MMSEA Section 111
Medicare Secondary Payer Mandatory Reporting

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

Chapter I: INTRODUCTION AND OVERVIEW

Version 4.2

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Revision History

Date	Version	Reason for Change
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	The version number was updated to keep in sync with other chapters of the NGHP User Guide.
May 6, 2013	3.6	The version number was updated to keep in sync with other chapters of the NGHP User Guide.
October 7, 2013	4.0	• Change Release (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 • Outdated hyperlinks have been replaced.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 Release (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).
March 3, 2014	4.2	Edits to reflect change in liability insurance (including self-insurance) TPOC reporting threshold change in Chapters III & IV.

Table of Contents

List of Tables

List of Figures

Chapter 1: Summary of Version 4.2 Updates

The updates listed below have been made to the Introduction and Overview Chapter Version 4.2 of 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 applica1-1ble updates in the form of revisions to Alerts and the User Guide as necessary.

There are no changes to Chapter I of the NGHP User Guide. See Chapters III & IV for changes for this release.

Chapter 2: Introduction and Important Terms

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" - provides 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 **Introduction and Overview Chapter** of Version 4.1 of the MMSEA Section 111 NGHP User Guide provides an overview of Medicare, Medicare Secondary Payer (MSP), Section 111 Mandatory Insurer reporting requirements, the reporting process for Section 111, and training and education resources. The other four chapters of the NGHP User Guide: Registration Procedures, Technical Information, Policy Guidance and the Appendices should be referenced for more specific information and instruction on Section 111 NGHP Registration, Policy or Technical information and/or guidance.

Please note that CMS will continue to implement the Section 111 requirements in phases. New versions of the Section 111 User Guide will be issued when necessary to document revised requirements and when additional information has been added for 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 guidance published in the form of an Alert 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 NGHP Alerts posted prior to the publication of this User Guide.

All official instructions pertinent to Section 111 reporting are on the Section 111 Web site 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 new Alerts. In order to be notified via e-mail of updates posted 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.

Important Terms Used in Section 111 Reporting

The following terms are frequently referred to throughout this Guide, and are critical to understanding the Section 111 NGHP reporting process.

- Entities responsible for complying with Section 111 are referred to as "Responsible Reporting Entities" or "**RREs.**" The NGHP User Guide Policy Guidance Chapter (Section 6) has a detailed description of who qualifies as an RRE.
- Liability insurance (including self-insurance), no-fault insurance, and workers' compensation are often collectively referred to as **"Non-Group Health Plan" or "NGHP" insurance.**
- **Ongoing responsibility for medicals (ORM)** refers to the RRE's responsibility to pay, on an ongoing basis, for the injured party's (the Medicare beneficiary's) "medicals" (medical care) associated with a claim. Typically, ORM only applies to no-fault and workers' compensation claims. Please see the NGHP User Guide Policy Guidance Chapter (Section 6.3) for a more complete explanation of ORM.
- The **Total Payment Obligation to the Claimant (TPOC)** 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.
- CMS defines the **Date of Incident (DOI)** as follows:
  - The date of the accident (for an automobile or other accident);
  - The date of first exposure (for claims involving exposure, including; occupational disease, or any associated cumulative injury);
  - The date of first ingestion (for claims involving ingestion);
  - The date of the implant or date of first implant, if there are multiple implants (for claims involving implant(s); or
  - The earlier of the date that treatment for any manifestation of the cumulative injury began, when such treatment preceded formal diagnosis, or the first date that formal diagnosis was made by a medical practitioner (for claims involving cumulative injury).

This CMS definition differs from the definition of that generally used by the insurance industry under specific circumstances. For the DOI used by insurance/workers' compensation industry, see Field 13 of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter V.

Chapter 3: Medicare Entitlement, Eligibility, and Enrollment

This section provides a general overview of Medicare entitlement, eligibility and enrollment. Please refer to http://www.cms.gov for more information on this topic.

