCRC did not finish processing the record in time to create a response record within the required 45-day turnaround. Only the records on the file that did not complete processing will be returned with a '50'. Records that completed processing by the time the response file was created will be returned with one of the disposition codes described above.
  - A record returned with a '50' will continue to be processed to completion by the BCRC. But in order to receive the final disposition code, **an RRE must resubmit it on the next quarterly update file**. As a rule, you should check these records for accuracy, update *non-key fields* as needed, and resubmit with the same action type sent previously. When a record originally returned with a '50' is resubmitted, it will be reprocessed by the BCRC and returned on the corresponding response

file with one of the disposition codes described above. Note that the system will treat a resubmitted “add” like an “update”, if the original add record was accepted after the ‘50’ Disposition Code was returned.

- If you find you need to change key fields (see Section 6.8.2) after getting a disposition code ‘50’, but before resubmission, assume the record was accepted with a ‘01’ or ‘02’ disposition code. In the next quarter send “delete” and “add” transactions to change the key fields. If the original record that was returned with disposition code ‘50’ was actually processed and accepted by the system after the response was returned, then the delete will match up with the original and process normally. The add transaction will add the claim report back with the changed keys.
- However, if the original record returned with disposition code ‘50’ was NOT actually processed and accepted by the system after the ‘50’ was returned, the delete you send will NOT match a previously accepted record. The delete will be returned with an ‘SP’ disposition code and a SP47, SP48 or SP49 error. All of these error codes indicate that a delete can’t be matched to a previously accepted record. In this case you can then ignore those codes and assume there is nothing to delete, since you will know that original record was never accepted. The add record with the new key fields you sent will be treated like any other add and process normally.
- Remember, if the key fields did not change, just resubmit the record with the original transaction type, the original key fields and the most current information you have for non-key fields in the next quarter’s file. Only go through the delete/add process if a key field changed between submissions.

Note: If you receive a disposition code other than those documented above, report the code (or codes) immediately to your EDI Representative.

7.2 Error Codes

Error codes are documented in the NGHP User Guide Appendices Chapter (Appendix F). Review both the error code descriptions in the NGHP User Guide Appendices Chapter (Appendix F) and the field descriptions in the file layouts documented in the NGHP User Guide Appendices Chapter (Appendix A). Up to ten error codes may be returned on a Claim Response File Detail Record.

In most cases, RREs must correct information on records returned in error and resubmit them on their next quarterly Claim Input File. DDE submitters must correct and resubmit claims returned in error as soon as possible using the Section 111 COBSW. A few errors, specified in the error code descriptions, do not require correction or resubmission. If a large percentage of records are rejected in error, your EDI Representative will advise you as to whether immediate correction and resubmission of these records outside of your assigned file submission time frame is required.

Note that errors that result in rejection of *TIN Reference File Detail Records* may also cause rejection of associated Claim Input File Detail Records. Your TIN Reference File must be processed successfully, either prior to or in conjunction with the associated

Claim Input File (See Section 6.3). You may need to correct and resubmit records on your TIN Reference File in order to resolve errors (e.g., TN99) on your Claim Input File.

RREs are advised to contact their EDI Representatives directly with any questions they may have that are related to disposition and error codes returned or about error handling. If you receive an error code other than those documented in the NGHP User Guide Appendices Chapter (Appendix F), report this immediately to your EDI Representative.

Special Consideration for SP31 Error Code

The most common way individuals become Medicare beneficiaries is through action taken by the Social Security Administration. As a result, the BCRC often receives entitlement information for individuals in advance of their actual Medicare entitlement date. If an individual is to become entitled to Medicare on 7/1/2010 and a *query record* is processed on 6/10/2010, the query response record disposition code may very well be '01' since the record can already be matched to an identified Medicare beneficiary, albeit a future one. However, if you then send a Claim Input File Detail Record for this person and it is processed prior to the beneficiary's actual entitlement date of 7/1/2010, it will be rejected with an SP disposition code and you will receive the SP31 error. In this case, **no correction on the part of an RRE is necessary** for the SP31 error. RREs only need to **resubmit the record** on their next quarterly Claim Input File and it will be processed and returned with the appropriate disposition. SP31 errors are not included in the 20% Error threshold described in Section 7.3.2.

Special Consideration for SP47, SP48 and SP49 Error Codes

Error codes SP47, SP48 and SP49 indicate that a delete transaction could not be matched to a previously submitted and accepted claim report. These may be caused because:

- The RRE submitting incorrect key matching fields on the delete transaction;
- The claim report has already been deleted by the RRE or by the BCRC based on information from another entity;
- The original claim report was not previously accepted and returned with a '01' or '02' disposition code.

The distinction between the three errors is not important to an RRE – it is only meaningful internally to the BCRC. Your error handling for SP47, SP48 and SP49 is the same, and should include:

- A check to make sure that the key fields submitted were correct;
- If key fields were incorrect, correct and resubmit the delete transaction;
- If key fields were correct, take no further action.

Special Consideration for SP50 Error Code – Locked ORM Records

Error code SP50 (not to be confused with *Disposition Code 50*) may be returned on a Claim Response File Detail Record when the BCRC already has a matching record of a claim with ORM and that matching record has been locked by the BCRC to prevent subsequent changes by any entity other than the BCRC. This may occur under limited circumstances, particularly when problems arise related to the payment of a beneficiary's Medicare claims in relation to the ORM record.

If the correct key matching fields were submitted, do **NOT** attempt to resubmit a claim report returned with an SP50 error. Keep a record of the rejected claim report as documentation of your attempt to report for future reference. Contact your EDI Representative with questions. If you believe changes to this existing ORM record are necessary, contact the BCRC Call Center Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired. Be prepared to supply your RRE ID when making this call.

7.3 File Level and Threshold Errors

7.3.1 Severe Errors

A file that is submitted with any of the following Severe Errors will be *suspended from processing*.

- File does not contain a header record
- Header record not properly formatted (refer to file layout)
- Header record does not contain a valid Section 111 RRE ID
- Header record must be at the beginning of a file
- File does not contain a trailer record
- Trailer record not properly formatted (refer to file layout)
- Trailer record must have a corresponding header record
- RRE ID on the trailer record must match the RRE ID of the header record
- Record count on the trailer record must equal the number of detail records submitted
- File must start with a header record and end with a trailer record.

The Account Manager for the RRE ID will receive an e-mail notification identifying all severe errors. You must contact your EDI Representative (see Section 7.3) to resolve all severe errors. You must send a corrected file, as instructed by your EDI Representative. Files with severe errors will be deleted by your EDI Representative.

Table 7-1 provides some additional information for each severe error an RRE may receive. RREs must always contact their EDI Representative when notice of a severe error is received.

Table 7-1: Correction Methods for Severe Errors

Severe Error	Correction
File has invalid RECFM/Record Format	Files must be submitted in a fixed-block format with all records of the same fixed length.
File has invalid LRECL/records with invalid record lengths	The record length of each record on the file must match that specified in the record layouts found in the appendices of this guide. All unused fields and filler at the end of the record must be filled with spaces to the end of the record length (2220 bytes for the Claim Input File and TIN Reference File and 200 bytes for the Query Input File).
File empty	A file with no records was transmitted to the BCRC. Transmission may have failed or there was a problem at the RRE with the creation of the file. If you have nothing to report for a quarter, submit a header record, no detail records and a trailer record with a zero record count or no file at all.
Header record was missing	Header record was not present prior to encountering a detail or trailer record.
Header record does not match filename –or- Header record RRE ID does not match mailbox RRE ID	The RRE ID on the file header record does not match the RRE ID under which it was uploaded. The file was uploaded via HTTPS under the wrong RRE ID or sent to the wrong SFTP mailbox.
Header record not formatted properly	Refer to the file layouts in the appendices for proper header record formats. In particular, the header record identifier and file type must be valid, RRE ID must be numeric with leading zeroes as appropriate, date fields must contain a valid date and be formatted as MMDDYYYY.
Trailer record missing	No trailer record was found at the end of the file or prior to encountering the header of the TIN Reference File.
Trailer record not formatted properly	Refer to the file layouts in the appendices for proper trailer record formats. In particular, the trailer record identifier and file type must be valid, RRE ID must be numeric with leading zeroes as appropriate, date fields must contain a valid date and be formatted as MMDDYYYY, and the record count must be numeric with leading zeroes as appropriate.
Trailer record does not match header record	The RRE ID and/or file submission dates on the header and trailer records are not the same.
Trailer record count does not match count of records in file	The trailer record count should only include the number of detail and auxiliary records on the file. Do not include the header and trailer records in this count.
Test file with more than 200 records	Claim Input test files must be limited to 200 detail and auxiliary records or less. Resubmit a new test file with fewer records.

Severe Error	Correction
Production file reporter status not equal to P	A production file was received for an RRE ID that is not in a production status. Make sure your profile report has been signed by your Authorized Representative and returned to the BCRC. Verify testing requirements have been met. If so, contact your EDI Representative to request that your RRE ID be changed to a production status.
Claim detail record does not match header record	Detail records must have type of NGCD or NGCE.
TIN detail record does not match header record	Record Identifier must be NGTD.
Reporter in discontinued/inactive status	A test or production file was received but your RRE ID has been deactivated. File submitted in error. Check to see that the proper RRE ID was used and that the file was sent to the proper RRE ID mailbox/dataset. If this RRE ID is still in use, ask your EDI Representative to correct the status of your RRE ID.

