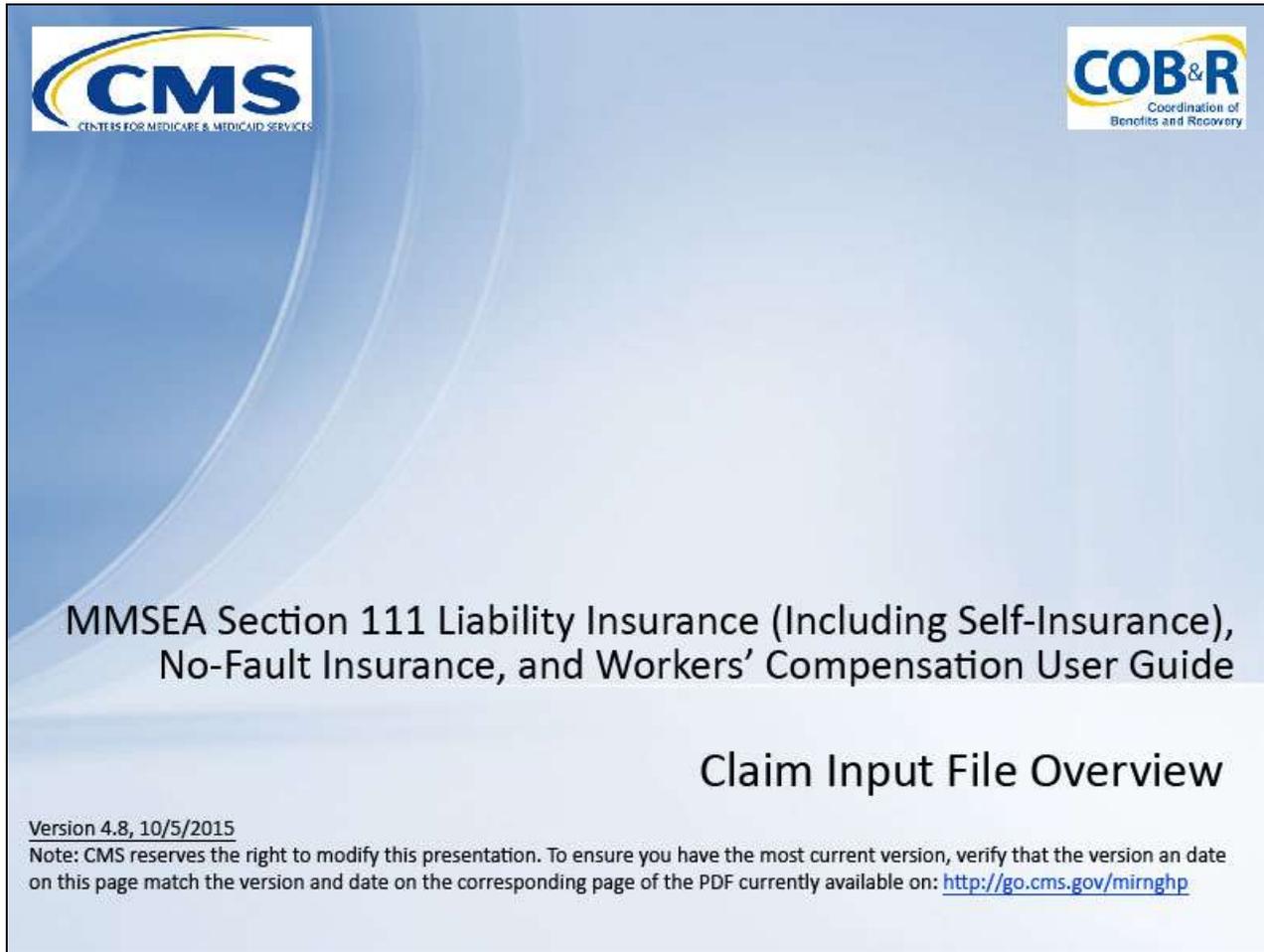


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The slide features a light blue background with a subtle wave pattern. In the top left corner is the CMS logo (Centers for Medicare & Medicaid Services). In the top right corner is the COB&R logo (Coordination of Benefits and Recovery). The main title is centered in the lower half of the slide. At the bottom left, there is a version number and a note about updates, including a URL.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of
Benefits and Recovery

**MMSEA Section 111 Liability Insurance (Including Self-Insurance),
No-Fault Insurance, and Workers' Compensation User Guide**

Claim Input File Overview

Version 4.8, 10/5/2015
Note: CMS reserves the right to modify this presentation. To ensure you have the most current version, verify that the version and date on this page match the version and date on the corresponding page of the PDF currently available on: <http://go.cms.gov/mirmghp>

Slide notes

Welcome to the Claim Input File Overview course.