Medicare is a health insurance program for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (ESRD - permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has:

Part A Hospital Insurance—Most people receive premium-free Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance or HI) helps cover inpatient care in hospitals and skilled nursing facilities (but not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to receive these benefits.

Part B Medical Insurance—Most people pay a monthly premium for Part B. Medicare Part B (Supplemental Medical Insurance or SMI) helps cover physician and other supplier items/services as well as hospital outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.

Part C Medicare Advantage Plan Coverage—Medicare Advantage Plans are health plan options (like HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called “Part C” or “MA plans.” These plans are an alternative to the fee-for-service Part A and Part B coverage and often provide extra coverage for services such as vision or dental care.

Prescription Drug Coverage (Part D)—Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Private companies provide the coverage. Beneficiaries choose the drug plan they wish to enroll in, and most will pay a monthly premium.

Exclusions—Medicare has various coverage and payment rules which determine whether or not a particular item or service will be covered and/or reimbursed.

Chapter 4: MSP Overview

Medicare Secondary Payer (MSP) is the term used when the Medicare program does not have primary payment responsibility—that is, when another entity has the responsibility for paying before Medicare. Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation (including black lung benefits) or for care which is the responsibility of another government entity. With the addition of the MSP provisions in 1980 (and subsequent amendments), Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation. An insurer or workers' compensation plan cannot, by contract or otherwise, supersede federal law, as by alleging its coverage is "supplemental" to Medicare.

The coverage data collected through Section 111 reporting is used by CMS in processing claims billed to Medicare for reimbursement for items and services furnished to Medicare beneficiaries, and for MSP recovery efforts. Medicare beneficiaries, insurers, self-insured entities, third party administrators and their agents, and attorneys, are always responsible for understanding when there is coverage primary to Medicare, for notifying Medicare when applicable, and for paying appropriately.

Section 111 reporting is a comprehensive method for obtaining information regarding situations where Medicare is appropriately a secondary payer. It does not replace or eliminate existing obligations under the MSP provisions for any entity. (For example, Medicare beneficiaries who receive a liability settlement, judgment, award, or other payment have an obligation to refund any conditional payments made by Medicare within 60 days of receipt of such settlement, judgment, award, or other payment. The Section 111 reporting requirements do not eliminate this obligation.)

4.1 MSP Statutes, Regulations, and Guidance

The sections of the Social Security Act known as the Medicare Secondary Payer (MSP) provisions were originally enacted in the early 1980s and have been amended several times, including by the MMSEA Section 111 mandatory reporting requirements. Medicare has been secondary to workers' compensation benefits from the inception of the Medicare program in 1965. The liability insurance (including self-insurance) and no-fault insurance MSP provisions were effective December 5, 1980.

See 42 U.S.C. 1395y(b) [section 1862(b) of the Social Security Act], and 42 C.F.R. Part 411, for the applicable statutory and regulatory provisions. See also, CMS's manuals and Web pages for further detail. For Section 111 reporting purposes, use of the "Definitions and Reporting Responsibilities" document provided in the NGHP User Guide Appendices Chapter (Appendix H) is critical.

Additional information can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. The MSP Manual is CMS Publication 100-05. Chapter 1 can be found at http://www.cms.gov/manuals/downloads/msp105c01.pdf.

4.2 Liability Insurance (Including Self-Insurance) and No-Fault Insurance

Liability insurance (including self-insurance) is coverage that indemnifies or pays on behalf of the policyholder or self-insured entity against claims for negligence, inappropriate action, or inaction which results in injury or illness to an individual or damage to property. It includes, but is not limited to, the following:

- Homeowners' liability insurance
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance
- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

Pursuant to 42 C.F.R. Part 411.50: "Liability insurance means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. Liability insurance payment means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan."

Entities and individuals engaged in a business, trade, or profession are self-insured if they have not purchased liability insurance coverage. This includes responsibility for deductibles. See the NGHP User Guide Appendices Chapter (Appendix H) for the full CMS definition of "self-insurance."