7.3.2 Threshold Errors

After completion of data quality edits, the BCRC will check your Claim Input File to ensure it does not exceed any threshold restrictions. Threshold checks are performed to identify a file that may be in error and to prevent erroneous information from being accepted and processed by the BCRC. The file threshold checks include:

- There are delete transactions for more than 5% of the total records submitted
- 20% or more of the total records failed, with a disposition code of “SP,” due to errors

A file that exceeds the threshold error checks will be suspended from further processing until the suspension is overridden by your EDI Representative. An e-mail will be sent to your Account Manager to inform him/her of this suspension. You must contact your assigned EDI Representative to analyze and resolve file threshold errors. Your file may be released for processing. Or, if it was sent in error, it will be deleted by your EDI Representative, in which case you may need to resend a corrected file, as instructed by your EDI Representative.

Table 7-2 provides some additional information about each threshold error an RRE may receive. However, RREs must *always* contact their EDI Representative when notice of a threshold error is received.

Table 7-2: Correction Methods for Threshold Errors

Threshold Error	Correction
5% or more of records are delete transactions	Examine use of the delete function. Do not submit deletes when ORM ends – submit updates with ORM Termination Dates instead. Only submit deletes to remove erroneous records that were previously accepted with a '01' or '02' disposition code. Very small files may suspend even if they have very few delete records. If the delete transaction was used correctly, your EDI Representative will release the file for normal processing. **Note**: If the RRE is unable to provide a sufficient explanation for these deletions, the BCRC will not allow the file to process
20% or more of records failed record level edits	Error messages will display in the e-mail. Contact your EDI Representative to discuss the most common errors found. Your EDI Representative will provide further instruction. Very small files may suspend even if they have very few records in error. In that case, your EDI Representative may release the file for processing. **Note**: If a small file errors-out in its entirety and the EDI Representative is able to assist the RRE in correcting the errors, the RRE may be able to resubmit a corrected file without the need to process the initial file with the errors.
File submitted prior to assigned submission period	Claim Input Files received up to 14 days prior to the start of the RRE's assigned file submission time slot will be considered early and placed in a hold status. Once the assigned file submission time slot arrives, the file will automatically be released for processing. If you believe this file should be processed immediately, contact your EDI Representative.
A file from the prior submission period is still processing	A file of the same type submitted previously is still processing. The earlier file must finish processing before the new file can be released for processing by your EDI Representative.
File held - watch list	Your RRE ID has been put on a "watch list" by the BCRC due to numerous past problems with erroneous file submissions. Contact your EDI Representative to resolve.

7.4 Compliance Flags

"Compliance flags" are indicators that provide information on issues related to your compliance with the reporting requirements. The Claim Response File contains space for ten 2-byte Compliance Flags, in Fields 38 – 47. The possible values that could be indicated by these flags are documented in the Compliance Flag Code table in the NGHP User Guide Appendices Chapter (Appendix F). If no compliance issue is found with the record, all the Compliance Flags on the response file record will be blank. If only one issue is found, the code will be placed in the first flag field. If additional issues are found additional compliance flag codes will be placed in the second and subsequent flag fields

(i.e., in the next available flag field). Compliance flags will only be “set” for records receiving a ‘01’ or ‘02’ Applied Disposition Code.

Compliance flags are different from error codes. Unlike an error code, a record will **not** be rejected if one of the conditions that will set a compliance flag is found on the record. The record is processed normally. However the BCRC will set any flags, track the reason(s) for any flags, and include the findings on compliance reports.

Compliance flags provide the RRE notice that the submitted record was not in compliance with particular Section 111 reporting requirements. When a compliance flag is received due to a late submission, the RRE must take the appropriate steps to ensure that subsequent submissions are submitted timely.

The first compliance flag has a value of ‘01’, which indicates that the submitted **add** record that contains one or more TPOC Dates was not sent timely. ‘01’ is put in the first available Compliance Flag field when **the most recent TPOC Date** on the claim is more than 45 calendar days older than the start of the RRE’s *prior* quarter’s submission time slot. If the date of the most recent TPOC you need to report is within 45 days prior to the start of your regular 7-day file submission time slot, then you may submit that TPOC report on your next (following) quarterly file. This “grace period” allows you time to process the new claim information internally, before including it in a Section 111 submission. Putting all this another way: Any add record received on a quarterly file submission will be marked as late if the most recent TPOC Date in the record is more than 135 days older than the start date of the file submission period. (This compliance flag does not apply to update or delete records.)

Example: Your second quarter file submission time slot is June 1-7 and your third quarter file submission time slot is September 1-7. The start date of your second quarter file submission is then June 1 and the start date of your third quarter file submission is September 1. A record with the most recent TPOC Date of April 1 MUST be submitted on your second quarter file submission since April 1 is more than 45 days prior to June 1. If it is received in your third quarter file submission in September (or later), it will be considered late, and the corresponding response record will have a ‘01’ in the first available Compliance Flag. However, a record with the most recent TPOC Date of May 1, if received in your third quarter file submission, will not be marked as late since it is not more than 45 days older than June 1. The record with the most recent TPOC Date of May 1 *can* be submitted with your second quarter file submission in June if you have the information available in your system at that time. If not submitted in June, it MUST be submitted in your third quarter file submission in September.

You may receive a value of ‘03’ in a Compliance Flag field, which indicates that the submitted record containing the ORM Termination Date was not sent timely. It is put in the first available Compliance Flag field when the ORM Termination Date on the claim record is more than 45 calendar days older than the start of the RRE’s prior quarter submission time slot. But the same reporting “grace period” permitted for TPOCs is allowed for ORM reporting. If the ORM Termination Date is within 45 days prior to the start of your 7-day file submission time slot, then you may submit that information on your next quarterly file. This grace period allows you time to process the new claim information internally prior to submission for Section 111. Another way to look at it is

that any record received on a quarterly file submission will be marked as late if the ORM Termination Date in the record is more than 135 days older than the start date of that same file submission period.

The establishment or assumption of ongoing responsibility for medicals can take place at various times during a claim review. The actual date of when the RRE assumed ORM is not collected as part of the claim report. RREs will not receive a compliance flag regarding possible late submission of a 'Y' value for the ORM Indicator (Field 78 on the Claim Input File Detail Record). However, CMS does reserve the right to audit an RRE and/or their agent(s) with respect to this issue (or any other Section 111 reporting issue). The RRE must have a record of when ongoing responsibility for medicals on a reported claim was assumed and was then terminated, and when such ongoing responsibility for medicals was reported to the BCRC under Section 111, in order to establish timely reporting.

Chapter 8: Query Files

NOTE: This section does not apply to RREs using the DDE reporting option. Query functionality (beneficiary lookup) is built into the first step of the DDE claim submission process on the Section 111 COBSW. For more information on DDE, see Section 10.5.

8.1 Query Process

RREs must determine whether an injured party is a Medicare beneficiary. If a reported individual is not identified as a Medicare beneficiary based on the claim information submitted by the RRE, the BCRC will reject the record for that individual. RREs must submit either the injured party's Medicare Health Insurance Claim Number (Medicare HICN) or Social Security Number (SSN) on all Claim Input File Detail Records. RREs are only to report information about Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award, or other payment).

Two methods of querying the Medicare status of an injured party are available to Section 111 RREs:

- Query Input and Response File exchange with the BCRC, and
- Limited online query feature using the Section 111 COBSW, as described in Section 8.5.

The Query Input File is a dataset transmitted from a Section 111 RRE to the BCRC, to request information about whether a particular injured party is or was a Medicare beneficiary prior to submitting a claim. Use of Query Input and Response Files is optional under Section 111 reporting. However, you may use the query process to help you determine whether a particular claim must be reported under Section 111 because the injured party is a Medicare beneficiary. The query process is to be used only for Section 111 reporting purposes. ***Please review the Data Use Agreement in Section Chapter*** 11 ***of this guide for restrictions on the use of data exchanged for Section 111.***

To determine whether an injured party is a Medicare beneficiary, the BCRC must match the data you submit to Medicare's own data. To determine if an individual is a Medicare beneficiary the BCRC must be provided:

- A HICN or SSN
- The first initial of the first name
- The first 6 characters of the last name
- A date of birth (DOB)
- Gender (M/F)

First the BCRC must find an exact match on the HICN or SSN you have submitted. Then at least three out of the four remaining matching criteria must match exactly.

If a match is found, you will always be returned the correct HICN for the individual you are querying on. You must store this HICN on your internal files and use it on future Claim Input File transactions. This is CMS's official identifier for the beneficiary and it will be used by the BCRC when matching claim records to Medicare beneficiaries. Also using CMS's data, the BCRC will supply updated values for the first initial, first 6 characters of the last name, date of birth and gender in the applicable fields of the Query Response File Detail Records Note, however, that the SSN returned on the response record will always be the SSN that was submitted on the query input record by the RRE. The BCRC will never return an updated or corrected SSN on the Query Response File.

Other than the HICN, the updated fields returned on the response record are simply for informational purposes. Note that if an RRE submits a value of '0' for an unknown gender for an individual, the BCRC will change this value to a '1' for matching purposes and may return that changed value of '1' on the response record even if a match is not found. Finally, due to privacy concerns this Response file does not provide the actual dates of Medicare entitlement and enrollment or the reason for entitlement.

The Query Input and Response Files are transmitted using the ANSI X12 270/271 Entitlement Query transaction set (currently using version 5010A1). However, the BCRC will supply software (the HIPAA Eligibility Wrapper or "HEW software") to translate flat files to and from the X12 270/271 formats. The file layouts that serve as input and output for Version3.0.0 of the HEW software are documented in the NGHP User Guide Appendices Chapter (Appendix E).

If you choose to use your own ANSI X12 translator to create the ANSI X12 270 files for the Section 111 Query File and process the X12 271 response, you may download the Section 111 X12 270/271 companion guide with the necessary mapping information on the NHGP page found at the following link: http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Downloads/New-Downloads/NGHPInterfaceSpec50.pdf ("270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide for NGHP Entities"), or contact your EDI Representative for a copy.