Note: This module applies to Responsible Reporting Entities (RREs) that will be submitting Section 111 claim information via an electronic file submission as well as those RREs that will be submitting this information via Direct Data Entry (DDE).

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Disclaimer

While all information in this document is believed to be correct at the time of writing, this Computer Based Training (CBT) is for educational purposes only and does not constitute official Centers for Medicare & Medicaid Services (CMS) instructions for the MMSEA Section 111 implementation. All affected entities are responsible for following the instructions found at the following link: <http://go.cms.gov/mirnghp>.

Slide notes

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Course Overview

- Claim Input File
 - Reporting requirements
 - Submission timeframes
 - Claim responses



Although information in this CBT pertains to the creation of the electronic Claim Input File, DDE submitters must adhere to essentially the same requirements and submit the same data on the Section 111 COBSW

Slide notes

This learning module provides an introduction to the Claim Input File, including an overview on reporting requirements, submission timeframes and claim responses.

Although the information in this CBT pertains to the creation and submission of the electronic Claim Input File, DDE submitters must adhere to essentially the same Section 111 reporting requirements and are also required to submit the same data on the Section 111 Coordination of Benefits Secure Web site (COBSW).

NOTE: Liability insurance (including self-insurance), no-fault insurance, and workers' compensation are sometimes collectively referred to as "non-group health plan" or "NGHP." The term NGHP will be used in this CBT for ease of reference.

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Claim Input File

- Data set transmitted from an RRE to the BCRC
- Used to report NGHP claim information where
 - Injured party is a Medicare beneficiary
 - Medicals are claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals

Slide notes

The Claim Input File is the data set that is transmitted from an RRE to the Benefits Coordination & Recovery Center (BCRC) that is used to report NGHP claim information where the injured party is a Medicare beneficiary and medicals are claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals.

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Reporting Requirements

- Claim information is reported after
 - ORM has been assumed by the RRE, or
 - A TPOC settlement, judgment, award or other payment has occurred
- A TPOC single payment obligation is reported in total regardless of whether it is funded through
 - A single Payment
 - An annuity
 - A structured settlement
- For more information, please review the
 - Ongoing Responsibility for Medicals (ORM) CBT
 - Total Payment Obligation to Claimant (TPOC) CBT

Slide notes

Claim information is reported after ongoing responsibility for medicals (ORM) has been assumed by the RRE or after a Total Payment Obligation to Claimant (TPOC) settlement, judgment, award or other payment has occurred.

A TPOC single payment obligation is reported in total regardless of whether it is funded through a single payment, an annuity or a structured settlement.

For a more thorough explanation of these topics, please see the Ongoing Responsibility for Medicals CBT and the Total Payment Obligation to Claimant CBT.

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Reporting Requirements

- No-fault insurance and workers' compensation claims
 - Addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award or other payment
 - On or after 10/1/2010
 - Meet the reporting thresholds

Slide notes

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 the NGHP User Guide Policy Guidance Chapter (Section 6.4) and in the Mandatory Reporting Thresholds CBT.

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Reporting Requirements

- Liability insurance (including self-insurance) claims
 - Addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award or other payment
 - On or after 10/1/2011
 - Meet the reporting thresholds

Slide notes

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 the NGHP User Guide Policy Guidance Chapter (Section 6.4) and in the Mandatory Reporting Thresholds CBT.

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Reporting Requirements

- ORM related to a no-fault, workers' compensation or liability claim
 - Assumed by the RRE on or after 1/1/2012
 - Exists on or through 1/1/2010 regardless of the date of an initial acceptance of payment responsibility
- For more information on the types of claims that must be reported, please see
 - Reportable Claims CBT

Slide notes

RREs must also report claim information where 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 Special Qualified Reporting Exception in the NGHP User Guide Policy Guidance Chapter [Section6.3.2]).

For further guidance on the types of claims that must be reported, please see the Reportable Claims CBT.

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Reporting Requirements

For settlement, judgment, award, or other payment without a separate ORM

- Report one initial record on Claim Input File
- See Event Table in the NGHP User Guide for events that trigger subsequent updates
 - For example, send update if you need to modify a previously submitted diagnosis code or report an additional TPOC Amount



Slide notes

In the case of a settlement, judgment, award, or other payment without separate ORM at any time, only one Claim Detail Record is required to be submitted per liability (including self-insurance), no-fault insurance, or workers' compensation claim where the injured party is a Medicare beneficiary.