No-fault insurance is insurance that pays for health care services resulting from injury to an individual or damage to property in an accident, regardless of who is at fault for causing the accident. Some types of no-fault insurance include, but are not limited to the following:

- Certain forms of automobile insurance
- Certain homeowners' insurance
- Commercial insurance plans
- Medical Payments Coverage/Personal Injury Protection/Medical Expense Coverage

Pursuant to 42 C.F.R. Part 411.50: "No-fault insurance means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in

the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called ‘‘medical payments coverage’’, ‘‘personal injury protection’’ (PIP), or ‘‘medical expense coverage’’.”

In general, when the injured party is a Medicare beneficiary **and the date of incident is on or after December 5, 1980**, liability insurance (including self-insurance) and no-fault insurance are, by law, primary payers to Medicare. If a Medicare beneficiary has no-fault coverage, providers, physicians, and other suppliers must bill the no-fault insurer first. If a Medicare beneficiary has made a claim against liability insurance (including self-insurance), the provider, physician, or other supplier must bill the liability insurer first unless it has evidence that the liability insurance (including self-insurance) will not pay “promptly” as defined by CMS’s regulations. (See 42 C.F.R. 411.21 and 411.50 for the definitions of the term “promptly”). If payment is not made within the defined period for prompt payment, the provider, physician, or other supplier may bill Medicare as primary. If the item or service is otherwise reimbursable under Medicare rules, Medicare may pay conditionally, subject to later recovery if there is a settlement, judgment, award, or other payment.

4.3 Workers’ Compensation

A workers’ compensation law or plan means a law or program administered by a State (defined to include commonwealths, territories and possessions of the United States) or the United States to provide compensation to workers for work-related injuries and/or illnesses. The term includes a similar compensation plan established by an employer that is funded by such employer directly, or indirectly through an insurer, to provide compensation to a worker of such employer for a work-related injury or illness. Workers’ compensation is a law or plan that compensates employees who get sick or injured on the job. Most employees are covered under workers’ compensation plans.

Pursuant to 42 C.F.R Part 411.40: *“Workers’ compensation plan of the United States” includes the workers’ compensation plans of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands, as well as the systems provided under the Federal Employees’ Compensation Act and the Longshoremen’s and Harbor Workers’ Compensation Act.”*

Workers’ compensation is a primary payer to the Medicare program for Medicare beneficiaries’ work-related illnesses or injuries. Medicare beneficiaries are required to apply for all applicable workers’ compensation benefits. If a Medicare beneficiary has workers’ compensation coverage, providers, physicians, and other suppliers must bill workers’ compensation first. If responsibility for the workers’ compensation claim is in dispute and workers’ compensation will not pay promptly, the provider, physician, or other supplier may bill Medicare as primary. If the item or service is reimbursable under Medicare rules, Medicare may pay conditionally, subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. (See 42 C.F.R. 411.21 for the definition of “promptly” with regard to workers’ compensation.)

4.4 Role of CMS's Benefits Coordination & Recovery Center (BCRC)

The purpose of Medicare's Coordination of Benefits (COB) process is to identify primary payers to Medicare for the health benefits available to Medicare beneficiaries and to coordinate the payment process to prevent the mistaken or unnecessary payment of Medicare benefits, including conditional payments. The Benefits Coordination & Recovery Center (BCRC) consolidates the activities that support the collection, management, and reporting of other insurance or workers' compensation coverage for Medicare beneficiaries. The BCRC updates the CMS systems and databases used in the claims payment and recovery processes. The BCRC does not process claims or answer claims-specific inquiries, nor does it handle MSP recoveries.

The BCRC assists in the implementation of MMSEA Section 111 mandatory MSP reporting requirements as part of its responsibilities to collect information to coordinate benefits for Medicare beneficiaries on behalf of CMS. In this role, the BCRC assigns each registered RRE an Electronic Data Interchange (EDI) Representative to work with them on all aspects of the reporting process.

The BCRC is also responsible for the recovery of amounts owed to the Medicare program as a result of settlements, judgments, awards, or other payments by liability insurance (including self-insurance), no-fault insurance, or workers' compensation.