Note: Where you have information early in your claim review process that the injured individual is or was a Medicare beneficiary, you know that you will be reporting for that person if there is a settlement, judgment, award, or other payment (TPOC and/or ORM). However, for an individual who is not Medicare beneficiary at the time he or she files a claim or for whom you are initially unable to identify as a beneficiary, you **must** also determine the person's beneficiary status as of the date of the settlement, judgment, award, or other payment (TPOC and/or ORM) if there is a TPOC and/or ORM. The HICN and Medicare coverage start dates are frequently established and on the BCRC database in advance of the actual Medicare coverage effective dates. **Consequently, it is recommended that an RRE send a query record associated with an initial claim report after the TPOC Date or after ORM has been assumed.** Although a query file may be sent monthly, RREs need only query a particular injured party once per quarter and use the results of that query when creating their quarterly Claim Input File. For example, an RRE could set up a process to collect and save injured party information on a tracking file, as ORM is assumed and as TPOCs are established. The injured party information for claims that require ongoing monitoring would be included as well.

Submit this information on a query file once a quarter, allowing enough time to receive and process the query file results for the creation of that quarter's Claim Input File. Since the Query Response File is returned within 14 days, an RRE might consider submitting the query file one month before the Claim Input File is due. Please refer to Section 6.8 for more information on the timeliness of claim reports.

8.2 HEW Software

"HEW" is the acronym for "HIPPA Eligibility Wrapper", and refers to the translator software needed to transmit Query Files. The Query Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set. You may use your own translator software, or the HIPAA Eligibility Wrapper (HEW) software, to submit a Query Input File and process the Query Response File.

The HEW software is maintained by the BCRC. It will be provided to you free of charge if you wish to use it. Mainframe and Windows PC/Server-based versions of the HEW software are available. You may download the Windows version of the HEW software after logging on to the Section 111 COBSW at http://www.section111.cms.hhs.gov. You may request a copy of the mainframe version from your EDI Representative or by contacting the EDI Department at 646-458-6740. The software is maintained free of charge by the BCRC. No source code will be provided.

Query Input and Response File specifications for the flat files that are the input and output of the HEW software can be found in the NGHP User Guide Appendices Chapter (Appendix E). The file format for the current (January 2012 Version 3.0.0) is provided there. **RREs using the HEW software must use Version 3.0.0 effective January 1, 2012.**

You will install and run the HEW software in your data center. To use the HEW software, you first will create an input file according to the specifications in the NGHP User Guide Appendices Chapter (Appendix E). This flat file is then used as input to the HEW software. The HEW software produces the X12 270 eligibility query file format which you then transmit to the BCRC. The BCRC will send back your response file in the X12 271 file format. You will feed that into the HEW software to produce the Query Response File, according to the specifications in the NGHP User Guide Appendices Chapter (Appendix E). The Medicare information for the individuals identified as Medicare beneficiaries can then be used in your internal systems to assist with Claim Input File creation. (Note that the Query Response File that is output from the HEW software does not contain any header or trailer records.)

The HEW Query Response File Detail Records contain a Disposition Code in Field 8. A value of '01' in Field 8 indicates that the injured party submitted on the input record was matched to a Medicare beneficiary. A value of '51' indicates that the information supplied on the query record could not be matched to a Medicare beneficiary.

The HEW software will *not* run on a Linux or UNIX platform. The mainframe version will not execute in an AS400 environment. Generally, the mainframe version of the HEW will execute on the standard IBM mainframe operating systems such as z/OS and z/VM, but **not** the Unix-like operating systems such as Linux, AIX, etc.

The Windows PC/Server version will execute on any Microsoft operating system of NT or better (2000, 2003, XP, etc.) and requires at least a Pentium II with 64 MB of memory. APIs are not made available for the Windows version. However, effective with Version 2.0.0 released in January 2010, the Windows PC/Server version of the HEW may be invoked using a command line interface. Instructions on how to invoke the HEW software from an automated process can be found in documentation that is contained in the software package download. Network communication ports are not part of the HEW application. The HEW only converts incoming/outgoing files. Telecommunications must be done separately. See Section Chapter 10 for more detailed information on file transmission options.

8.3 Query File Requirements

- Query Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set.
- Query Input Files may be submitted up to once per calendar month per RRE ID at any time within the month. These files do not have to be submitted during a specific submission time frame.
- If more than one Query Input File is received during a calendar month or is received while a previous file is still processing, the new Query Input File will suspend with a threshold error. If this second file is indeed suspended due to another file still in process, you must contact your EDI Representative to have the suspended file released for processing. Note that if you send more than one file during a calendar month, the second file will be deleted and not processed.
- Query Response Files will be returned to you within 14 calendar days.
- An RRE ID must be in at least a testing status in order for test or production Query Input Files to be accepted. Once in a production status (dependent on completion of Claim Input File testing), both test and production files will continue to be accepted.
- The following edits will be applied to the Query Input File. Any failure of these edits will result in the file being placed in a severe error status. The Account Manager for the RRE ID will receive an e-mail notification and the RRE or its agent must contact the assigned EDI Representative to address the identified errors. Files failing for these errors must be corrected and resubmitted before they can be processed.
    - File does not contain a header record
    - Header record does not contain a valid Section 111 RRE ID
    - File does not contain a trailer record.
- E-mail notifications will be sent to the Account Manager for the RRE ID after the file has been received and when a response file has been transmitted or is available for download. File processing status may be viewed on the Section 111 COBSW by any user associated with the RRE ID.
- The HEW Query Response Files have NO header and trailer records.
- Each query response will contain the results of matching the input record information to Medicare’s file of beneficiary information. An exact match must be found on either the SSN or HICN supplied. Then three out of four of the remaining fields (first initial,

first 6 characters of the last name, date of birth, and/or gender) must match in order for the record to be considered a match to a Medicare beneficiary. A value of '01' in the disposition code on the HEW response record indicates that the injured party submitted on the input record is or was a Medicare beneficiary. A value of '51' in the HEW response record indicates that the individual could not be identified as a Medicare beneficiary based upon the information submitted. If you are using your own translator and not using the HEW software, the matching algorithm is the same, but please refer to the X12 270/271 companion guide for information on interpreting query results.

- If a match is found, the response record will also contain the current HICN for the Medicare beneficiary as well as updates to the name fields, date of birth and gender as they are stored on Medicare's files.
- If a match is not found, the record will be returned with fields as they were submitted on the input record. No information regarding "partial matches" or why a match was not found is provided.
- The SSN returned on the response record will **always** be the same SSN that was submitted on the query input record by the RRE.
- If an RRE submits a value of '0' for an unknown gender for an individual, the BCRC will change this value to a '1' for matching purposes and therefore may return that changed value of '1' on the response record even if a match was not found.
- Two RRE-defined, optional document control number (DCN) fields are available for use on the X12 270/271 and HEW Versions 3.0.0 Query Input/Response Files. The RRE DCN 1 and RRE DCN 2 fields are alphanumeric, may contain spaces, numbers, letters, and special characters as defined for an alphanumeric field type, are left justified and unused bytes must be space-filled. The BCRC will always return query response records with whatever value the RRE submitted in these DCNs so that the RRE may use them to match response records to input records.

8.4 Query Files and HEW Software Requirements

The BCRC will only accept test and production query files submitted using Version 5010A1 (and HEW Version 3.0.0) of the ASC X12 270/271.

- A copy of the PC/server Version 3.0.0 of the HEW software is available for download on the Section 111 COBSW at http://www.section111.cms.hhs.gov.
- RREs using the mainframe version of the HEW may request a copy of new HEW Version 3.0.0 from their EDI Representative.
- Query files submitted under Version 4010A1 (or created using HEW Versions 1.2.0 and 2.0.0) will be rejected with a severe error and not processed.

8.5 Querying Using the Beneficiary Lookup on the COBSW

When a Section 111 RRE has an immediate need to determine the Medicare status of an injured party, the Beneficiary Lookup feature on the Section 111 COBSW permits the RRE to submit a query online to see if the individual can be matched to a Medicare beneficiary.

If you are an NGHP RRE, and are in production status, and you have *not* selected the Direct Data Entry (DDE) reporting option, you have the Beneficiary Lookup function available to you on the RRE Listing page, after logging on to the Section 111 COBSW (http://www.section111.cms.hhs.gov). The COBSW Beneficiary Lookup function uses the same matching criteria used by the Query Input File and the Claim Input File.

To use the Beneficiary Lookup action:

- Log on to the Section 111 COBSW
- The RRE Listing page will display
- Click on the *Actions* drop-down box for the RRE ID under which you wish to query
- Select the *Beneficiary Lookup* action from the list and click on the *Go* button
- The Beneficiary Lookup page will display
- On the Beneficiary Lookup page, enter the following required information
  - HICN or SSN
  - Injured Party First Name
  - Injured Party Last Name
  - Injured Party Date of Birth
  - Injured Party Gender
- Click on the *Next* button
- The system will attempt to match the information submitted to a Medicare beneficiary.
- If a match is found, the Beneficiary Lookup Response page will display.
- If the information entered cannot be matched to a Medicare beneficiary, the Beneficiary Not Found page will display.

Important Considerations:

- Using the Beneficiary Lookup on the COBSW, RREs are limited to 100 query requests per RRE ID per calendar month.
- Use of the Beneficiary Lookup action is limited to that prescribed by the Section 111 Data Use Agreement as documented in Section Chapter 11, and as agreed to by the RRE's Authorized Representative (on the signed Profile Report) as well as by each user of the Section 111 COBSW.
- The Beneficiary Lookup action will only be available for RREs that are in a production status.
- The Beneficiary Lookup action will not be available to RREs that have selected Direct Data Entry (DDE) as a submission method, since this same functionality is a part of the DDE process.
- All users associated to the RRE ID (Account Manager and Account Designees) will be able to use the Beneficiary Lookup function.
- Use of the Beneficiary Lookup action is optional. It is available to all non-DDE RRE IDs. No special application or sign-up is required.