This record will be entered as a detail record on the Claim Input File. The Event Table in the NGHP User Guide lists the events that will trigger subsequent update record submissions. For example, you will have to send an update to modify a previously submitted diagnosis code or to report an additional TPOC Amount.

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Reporting Requirements

Report assumption or termination of ORM along with one-time reporting of payments where ORM is not assumed

- Do not report individual payments for each medical item or service
- Do not report a previously submitted and accepted record unless you have an update to make
- See Event Table in the NGHP User Guide for events that require updates

Slide notes

An RRE is to report the assumption or termination of ORM situations along with the one-time reporting of payments where ORM is not assumed. When reporting these claims, do not report individual payments for each medical item or service.

Do not report a previously submitted and accepted record each quarter, unless you have an update to make. The Event Table in the NGHP User Guide explains all situations that require an update record on the quarterly Claim Input File.

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Reporting Requirements

- Must report two events, if RRE has accepted ORM
 - Initial (add) record to reflect the acceptance of ORM
 - Second (update) record to reflect end date of ORM
 - ORM Indicator must remain as Y for yes
 - Do not change to N
 - Y indicates current ORM only until termination date is reported
 - Once the termination date is reported, the Y reflects the existence of ORM prior to termination date

Slide notes

The RRE must report two events if they have accepted ORM, as is the case with many workers' compensation and no-fault claims; an initial (add) record to reflect the acceptance of ORM, and a second (update) record to reflect the end date of ORM, with the corresponding end date reflected in the ORM Termination Date (Field 79).

When the RRE sends the update record, they will be updating the previously accepted ORM record. Please note, when termination of ORM is reported, the ORM Indicator in Field 78 must remain as Y (for yes); do not change it to N.

The Y indicates current ORM only until a termination date is reported. Once the termination date is reported, the Y reflects the existence of ORM prior to the termination date.

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Reporting Requirements

- Some situations require RRE to report assumption of ORM in same record as its termination date
 - Report only one add record for claim report
- Do not submit a claim report every time a payment is made for situations involving ORM
- When reporting no-fault claim information, include
 - No-Fault Insurance Limit (Field 61)
 - When reporting the assumption of ORM
 - Exhaust Date for the Dollar Limit of No-Fault Insurance (Field 62)
 - When ORM is terminated

Slide notes

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.

In this case, only one add record will be submitted for the claim report. RREs are not to submit a report on the Claim Input File every time a payment is made for 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 6.6, of the NGHP User Guide IV, for further information on reporting ORM.

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Reporting Requirements

- RREs must implement a procedure to determine if injured party is a Medicare beneficiary
- File submitters may use the following tools
 - Query File process
 - Beneficiary Lookup action
- DDE submitters
 - Query functionality is built into process



Slide notes

RREs must implement a procedure to determine whether an injured party is a Medicare beneficiary. RREs that are file submitters may use the Section 111 Query File process or the Beneficiary Lookup action on the Section 111 COBSW as a tool to identify Medicare beneficiaries.

Note: Query functionality (beneficiary lookup) is built into the first step of the DDE claim submission process on the Section 111 COBSW.

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Reporting Requirements

Not acceptable to send claim information without regard for injured party's Medicare status

CMS will monitor Claim Input File submissions to ensure RREs have verified injured party's Medicare status

Slide notes

It is not acceptable for an RRE to send claim information without regard to 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 rather than submitting their entire set of claims to satisfy Section 111 reporting requirements.

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Reporting Requirements

- Submit Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN) for the injured party
- Report only with respect to Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award, or other payment)
- If reported individual is not a Medicare beneficiary, or if CMS is unable to validate a particular HICN or SSN
 - Record will be rejected
 - Applied Disposition Code (Field 27) on Claim Response File Detail Record will be returned with '51'
- For more information on response file processing, please see the Claim Response File CBT

Slide notes

RREs must submit either the Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN) for the injured party on all Claim Input File Detail Records.

RREs are to report only with respect to 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 if CMS is unable to validate 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.

For more information on response file processing, please see the Claim Response File CBT.

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Matching Criteria

- The BCRC must match your data to Medicare's
- Matching can be done using the HICN or the SSN
 - HICN is preferred
- Once the HICN is returned on a response file
 - RRE must use it on all subsequent transactions
- Required to send either the HICN or the SSN on the Claim Input File or the Query Input File

Slide notes

In order 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 either an individual's Medicare HICN or by using an individual's SSN.

The Medicare HICN is preferred and once the HICN is returned on a response file, the RRE is required to use it on all subsequent transactions. 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.