Chapter 5: Section 111 Overview

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111) adds mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements, and for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Implementation dates were January 1, 2009, for GHP arrangement information and July 1, 2009, for information concerning liability insurance (including self-insurance), no-fault insurance and workers' compensation.

The MMSEA Section 111 statutory language (42 U.S.C. 1395y(b)(8)) for the liability insurance (including self-insurance), no-fault insurance, and workers' compensation provisions can be found in the NGHP User Guide Appendices Chapter (Appendix G). Section 111 authorizes CMS's implementation of the required reporting by program instruction or otherwise. All implementation instructions, including this User Guide, are available on (or through a download at) CMS's dedicated Web page: http://go.cms.gov/mirnghp.

Section 111:

- Adds reporting rules; it does not eliminate any existing statutory provisions or regulations.
- Does not eliminate CMS's existing processes, including CMS's process for self-identifying pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation claims to CMS's Benefits Coordination & Recovery Center (BCRC) or the processes for Non-Group Health Plan MSP recoveries, where appropriate.
- Includes penalties for noncompliance.

Who Must Report:

- An applicable plan.
- The term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:
  - (i) Liability insurance (including self-insurance).
  - (ii) No-fault insurance.
  - (iii) Workers' compensation laws or plans.
- See 42 U.S.C. 1395y(b)(8)(F).

What Must Be Reported:

- The identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue as well as such other information specified by the Secretary of Health and Human Services (HHS) to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim. Data elements are determined by the Secretary.

When/How Reporting Must Be Done:

- In a form and manner, including frequency, specified by the Secretary.
- Information shall be submitted within a time specified by the Secretary after the claim is addressed/resolved (partially addressed/resolved through a settlement, judgment, award, or other payment, regardless of whether or not there is a determination or admission of liability).
- Submissions will be in an electronic format. See detailed information in the NGHP User Guide Technical Information Chapter.

Note: To determine if you are an RRE, you must use the applicable statutory language in conjunction with "Attachment A – Definitions and Reporting Responsibilities" to the Supporting Statement for the Paperwork Reduction Act (PRA) Notice published in the Federal Register. Attachment A of the PRA is also available in the NGHP User Guide Appendices Chapter V. See either of these appendices in order to determine if you are an RRE for purposes of these provisions. The statutory language, the PRA Notice and the PRA Supporting Statement with Attachments are all available as downloads at: http://go.cms.gov/mirnghp.

Chapter 6: 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 BCRC 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 (MBD). The reason for Medicare entitlement, and the dates of Medicare entitlement and enrollment (coverage under Medicare), are not returned on the query file response.

Note: With DDE, the separate query function is not available. Instead, with the DDE application, the RRE 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 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 7 (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 the NGHP User Guide Technical Information Chapter (Section 10).

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 the NGHP User Guide Technical Information Chapter IV.