- RREs using the Beneficiary Lookup action may continue to submit the Query Input File.

Chapter 9: Testing the Section 111 Reporting Process

NOTE: The information in this section does **not** apply to RREs that have chosen the DDE reporting option. If you are reporting via DDE, you may go directly to Section Chapter 10, Electronic Data Exchange.

9.1 Testing Overview

Many entities that report under Section 111 have (or will have) more than one RRE ID. Remember that Section 111 data exchanges are by RRE ID – each entity associated with an RRE ID is responsible for the data exchanges under that registration ID.

RREs using a file submission method must pass a testing process involving the Claim Input and Response Files prior to the RRE's sending of production Section 111 Claim Input Files. The testing process will ensure that the RRE has developed the capability of capturing and reporting data to the BCRC, and of processing the corresponding response files. A series of test files will be submitted to the BCRC in order to verify that the RRE can: transmit input files successfully in the correct format(s); accept and process response files, and; properly submit add, update, and delete records. If the RRE is using an agent to do the RRE's data exchanges, the agent must participate in and pass the testing process on behalf of the RRE. Testing must be completed for each RRE ID that has registered, unless the RRE has selected the DDE reporting option. No data exchange testing is done for RREs using the DDE option.

9.2 Claim File Testing

Claim Input File testing requirements:

Before an RRE begins testing:

- RREs must complete the registration and account setup process on the COBSW and return the signed profile report to the BCRC before testing may begin. Once the BCRC has recorded receipt of the signed profile report, the RRE ID will be updated to a test status and test files will be accepted.
- RREs must initiate registration on the COBSW early enough to allow for at least 90 days for file testing. Testing must be completed prior to the time claims must be reported. See Section 6.8 for more information on timely reporting. If you find you may not complete testing on time, please notify your EDI Representative immediately. You may continue to send test files for any file type as you deem necessary, even after your RRE ID has been put in a production status.

Important Testing Information:

- Testing must be completed for each RRE ID.
- The RRE must transmit test files to the BCRC using the same transmission method as that chosen for production files (HTTPS, SFTP or Connect:Direct).

- For the data exchange test environment the BCRC maintains a mirror image of the COB Beneficiary Master Database containing all beneficiary information the BCRC has in production, and programs that mimic the way the files would be processed in production. However, data used in testing will not actually update data in Medicare systems and databases. While this "test environment" will be refreshed, information returned on test response files should *not* be used in production applications.
- Test Medicare beneficiary data may be downloaded from the Section 111 COBSW for RREs to use in testing. After accepting the Login Warning, the Section 111 COBSW Login page displays. Click on the Reference Materials menu option to view the test beneficiary data files available for download. The test data includes: the SSN, HICN, name, date of birth and gender of the test beneficiaries. It does not include claim information.
- RREs may use actual production claim information, or their own fabricated test data. RREs should submit some test records using the test Medicare beneficiary identifiers for the injured party to test their ability to match to a Medicare beneficiary. On other test records, injured party information that does not match test Medicare beneficiary identifiers should be sent to test conditions where the injured party is not a Medicare beneficiary.
- Test files **must** be limited to no more than a combined total of 200 detail and auxiliary records (these counts exclude the header and trailer). Test files with more than 200 detail/auxiliary records will be rejected and not processed.
- The system will apply the same file error threshold checks to test files as those applied to production files.
- A test TIN Reference File must be submitted with, or prior to, your test Claim Input Files. RREs should submit and complete successful processing of test TIN Reference Files prior to attempting submission of production Claim Input Files, as the TIN information is required for successful processing of Claim Input Files.
- RREs choosing to transmit files via SFTP will receive a test submission mailbox/directory separate from their production submission mailbox/directory on the Section 111 SFTP server. RREs choosing to transmit files via HTTPS will do so using the "Upload File" action on the RRE Listing page after logging on to the Section 111 COBSW application which requires you to indicate whether you are submitting a test or production file. RREs choosing Connect:Direct will send test files to a different destination dataset name than production files
- Your EDI Representative will be your main point of contact to assist you throughout the testing process.
- Query File Testing-- Data exchange testing of Query Files is optional but highly recommended. An RRE ID must be in test **or** production status in order for production Query Input Files to be accepted. An RRE ID must be in production status in order for production Claim Input Files to be accepted. Test files may be sent at any time after the RRE ID is in a testing status – there is no file submission time slot assigned to the RRE ID for test files. There is no limit to the number of test files an RRE ID may submit.

RREs must submit at least the following test files:

- A TIN Reference File with records for each TIN/Office Code combination that will be used on test Claim Input Files. Note: the Office Code must be a 9 digit number or filled with nine spaces if it is not used.
- One initial Claim Input File with at least 25 “add” records.
- A second Claim Input File with at least 5 “updates” and 5 “deletes” for previously submitted records.

RREs must process at least the following test response files:

- Two Claim Response Files that correspond to a submitted test Claim Input File. Note: The BCRC will return test Claim Response Files within one week of submission of the test Claim Input File.

RREs must successfully perform the following to pass the testing process:

- Successfully process the TIN Reference File receiving a ‘01’ disposition code on TIN Reference Response File Detail Records.
- Post at least 25 new claims with add records in *one* file submission. These records must receive either a ‘01’, ‘02’, or ’03 disposition code on corresponding response file records.
- Complete at least 5 updates to previously posted records in *one* file submission.
- Complete at least 5 deletes to previously posted records in *one* file submission.
- *Additional test files must be submitted until these requirements are met, and are approved by your EDI Representative.*

The BCRC will track the progress made with test files, display results on the COBSW and put the RRE ID in a production status after the testing requirements have been successfully completed. In the Section 111 application on the COBSW, users will be able to see what test files were submitted and processed, the number of records accepted and rejected, and whether the testing requirements have been fulfilled.

Testing progress and completion dates will be tracked and reported in the system by the BCRC. The COBSW will provide a Testing Results page to show the status of test file processing. Information regarding the attainment of test requirements will be available there for review. All users associated with the RRE’s account on the COBSW will be able to monitor the status of the testing process on the COBSW. Please be sure that your EDI Representative is kept informed of your testing progress and any issues that you have encountered.

Once Claim Input File testing has been completed and your EDI Representative has moved the RRE ID to a production status, an e-mail will be sent to the RRE’s Authorized Representative and Account Manager as notification of the change in status and that the RRE may now begin submitting production files.

Once an RRE is in production status:

- Once an RRE ID has moved to a production status, any subsequent test files received will continue to be processed by the BCRC and results will be displayed on the COBSW. RREs may continue to submit test files even after production files have been submitted. This will allow RREs to test any changes to their internal reporting

processes without disruption to their production reporting. Test response files will be produced and transmitted.

9.3 Query File Testing

The RRE file exchange testing process is focused on the results of the required production Claim Input and Response File exchanges. Since the use of the query process is optional, the Query Input and Response File testing requirements are less stringent. As described previously, you may use the HEW software to produce your test Query Input Files and process your test Query Response Files, or use your own X12 translator software to exchange the ASC X12 270/271 transaction set.

However, there are certain test environment requirements for Query Input and Response Files. Query Input files **must** be limited to 100 records. RREs will submit test files using the same method they chose for submitting production files (HTTPS, SFTP or Connect:Direct). You may use the information for "test" Medicare beneficiaries provided for Claim Input File testing to test for positive query responses. You may provide your first test Query Input File to the BCRC after the BCRC has received your signed profile report and the RRE ID has been updated to a testing status.

After processing the test Query Input File, the BCRC will provide you a test Query Response File identifying those individuals recognized as Medicare beneficiaries and those individuals who could not be identified as Medicare beneficiaries based upon the information submitted, and as prescribed by the file record layouts in Appendix E (in the NGHP User Guide Appendices Chapter) (if using the HEW software) or as documented in the Section 111 X12 270/271 companion guide. Within a week of the receipt of your test file the BCRC will return a Query Response File. After you and the BCRC are satisfied with the results of the testing, you may begin submitting regular production Query Input Files on a monthly basis.

Testing for the query process may be completed before, during or after your testing of the Claim Input File. Testing for the query process may be completed after the RRE has been set to either a test or production status.

Specific Query File testing requirements:

- RREs must complete the registration and account setup process and return the signed profile report to the BCRC before testing may begin. Once the BCRC has recorded receipt of the signed profile report, the RRE ID will be updated to a test status and Query test and production files will be accepted.
- The RRE must transmit test files to the BCRC using the same transmission method it has chosen for production files.
- For the data exchange test environment the BCRC maintains a mirror image of the COB Beneficiary Master Database containing all beneficiary information the BCRC has in production, and programs that mimic the way the files would be processed in production. While this "test environment" will be refreshed, information returned on test response files should *not* be used in production applications.

- RREs should send actual injured party information (or derived test data) on records in the test files in order to simulate realistic situations. Include records for individuals age 65 and over in order to improve the likelihood of a positive match.
- Test files **must** be limited to no more than 100 records. Test files with more than 100 records will be rejected.
- RREs should process at least the following test input response files sent back by the BCRC:
- One (1) corresponding Query Response File.
- Additional response files as needed.
- The BCRC will return test Query Response Files within one week of submission of the test Query Input File.
- RREs choosing to transmit files via SFTP will receive a test submission mailbox/directory separate from their production submission mailbox/directory on the Section 111 SFTP server. RREs choosing to transmit files via HTTPS will do so using the “Upload File” action on the RRE Listing page after logging on to the Section 111 COBSW application which requires you to indicate whether you are submitting a test or production file. RREs choosing Connect:Direct will send test files to a different destination dataset name than it will use for production files.