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Matching Criteria

- To determine if individual is a beneficiary, the BCRC uses
 - HICN or SSN
 - First initial of the first name
 - First six characters of the last name
 - Date of birth
 - Gender
- First, an exact match on the HICN or SSN must be found
 - Then, an exact match must be found on at least three out of the four other key fields
- If a match is found, the following values will be returned
 - Correct, current HICN
 - Updated values for the name, date of birth, and gender

Slide notes

For matching an individual to determine if they are a Medicare beneficiary the BCRC uses: HICN or SSN; First initial of the first name; First six characters of the last name; Date of birth (DOB); and, Gender.

First, an exact match on the HICN or SSN (i.e. the last five digits or full 9 digits of the SSN, whichever is submitted) must be found.

Then an exact match must be found on at least three out of the four other key fields and all four must match when a partial SSN is used. If a match is found, you will always be returned the correct, current HICN on the Claim Response File.

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 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.

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HICNs

- May be changed by the Social Security Administration, but the BCRC can crosswalk the old HICN to the new HICN
- The BCRC will always return the most current HICN
 - RREs must update their system and use current HICN on subsequent record transmissions
- Updates and deletes sent under the original HICN/SSN will still be matched to the current HICN

Slide notes

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. 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.

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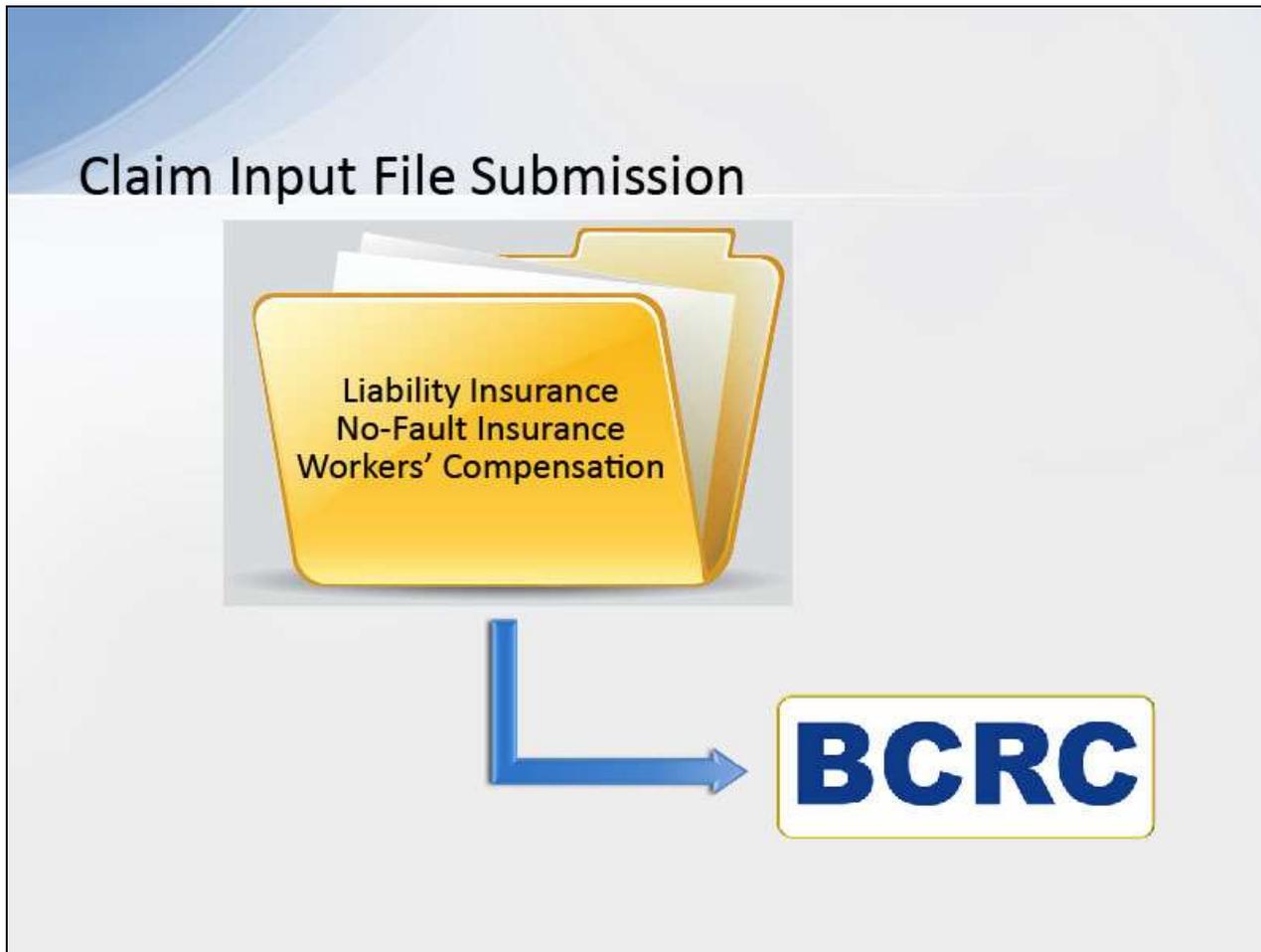
Claim Input File Submission