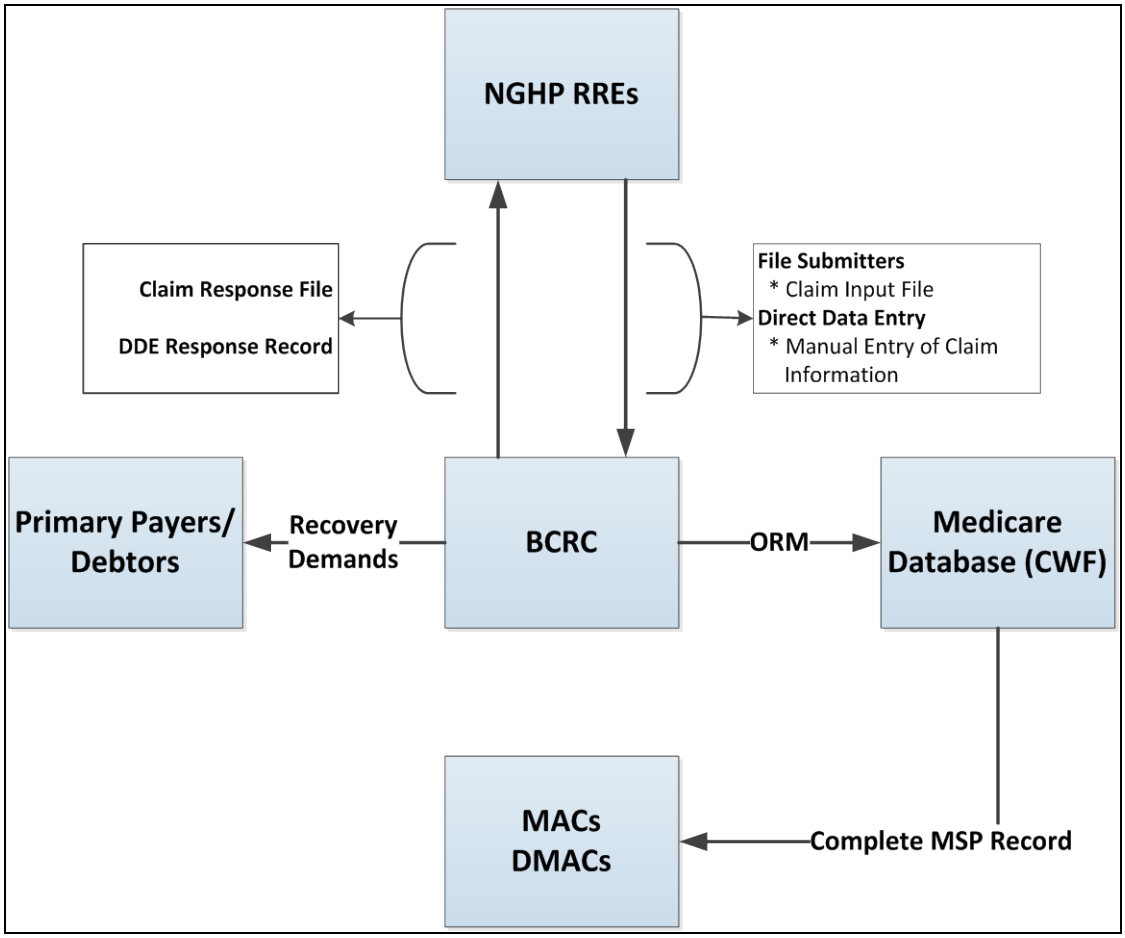
When the BCRC has cleared an RRE for "production" input file submissions, the RRE will submit claim information for all no-fault insurance, and workers' compensation claims involving a Medicare beneficiary as the injured party where the **TPOC Date** for the settlement, judgment, award, or other payment date is **October 1, 2010**, or subsequent, and which meet the reporting thresholds described in the NGHP User Guide Policy Guidance Chapter III. 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 III. 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 *Special Qualified Reporting Exception for ORM…* in the NGHP User Guide Policy Guidance Chapter III).

Ongoing DDE and quarterly file submissions are to contain only new or changed claim information using add, update and delete transactions. Detailed specifications for the Section 111 reporting process are provided in the NGHP User Guide Technical Information Chapter IV.

Data Exchange Process

Figure 6-1 illustrates the Data Exchange process. A narrative description of this process directly follows the figure.

Figure 6-1: Electronic File/DDE Submission 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 to the BCRC 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.
    - 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 using the file submission process, or a response on the DDE Claims Listing page for RREs 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 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 NGHP User Guide Technical Information Chapter IV.

Chapter 7: Section 111 COB Secure Web Site (COBSW)

The BCRC maintains an 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 register and set up accounts on the COBSW. The COBSW URL is http://www.Section111.cms.hhs.gov.

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

- Complete the registration process.
- 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 or SFTP directly with the BCRC. Alternatively, submit claim information via the Direct Data Entry option.
- View and update Section 111 reporting account profile information such as contacts and 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 and processing.
- View statistics related to compliance with Section 111 reporting requirements such as whether files and records have been submitted on a timely basis.
- Utilize 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.