Chapter 10: Electronic Data Exchange

10.1 Overview

There are four different methods of data transmission that Section 111 RREs may use. Three involve the submission of electronic files. The fourth method is Direct Data Entry (DDE) using an application on the Section 111 COBSW. As part of your registration for Section 111 on the COBSW, you will indicate the data transmission method you will use and submit the applicable transmission information.

Each file type (that is, Claim Input File or Query Input File) can be set up to use the same file transmission method – or you may select separate file transmission methods for each. However, the method selected for the Input File type will also be used to transmit the corresponding Response File back to the RRE (or its agent). If you select DDE, you will enter claim information directly, using an application on the Section 111 COBSW, instead of transmitting an electronic file. Remember that DDE is limited to RREs with few claims to report per year. See Section 10.5 for more information on the use of DDE.

Generally speaking, if you expect to be transmitting files with more than 24,000 records at once (in one file submission) on a regular basis, it is strongly suggested that you use either the Connect:Direct or SFTP methods, both of which are described below. HTTPS is more suitable for use with smaller files, due to the time it may take using HTTPS to upload and download files during an active user session. File sizes greater than 20 MB will not be accepted via HTTPS.

You may use more than one agent to submit Section 111 files under one RRE ID, if one agent is transmitting the Claim Input File, and the other agent is transmitting the Query Input File. In addition, the RRE may submit one file type (Claim or Query) and have an agent submit the other file type under the same RRE ID. However, only one Claim Input File per calendar quarter and one Query Input File per calendar month may be submitted under one RRE ID. If an RRE is using more than one agent to create separate Claim Input Files (or separate Query Input Files), then the RRE must register and set up more than one RRE ID – one RRE ID per separate file submission. **Note**: you may *not* set up an RRE ID to use just for query-only purposes

10.2 Connect:Direct (NDM) via the CMSNet

RREs with a very large transmission volume may wish to consider using Connect:Direct (formerly known as Network Data Mover or NDM) via a connection to the CMS Extranet Network and CMS's private CMSNet network hosted by Verizon Business Networx Services. Please contact the EDI Department at (646) 458-6740 or your EDI Representative for information on how to establish this connectivity. ***You are encouraged to do this as soon as possible since this setup can take a significant amount of time.*** There are implementation costs and ongoing charges related to this transmission method.

During your COBSW account setup, you will select the Connect:Direct option and provide the dataset names you want the BCRC to use when sending back response files. You must then contact your EDI Representative to complete the setup. After your registration has been processed and connectivity established, the BCRC will e-mail a profile report to confirm your Section 111 destination dataset names to which you will send your input files. If you have already registered for Section 111 under another file transmission method and wish to change to Connect:Direct, contact your EDI Representative.

The dataset naming convention you will use to transmit files to the BCRC under this method is:

Production Files

For Claim Input/TIN Reference Files:	PCOB.BA.MRNGHPCL.Rxxxxxxx(+1)
For Query Input Files:	PCOB.BA.MRNGHPQO.Rxxxxxxx(+1)

Test Files

For Claim Input/TIN Reference Files:	TCOB.BA.MRNGHPCL.Rxxxxxxx(+1)
For Query Input Files:	TCOB.BA.MRNGHPQO.Rxxxxxxx(+1)

NOTE: xxxxxxx is the last 7 digits of the Section 111 RRE ID assigned to you after registration as shown on your profile report.

The information your Account Manager must provide, *for each file type*, during Section 111 COBSW account setup is as follows:

- Test and production destination dataset names to which you want the BCRC to send your response files
- Optional special instructions such as file triggers you want the BCRC to use.

Note: Your Account Manager must have the destination dataset information listed above on hand when completing account setup on the COBSW. If this information cannot be entered, the account setup step cannot be completed. Other account information entered during that step will not be saved and your Account Manager will have to return at a later time to do the account setup again, from the beginning.

10.3 Secure File Transfer Protocol (SFTP)

RREs who select the SFTP method for Section 111 reporting will transmit files over the Internet to and from the BCRC using directories (mailboxes) created on the BCRC Section111 SFTP server. Separate directories are set up for each RRE ID. Subdirectories are set up for test input, production input, test response files and production response files. (See below). All the mailboxes (directories) are automatically created when your Account Manager selects SFTP as the file transmission method during Section 111 COBSW Account Setup.

A Login ID and Password are required for the SFTP file transmission method. Any Login ID/Password assigned to a user of the Section 111 application on the COBSW and that is associated with the RRE ID account may be used. During initial Account Setup on the Section 111 COBSW, the RRE’s Account Manager will create a Login ID and Password (or, when performing setup for multiple RRE IDs, use his previously defined Login ID).

The Account Manager may then log in to the site and invite other users associated with the RRE ID to become Account Designees. Each Account Designee will need to obtain his own Login ID and Password. These Login IDs and Passwords are to be used for SFTP transmission.

Each user of the COBSW will have one Login ID and Password. That same Login ID and Password can be used for multiple RRE ID SFTP transmissions. For example, an agent may be an Account Manager or Account Designee for many RRE IDs. That agent may use his one COBSW Login ID and Password to transmit files for all his RRE clients via SFTP as long as his Login ID is associated to all the applicable RRE IDs. The agent may also use this Login ID to log in to the Section 111 COBSW application and monitor file processing.

Note: Passwords for the COBSW must be changed every 60 days. All passwords are exactly eight characters. You must sign on to the Section 111 application on the COBSW in order to change your password. Failure to maintain a current password will result in an unsuccessful SFTP file transfer. The BCRC recommends that you login to the COBSW and perform the Change Password function once a month to avoid password expiration.

For this transmission method, you may use any SFTP client software or develop your own software as long as the software is SSH v2 capable.

Table 10-1 contains the information you will need to configure your SFTP software to transmit Section 111 files:

Table 10-1: SFTP Server Configuration

Type of Server	Standard SSH Server
Host or IP Address of Server	sftp.section111.cms.hhs.gov
Port Number of Server	10022
Credentials (User ID and Password)	Individual COBSW Login ID and Password assigned to an Account Manager or Account Designee associated with the RRE ID account.

Each RRE mailbox will be defined with the following directory/subdirectories (where RREID is the 9-digit Section 111 RRE ID.) Subdirectory names are in lower case. These are the directories to which you will send files for upload to the COBSW and from which you will pull files for download. The BCRC does not transmit response files back to the RRE or its agent. The RRE or agent must pull/download all response files from the COB SFTP mailbox directories.

Input Files (upload):

RREID/submission/test
RREID/submission/prod

Response Files (download):

RREID/response/test/claim
RREID/response/test/query-only

RREID/response/prod/claim
RREID/response/prod/query-only

In summary, the SFTP file directory is structured as:

- RRE ID
- submission
  - test
  - prod
- response
  - test
    - claim
    - query-only
  - prod
    - claim
    - query-only

Note: Effective October 1, 2011, TIN Reference Response Files are placed in the "claim" folders.

Using your SFTP client or other software (such as a command line interface), you will sign on to the Section 111 SFTP server, provide your credentials, navigate through the RRE ID directories and subdirectories to which you have access and then upload or download the applicable file(s).

To navigate to an RRE ID directory, take the following steps:

- Connect to the Section 111 SFTP server using the host name/IP address and port as provided above.
- Sign on with your Section 111 COBSW Login ID and Password.
- If your Login ID is associated with more than one RRE ID, you will be presented with the directories for each RRE ID to which the Login ID is associated. Navigate (change directories) to the RRE ID for which you will be uploading or downloading. If your Login ID is only associated with one RRE ID, you will automatically be routed into the directory for the single RRE ID with which you are associated.
- Within the RRE ID directory, you will find submission and response directories. Navigate (change directories) to the submission directory to upload input files or response directory to download response files.

Upload

- After going to the submission directory as described above, navigate (change directories) to either the test or prod (production) directory as applicable to the file you are uploading.
- Once you have navigated to the correct directory, proceed to upload your file. There is no specific file naming convention needed. The BCRC will determine the file type from the file contents and test/prod directory to which it's uploaded.

Download

- After going to the response directory, navigate (change directories) to either the test or prod (production) directory as applicable for the response file you wish to download.
- After selecting the test or prod directory, you will be presented with the response file directories to choose from (claim and query-only). Select or navigate to the applicable subdirectory for the response file you wish to download.
- Once you have navigated to the correct directory, proceed to download the response file. The response file naming convention that will be used is shown below and contains a date and timestamp. If you are automating your SFTP, you may wish to set up your software to pull response files subsequent to a certain date parameter or do a comparison of the files present in the directory to the files you previously downloaded. This will help ensure that you only pull new response files added by the BCRC since your last access. Response files remain on the Section 111 SFTP server for 180 days.

There is no specific naming convention needed for uploaded input files. Files uploaded successfully to the Section SFTP server are not subsequently accessible. You cannot delete a file once uploaded. If a file is uploaded in error, you should contact your EDI Representative for assistance.

The BCRC will name response files according to the following convention and place them in the corresponding subdirectories for download by the RRE or its agent:

Claim Response:	PCOB.BA.MR.NGHPCLM.RESP.Dccyymmdd.Thhmmsscc.TXT
TIN Response:	PCOB.BA.MR.NGHPTIN.RESP.Dccyymmdd.Thhmmsscc.TXT
Query Response:	PCOB.BA.MR.NGHPQRY.RESP.Dccyymmdd.Thhmmsscc.TXT

Where ‘Dccyymmdd’ is ‘D’ followed by a date as century/year/month/day and ‘Thhmmsscc’ is ‘T’ followed by a time as hours/minutes/seconds/centiseconds.