The registration and account setup processes are described in the NGHP User Guide Registration Procedures Chapter (Section 4).

Sources of Help Related to Using the Section 111 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 home page will display.

- Information on the New Registration, Account Setup, and other processes can be found under the *How To* menu at the top of the home page. A Login ID is not needed to access this menu option. Click on the drop-down menu a 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 home page.

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 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 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.Contact your assigned EDI Representative for additional help and assistance using the COBSW. See Section 8.1—Electronic Data Interchange (EDI) Representative for more information.

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 SFTP (See the NGHP User Guide Technical Information Chapter IV). You can play one of two roles 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 II 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.

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 II, obtain a Login ID and complete the account setup tasks.
- Can be an Account Manager associated with another RRE ID if they receive 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 file transmission history.
- Can review file processing status and 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/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.

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 associated with one RRE ID.

The Account Designee:

- Must register on the Section 111 COBSW and obtain a Login ID.
- Can be associated with multiple RRE accounts, but only by an Account Manager invitation for each RRE ID.
- Can upload and download files to the Section 111 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 file transmission history.
- Can review file-processing statuses and file statistics.
- Can change his/her personal information.
- Can remove himself/herself from the RRE ID.
- Cannot be an Authorized Representative for any RRE ID.

- Cannot invite other users to the account.
- Cannot update RRE account information.
- Can query the Medicare status of an injured party using the Beneficiary Lookup feature.

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 may 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. In other words, the role you play on the COBSW is by RRE ID.

COBSW 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 notify 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 shown in Table 7-1 are generated by the system to the Authorized Representative and/or Account Manager for the RRE ID. E-mails will be sent from cobva@section111.cms.hhs.gov. 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 7-1: E-Mail Notification Table

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**: It is recommended that RREs return their signed profile report via e-mail to: their assigned EDI Representative. Do not return signed profile reports to the COBVA e-mail address from which it had initially been 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 theBCRC. 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 8: Customer Service and Reporting Assistance for Section 111

Please be sure to visit the Section 111 page on the CMS web site at 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.

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

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.

8.1 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 step of the registration process. Your profile report is sent to the RRE's Authorized Representative and Account Manager via e-mail after the account set up has been completed.

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.

8.2 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, the first person to contact is**

your own EDI Representative at the BCRC. Your EDI Representative should always be sought out first to help you find solutions for any questions, issues or problems you have.

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

Escalation Process

The CMS and the BCRC places great importance in providing exceptional service to its customers. To that end, we have developed the following escalation process to ensure our customers' needs are met. It is imperative that RREs and their reporting agents follow this process so that BCRC Management can address and prioritize issues appropriately.

1. Contact your EDI Representative at the BCRC. If you have not yet been assigned an EDI Representative, please call the EDI Department number at 646-458-6740 for assistance.
2. 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.
3. 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 COB Director, William Ford, at 646-458-6613. Mr. Ford's e-mail address is WFord@ehmedicare.com.
4. 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 9: Training and Education

Various forms of training and educational materials are available to help you with Section 111 in addition to this guide.

- CMS Publications—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. 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.
- Section 111 Teleconferences—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.
- Free Computer Based Training (CBT) Courses—CMS has made available a curriculum of computer based training (CBT) courses to 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, DDE 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 V contains a list of all the applicable NGHP Alerts posted prior to the publication of this version of the user guide.

Note: The Section 111 User Guides and instructions do not, and are not intended to, cover all aspects of the MSP program. Although these materials may provide high level overviews of MSP in general, any individual/entity which has responsibility as 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
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

The MSP Manual is CMS Publication 100-05.

Chapter 10: 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 Procedures, Technical Information, and Policy Guidance 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 to their assigned EDI Representative. Do not return signed profile reports to the COBVA email address from which it had initially been 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).
- 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).
- Confirm via e-mail that the information on the annual profile report is correct. Failure to confirm this information may result in deactivation of the RRE ID.

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.