The date and timestamp used in the response file names are generated by the BCRC when it creates the response file.

Response files will remain available for downloading for 180 days. Response files can be downloaded more than once as needed. You cannot delete response files from the COBSW SFTP server. The BCRC will remove these files automatically after 180 days.

Files submitted via SFTP to the COBSW should utilize an ASCII format. Fields within the records are length delimited and all records are fixed length.

10.4 Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)

Files uploaded via HTTPS are sent over the Internet to the Section 111 COBSW. This is done using the Section 111 COBSW application. There is no additional software or cost associated with this method as long as a standard Internet browser is used. However, because this method requires a user to be logged in to the COBSW on an active session, use of HTTPS is only recommended for entities with a relatively small amount of data to submit (less than 24,000 records at one time on a regular basis).

During account setup on the COBSW, your Account Manager can select use of this method for file transfer. The account setup process is described in the NGHP User Guide Registration Procedures Chapter. The RRE's Account Manager obtains a COBSW Login ID and Password during the account setup process. After that, the Account Manager and the Account Designees can sign on to the COBSW. All users associated with the RRE's account will have the ability to upload input files and download response files.

The RRE's COBSW users will log on to the Section 111 application on the COBSW at http://www.Section111.cms.hhs.gov and use the application interface to upload and download files. Instructions are provided in the Section 111 COBSW User Guide and associated Help pages available on the site. Users must be in an active session on the Section 111 application on the COBSW when uploading or downloading files via the HTTPS file transfer method.

Files successfully uploaded by the RRE to the Section 111 COBSW are not subsequently accessible by users of the Section 111 COBSW. A user cannot view or delete a file once uploaded. If you uploaded a file in error, you should contact your EDI Representative for assistance.

Response files will remain available for downloading for two calendar quarters (180 days). Response files can be downloaded more than once as needed. COBSW users cannot delete response files from the COBSW. The BCRC will remove these files automatically after 180 days.

When uploading input files, no specific naming convention is needed when uploading input files. The BCRC will name response files according to the following convention. A list of files available for download will be presented to users of the COBSW on the File Listing page of the Section 111 COBSW application.

Claim Response:	PCOB.BA.MR.NGHPCLM.RESP.Dccyymmdd.Thhmmsscc.TXT
TIN Response:	PCOB.BA.MR.NGHPTIN.RESP.Dccyymmdd.Thhmmsscc.TXT
Query Response:	PCOB.BA.MR.NGHPQRY.RESP.Dccyymmdd.Thhmmsscc.TXT

Where 'Dccyymmdd' is 'D' followed by a date as century/year/month/day and 'Thhmmsscc' is 'T' followed by a time as hours/minutes/seconds/centiseconds.

The date and timestamp used in the response file names are generated by the BCRC when it creates the response file.

You should use an ASCII format for files submitted via HTTPS to the COBSW should utilize an ASCII format. Fields within the records are length delimited and all records are fixed length.

10.5 Direct Data Entry (DDE)

This section of the User Guide was created to provide a high-level overview on DDE. Detailed information on the Direct Data Entry (DDE) option can be found in the Section 111 COBSW User Guide available for download after logging in at http:www.Section111.cms.hhs.gov. There are also computer-based training modules (CBTs) available free of charge that provide both an overview and step-by-step instructions for DDE. See Section Chapter 14 for information on how to enroll in the CBT courses.

Please note: DDE RREs are responsible for following all of the instructions set forth in the NGHP User Guide except for the instructions that pertain specifically to the physical creation and transmission of electronic files. DDE RREs are required to submit the same data elements and adhere to essentially the same Section 111 reporting requirements as file submitters. The only difference is that DDE submitters enter claim information manually on the Section 111 COBSW while file submitters transmit this same information in the form of an automated electronic file.

Who is the DDE Option Available To?

DDE is only available for the use of "Small Reporters". A Small Reporter is an RRE that will submit **500 or fewer** NGHP claim reports per calendar year. (Please see the "Query" discussion below for information about how DDE queries can affect the 500 annual submission limit.)

What is the DDE Option?

The DDE Option is available to small reporters in lieu of using one of the file-based data exchange methods (HTTPS, SFTP, Connect:Direct). Small Reporters may use the Section 111 Coordination of Benefits Secure Website (COBSW) at http://www.section111.cms.hhs.gov/ to manually enter and submit individual NGHP claim reports online instead of submitting a multiple record electronic file. Small Reporters will be required to report the same data elements as those required under the file submission methods by manually keying the information into the Section 111 COBSW pages (screens).

How Can "Small Reporters" Register for the DDE Option?

Small Reporters may register for DDE as a reporting option on the Section 111 COBSW.

- The DDE option is open to all current and new RREs that meet the definition of a Small Reporter.
- If an RRE has already registered under one of the current file-based transmission methods and wants to change to the DDE option, the Account Manager for the RRE ID should log into the COBSW and change from a file transmission reporting method to DDE. To do so, select "Register for DDE" under the Actions dropdown box next to your RRE ID on the RRE Listing page. Contact your EDI Representative if you need assistance.
- If an RRE has not previously registered, the Account Manager should select DDE during the Account Setup step of the registration process.

Upon completion of registration, DDE reporters move directly into production status after the signed profile report is received at the BCRC; testing is not required or needed; production reporting may begin immediately thereafter.

When Can "Small Reporters" Begin Reporting Using the DDE Option?

DDE became available to Small Reporters on July 11, 2011.

How Does the DDE Option Differ From the Current File Submission Method?

Testing:

- No testing is performed by RREs using the DDE option.

Submission of claim information:

- There is no assigned submission window.
- Claim information will be submitted one claim report at a time as soon as the conditions related to the claim require reporting under Section 111.
- Claim information must adhere to the reporting thresholds that have been established for Section 111 reporting on initial and subsequent DDE submissions. See Section 6.4.
- All add and update claim reports must include all required data elements as defined in the NGHP User Guide Appendices Chapter (Appendix A and Appendix B).
  - This includes RRE TIN and RRE TIN address information. The Section 111 COBSW will perform basic editing of the TIN information.
  - **Note**: The Document Control Number (DCN) will be automatically generated by the processing system for DDE claim reports.
- Claim record submissions are required within 45 calendar days of the TPOC Date of a reportable TPOC Amount or within 45 calendar days of assuming ORM.
- An ORM Termination Date submission must be made via DDE within 45 calendar days of the ORM Termination Date. Do not call your EDI Representative to report an ORM Termination Date.

Response File:

- DDE RREs will receive a Claim Response for each claim report submitted, on a one for one basis. Responses to submitted claim reports will be displayed on the Section 111 COBSW on the Claims Listing page. For a detailed description of the claim response file process see , "Claim Response File",
- RREs must react to and take action, when necessary, on the information returned and displayed on the DDE Claim Listing page. For example, if a response record indicates that the Claim Input record was not accepted due to errors it must be corrected and resubmitted on the Section 111 COBSW as soon as possible.

Query:

- A *separate* query function is *not* available under the DDE option. However the initial step in the DDE process provides this functionality.

- Injured party information will be matched online in real-time to the BCRC's file of Medicare beneficiary information, as the DDE data is entered on the Section 111 COBSW.
- The application will prompt the user performing the data entry to enter the injured party's information first. Then, the system will attempt to match it to a Medicare beneficiary.
- If no match is found and the user confirms that the information they entered was complete and accurate, no further data elements will be required at that time. A DDE "non-match" will be essentially the same as receiving a "51" disposition code on a Claim Response File.
- Even if an injured party's information does not match to a Medicare beneficiary, the DDE claim submission *will still count* toward the RRE's limit of 500 claim submissions per year.

Issues to Consider Before Selecting the DDE Option:

- Small Reporters that use the DDE option have the same responsibility and accountability as any other Section 111 RRE.
- Small Reporters will be required to report the same data elements as those required under the current file submission methods (HTTPS, SFTP, Connect:Direct). Due to the number of data elements required, the manual data entry for a single claim report may take a considerable amount of time.
- **Note**: Small Reporters will have the ability to save an individual claim report that is in progress (not yet submitted) for 30 calendar days before it will be deleted by the system.
- The DDE option is intended for RREs who expect to have only an occasional claim report to make. RREs that will have claims to report on a frequent and on-going basis are advised to use any of the current file submission methods instead of the DDE option to ensure that RREs are able to adhere to the timely reporting requirements.
- Remember: RREs selecting the DDE option have a very real limit to the number of claims they can submit each year. RREs that select the DDE option can only submit 500 (or fewer) claim reports per calendar year, and claim reports resulting in a "no beneficiary match" do count against the 500 claim report limit.

Chapter 11: Data Use Agreement

As part of the Section 111 registration process, the Authorized Representative for each Section 111 RRE will be asked to sign a copy of the following Data Use Agreement. It will be included on the profile report sent to the Authorized Representative after Section 111 COBSW registration and account setup. The Authorized Representative must sign and return the last page of the profile report to the BCRC. In addition, all users must agree to the Data User Agreement language each time they log on to the Section 111 application of the COBSW. Data exchanged for Section 111 is to be used solely for the purposes of coordinating health care benefits for Medicare beneficiaries between Medicare and Section 111 RREs. Measures must be taken by all involved parties to secure all data that is exchanged and to ensure it is used properly.

SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

I, the undersigned Authorized Representative of the Responsible Reporting Entity (RRE) defined above, certify that the information contained in this Registration is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS to verify this information. I agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged for the purposes of complying with the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395kk(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The Responsible Reporting Entity and its duly authorized agent for this Section 111 reporting, if any, shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. I agree that the only entities authorized to have access to the data are CMS, the RRE or its authorized agent for Mandatory Reporting. RREs must ensure that agents reporting on behalf of multiple RREs will segregate data reported on behalf of each unique RRE to limit access to only the RRE and CMS and the agent. Further, RREs must ensure that access by the agent is limited to instances where it is acting solely on behalf of the unique RRE on whose behalf the data was obtained. I agree that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the RRE and its duly authorized agent, if any, is in compliance with the security requirements specified above. Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and RRE employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized under Section 111 of the MMSEA of 2007. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required

to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

Chapter 12: Section 111 COB Secure Web Site (COBSW)

The BCRC maintains an interactive application on the Section 111 COB Secure Web site (COBSW) to support Section 111 reporting. Section 111 Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation RREs use the COBSW to register for Section 111 reporting and to set up their accounts. The COBSW URL is http:/www.Section111.cms.hhs.gov.

Using the COBSW, Section 111 reporters will be able to:

- Complete the registration process and obtain RRE IDs for each account under which the RRE will submit files.
- Obtain Login IDs and assign users for Section 111 RRE ID COBSW accounts.
- Exchange files via HTTPS directly with the BCRC. As an alternative (if qualified), submit claim information via the Direct Data Entry option.
- View and update Section 111 reporting account profile information such as contacts and other company information.
- View the status of current file processing such as when a file was marked as received and whether a response file has been created.
- View statistics related to previous file submission(s) and processing.
- View statistics related to compliance with the Section 111 reporting requirements such as whether files and records have been submitted on a timely basis.
- Use an online query function, the Beneficiary Lookup, to determine the Medicare status of an injured party.
- Extract a list of all RRE IDs to which the user is associated.

Note: SFTP file submitters will use their Section 111 COBSW credentials (Login ID and Password) to exchange files with the BCRC via the SFTP server.

The registration and account setup processes are described in the NGHP User Guide Registration Procedures Chapter.

Sources of Help Related to Using the Section 111 COBSW

There are various helpful guides available directly on the COBSW. To access the Section 111 COBSW, go to http://www.Section111.cms.hhs.gov using your Internet browser. Once you click on the "I Accept" link and accept the terms of the Login Warning, the homepage will display.

- Information on the New Registration, Account Setup, and other processes can be found under the **"How To" menu option** at the top of the COBSW homepage. A Login ID is not needed to access this menu option. Click on this menu option and a drop down list will appear. Then click on the item desired in the list.

- All pages of the Section 111 COBSW application provide access to **"Quick Help"** information. Click on the link for Quick Help and a new window will open with instructions and information needed to complete the page you are working on.
- Once you have obtained a Login ID for the Section 111 COBSW, you may log into the application using the Login fields displayed on the right side of the homepage. After login, a detailed **Section 111 COBSW User Guide** is available under the "Reference Materials" menu option at the top of the page. You must be logged into the application to gain access to the COBSW User Guide.
- **Computer-Based Training (CBT)** modules for the Section 111 application on the COBSW are available free of charge to RREs and their agents.
- These courses are all available on the Mandatory Insurer Reporting (NGHP) Training Materials page at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-Training-Material/NGHP-CBTs.html on the CMS web site.

Contact your assigned **EDI Representative** for additional help and assistance using the COBSW.

Login IDs

Each person using the Section 111 COBSW must obtain their own Login ID and password. Your personal Login ID may be used for access to multiple RRE IDs. Your Login ID will also be used to transmit files via STFP (see Section Chapter 10). You can have one of two functional responsibilities under an RRE ID with your single Login ID - Account Manager or Account Designee. Authorized Representatives **cannot** be users of the COBSW (See the NGHP User Guide Registration Procedures Chapter (Section 4).

To obtain a Login ID, you must: Either perform the Account Setup step of the registration process for the RRE ID on the COBSW and become the **Account Manager**; or be invited by an already established Account Manager to be associated to the RRE ID as an **Account Designee**. Refer to the information in the NGHP User Guide Registration Procedures Chapter (Section 4) on the registration process and the "How Tos" referenced above for more information on obtaining Login IDs during the registration process.

If your organization has completed the registration process and you need a Login ID for the COBSW, contact your Account Manager and request that he or she add you as an Account Designee. You will receive an e-mail invitation to come to the site and set up your Login ID and password. Likewise, if you are a reporting agent and need access to a customer's COBSW account to assist with the reporting process, contact the RRE's Account Manager to be invited as an Account Designee.

Account Manager and Account Designees

Each RRE must assign or name an Account Manager. The Account Manager may be an employee of the RRE or a reporting agent. Each RRE ID can have only one Account Manager. This is the individual who controls the administration of an RRE's account and manages the overall reporting process. The Account Manager may choose to manage the entire account and data file exchange, or may invite other company employees or data processing agents to assist.

The Account Manager:

- Must register on the COBSW using the PIN for the RRE ID (See the NGHP User Guide Registration Procedures Chapter (Section 4)), obtain a Login ID and complete the account setup tasks.
- Can be an Account Manager associated with another RRE ID if he or she receives the authorized PIN from the BCRC mailing. This can occur when a reporting entity has multiple RRE IDs under which they will report separate Claim Input Files or when the entity chooses to name an agent as its Account Manager.
- Can invite other users to register on the COBSW as Account Designees for an RRE ID.
- Can manage the RRE's profile including selection of a file transfer method or DDE.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use his/her Login ID and Password to transmit files if the RRE has specified SFTP as the file transfer method.
- Can submit claim information via DDE if the RRE has specified DDE as its submission method.
- Can review the file transmission history.
- Can review any file-processing status and all file statistics.
- Can remove an Account Designee's association to an RRE ID account.
- Can change account contact information (e.g. address, phone, etc.)
- Can change his or her personal information.
- Cannot be an Authorized Representative for any RRE ID.
- Can query the Medicare status of an injured party using the Beneficiary Lookup feature.
- *Cannot* be an Authorized Representative for any RRE ID.

At the RRE's discretion, the Account Manager may designate other individuals, known as Account Designees, to register as users of the COBSW associated with the RRE's account. Account Designees assist the Account Manager with the reporting process. Account Designees may be RRE employees or agents. There is no limit to the number of Account Designees that can be associated with one RRE ID.

The Account Designee:

- Must register on the COBSW and obtain a Login ID.
- Can be associated with multiple RRE accounts, but only by a separate Account Manager invitation for each RRE ID.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use his or her Login ID and Password to transmit files if the RRE has specified SFTP as the file transfer method.

- Can submit claim information via DDE if the RRE has specified DDE as its submission method.
- Can review file transmission history.
- Can review any file-processing status and all file statistics.
- Can change his or her personal information.
- Can remove himself/herself from the RRE ID
- Can query the Medicare status of an injured party using the Beneficiary Lookup feature.
- Cannot be an Authorized Representative for any RRE ID.
- Cannot invite other users to the account.
- Cannot update RRE account information.

Note: Each user of the Section 111 application on the COBSW will have only one Login ID and password. With that Login ID and password, you can be associated with multiple RRE IDs (RRE accounts). With one Login ID, you may be an Account Manager for one RRE ID and an Account Designee for another. Once you have used your personal Login ID and Password, the functions you perform on the COBSW are specific to your relationship to the RRE ID you are working under.

COBSW Routine Maintenance

Routine maintenance on the COBSW and Section 111 SFTP server is typically performed during the third weekend of each month as needed. However, bulletins will be posted to the COBSW Login screen to notify RREs of any changes to scheduled maintenance. During this time, access to the COBSW and SFTP will be limited. When the COBSW is unavailable, users attempting to login will receive a page to notifying them that the site is unavailable. This work usually commences on Friday at 8:00 p.m. (EST) and is completed no later than Monday at 6:00 a.m. (EST).

Best Practices

CMS advises all Section 111 COBSW users to implement the following best practices:

- Keep the personal computer Operating System and Internet Browser software (e.g., Internet Explorer or Firefox) at the most current patch level.
- Install and use the latest versions of anti-virus/spyware software to continuously protect personal computers.
- Use desktop firewall software on personal computers and ensure that file sharing is disabled.
- Never use a public computer (library, internet café, etc.) to login to CMS resources.

System-Generated E-Mails

The e-mails listed in Table 12-1 are generated by the system to the Authorized Representative and/or Account Manager for the RRE ID. E-mails will be sent from cobva@ghimedicare.com. mailto:Please do not reply to this e-mail address as replies are not monitored by the BCRC. If additional information or action is needed, please contact your EDI Representative directly.

Table 12-1: System Generated E-Mails

E-Mail Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	Sent within 10 business days upon completion of the Account Setup step on the Section 111 COBSW. Includes attachment with profile report. The RRE's Authorized Representative must review, sign and return the profile report to the BCRC within 30 days. If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status. **Note**: RREs must return their signed profile via e-mail to their assigned EDI Representative. Do not return the signed profile report to the COBVA e-mail address from which it was received. When returning this via e-mail, ensure that the profile report is a scanned copy of the document with a wet signature (i.e., an original signature is included on the profile report).
Non-Receipt of Signed Profile Report	Authorized Representative, Account Manager	Generated 30 days after the profile report e-mail if a signed copy of the profile report has not been received at the BCRC. The Authorized Representative for the RRE ID must sign and return the profile report. If another copy is needed, contact your EDI Representative.
Successful File Receipt	Account Manager	Sent after an input file has been successfully received but not yet processed at the BCRC. Informational only. No action required. **Subsequent e-mails will be sent regarding the results of actual file processing that may require follow up action.**
Late File Submission	Authorized Representative, Account Manager	Sent 7 days after the end of the file submission period if no Claim Input File was received for the RRE ID. Send the file immediately and contact your EDI Representative. This e-mail may be ignored if you have nothing to report for the quarter.
Threshold Error	Account Manager	Sent after the Successful File Receipt e-mail when an input file has been suspended for a threshold error. Contact your EDI Representative to resolve.

E-Mail Notification	Recipient	Purpose
Severe Error	Account Manager	Sent after the Successful File Receipt e-mail when an input file has been suspended for a severe error. Contact your EDI Representative to resolve.
Ready for Testing	Account Manager	Account setup is complete and the signed profile report has been received at the BCRC. The RRE may begin testing.
Ready for Production	Account Manager	Testing requirements have been met and production files will now be accepted for the RRE ID.
Successful File Processed	Account Manager	The BCRC has completed processing on an input file and the response file is available.
Account Designee Invitation	Account Designee	Sent to an Account Designee after the Account Manager for the RRE ID adds the Account Designee to the RRE ID on the COBSW. If the Account Designee is a new user, the e-mail will contain an URL with a secure token link for the user to follow to obtain a Login ID for the COBSW.
Personal Information Changed	User Affected (Account Manager or Account Designee)	Generated after a user changes his personal information on the COBSW. Informational only.
Password Reset	User Affected (Account Manager or Account Designee)	Generated when a user's password is reset on the COBSW.
Login ID Request	User Affected (Account Manager or Account Designee)	Generated after a user completes the "Forgot Login ID" function on the COBSW.

Chapter 13: Customer Service and Reporting Assistance for Section 111

Please be sure to visit the Section 111 page on the CMS Web site http://go.cms.gov/mirnghp frequently for updated information on Section 111 reporting requirements including updates to this guide. In order to be notified via e-mail of updates to this Web page, click on the "Subscription Sign-up for Mandatory Insurer Reporting (NGHP) Web Page Update Notification" link found in the Related Links section of the web page and add your e-mail address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. To submit a policy-related comment or inquiry to CMS regarding Section 111 Mandatory Reporting, please send an e-mail to the Section 111 Resource Mailbox at PL110-173SEC111-comments@cms.hhs.gov. You will not receive a direct response from this e-mail address but CMS will review each submission received and follow up with additional outreach and education as needed.

Please note that e-mails from CMS or the BCRC may come from @section111.cms.hhs.gov, @cms.hhs.gov, @ghimedicare.com and @ehmedicare.com addresses. Please update your spam filter software to allow receipt of these e-mail addresses.

All technical questions should be directed to your EDI Representative, as explained below.

13.1 Electronic Data Interchange (EDI) Representative

After you register for Section 111 reporting, you will be assigned an EDI Representative to be your main contact for Section 111 file transmission and technical reporting issues. Contact information for your EDI Representative will be provided on the COBSW screens after completion of the New Registration portion of the registration process and will also be included within your profile report which is generated upon completion of the Account Setup portion of the registration process.

If you have not yet registered and been assigned an EDI Representative, and need assistance, please call the EDI Department number at 646-458-6740.

13.2 Contact Protocol for the Section 111 Data Exchange

In all complex electronic data management programs there is the potential for an occasional breakdown in information exchange. If you have a program or technical problem involving your Section 111 data exchange, you should first contact your EDI Representative at the BCRC. Your EDI Representative should always be sought out first to help you answer any questions, and to help find solutions to any issues or problems you may experience.

If you have not been assigned an EDI Representative, please call the EDI Department number at 646-458-6740 for assistance.

Escalation Process

The Centers for Medicare and Medicaid Services (CMS) and the Benefits Coordination & Recovery Center (BCRC) are committed to providing exceptional service to their customers. The following escalation process should be followed to ensure customers' needs are met. It is imperative that RREs and their reporting agents follow this process so BCRC Management can address and prioritize issues appropriately.

- If your Section 111 EDI Representative does not respond to your inquiry or issue within **two business days**, you may contact the EDI Department Manager, Jeremy Farquhar, at 646-458-6614. Mr. Farquhar's e-mail address is JFarquhar@ehmedicare.com.
- If the EDI Department Manager or the manager's designee does not respond to your inquiry or issue within **one business day**, you may contact the EDIDirector, William Ford, at 646-458-6613. Mr. Ford's e-mail address is WFord@ehmedicare.com.
- If the EDI Director does not respond to your inquiry or issue within **one business day**, you may contact the BCRC Project Director, Jim Brady, who has overall responsibility for the EDI Department and technical aspects of the Section 111 reporting process. Mr. Brady can be reached at 646-458-6682. His e-mail address is JBrady@ehmedicare.com. Please contact Mr. Brady only after attempting to resolve your issue following the escalation protocol provided above.

Chapter 14: Training and Education

A variety of training and educational materials are available to help you with Section 111 reporting, in addition to the material in this guide.

- The Section 111 CMS Web page (http://go.cms.gov/mirnghp) has links to all CMS publications regarding the MSP Mandatory Reporting Requirements under Section 111 of the MMSEA of 2007. To be notified via e-mail of updates to this Web page, click on the "Subscription Sign-up for Mandatory Insurer Reporting (NGHP) Web Page Update Notification" link found in the Related Links section of the web page and add your e-mail address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. CMS conducts Town Hall Teleconferences to provide information and answer questions regarding Section 111 reporting requirements. The schedule for these calls is posted (and updated as new calls are scheduled) on the Section 111 Web page under the What's New tab at http://go.cms.gov/mirnghp.
- CMS has made available a curriculum of computer-based training (CBT) courses for Section 111 RREs. These courses are offered free of charge and provide in-depth training on Section 111 registration, reporting requirements, the Section 111 COBSW, file transmission, file formats, file processing, and general MSP topics. These courses are all available on the Mandatory Insurer Reporting (NGHP) Training Material page at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-Training-Material/NGHP-CBTs.html on the CMS web site. All updated Section 111 policy guidance published in the form of an Alert can be found on the CMS Web page (http://go.cms.gov/mirnghp). Any Alert posted after the date of the currently published User Guide supersedes the applicable language in the User Guide. All Alerts will be incorporated into the next version of the User Guide. Until such time, RREs must refer to the current User Guide and any subsequently dated Alerts for complete information on Section 111 reporting requirements. The NGHP User Guide Appendices Chapter (Appendix K) contains a list of all the applicable NGHP Alerts posted prior to the publication of this User Guide.

Note: The Section 111 User Guides and other instructions do not and are not intended to cover all aspects of the MSP program. Although these materials provide wide-ranging overviews of MSP in general, any individual or entity that is a primary payer to Medicare is responsible for his/her/its obligations under the law. The statutory provisions for MSP can be found at 42 U.S.C. 1395y(b); the applicable regulations can be found at 42 C.F.R. Part 411. Supplemental guidance regarding the MSP provisions can be found at the following Web pages: http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-

Payer/Medicare-Secondary-Payer.html, http://go.cms.gov/wcmsa and http://www.cms.gov/manuals/IOM. The MSP Manual is CMS Publication 100-05.

Chapter 15: Checklist - Summary of Steps to Register, Test and Submit Production Files

The following summarizes the steps needed to participate in the reporting process for Section 111. Reference the Registration, Technical, and Policy sections for more detailed instruction.

Before you begin, determine the following:

- Individuals who will be the RRE's Authorized Representative, Account Manager and Account Designees.
- Whether reporting agents will be used.
- How claim files will be submitted – one file for the RRE or separate files based on line of business, agent, subsidiaries, claim systems, data centers, etc. which will require more than one RRE ID.
- Which file transmission method you will use or if you qualify for DDE. If you choose HTTPS, you will transmit files via the Section 111 COBSW application. If you choose SFTP, you will transmit files to and from the Section 111 SFTP server. If you choose Connect:Direct, contact your EDI Representative for information on how to establish a connection to the BCRC via the CMS Extranet and CMSNet, and create transmission jobs and datasets.

Register and set up your account:

- Complete your New Registration and Account Setup for each RRE ID needed, including file transmission information, on the Section 111 COBSW.
- Receive your profile report via e-mail (within 10 business days after registration is complete) indicating your registration and account setup were accepted by the BCRC.

Once you successfully register:

- The RRE's Authorized Representative must approve the account setup, by physically signing the profile report, which includes the Data Use Agreement, and returning it to the BCRC within 30 days. If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status. Note: It is recommended that RREs return their signed profile via e-mail directly to their assigned EDI Representative. When returning this via e-mail, ensure that the profile report is a scanned copy of the document with a wet signature (i.e., an original signature is included on the profile report).
- Review file specifications, develop software to produce Section 111 files, and schedule your internal quarterly submission process.
- Test each Section 111 file type you will be exchanging with the BCRC.
- Submit your initial TIN Reference and Claim Input File by your assigned production live date.

- Submit your Query File as needed but no more than once per calendar month (ongoing).

Submit your quarterly Claim Input File during your assigned submission periods (ongoing):

- Monitor file processing and statistics on the Section 111 COBSW on a regular basis.
- Update passwords used for the Section 111 COBSW and SFTP on a regular basis. The system requires you to change your Password every 60 days.
- Monitor automated e-mails generated by the system regarding file processing status. These e-mails are sent to the Account Manager for the RRE ID who should forward these e-mails to Account Designees and reporting agents as necessary.
- Contact your EDI Representative when issues are encountered or assistance is needed.
- Notify your EDI Representative of issues that will prevent you from timely file submission.
- As of January 2012, RRE's profile report is e-mailed to the Authorized Representative and Account Manager annually, based upon the receipt date of the last signed profile report. The RRE should confirm via e-mail that their current information is correct. Failure to confirm this information may result in deactivation of the RRE ID.