- Transmitted in a fixed-width, flat file format
 - File layout is in Appendix A
 - Field descriptions apply to both file submission and DDE

Slide notes

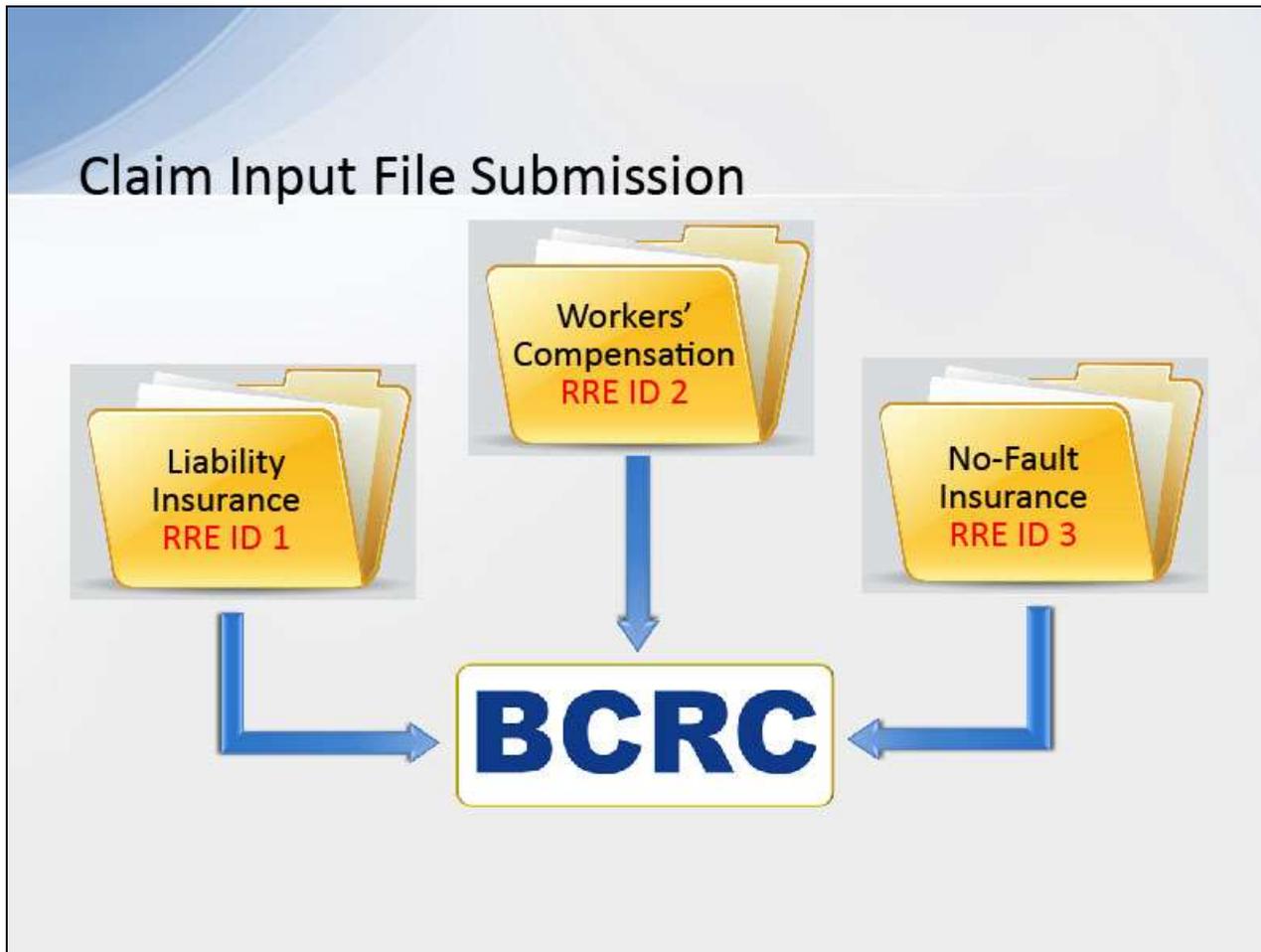
The Claim Input File is transmitted in a fixed-width, flat file format. The file layout is provided in the NGHP User Guide Appendices Chapter V (Appendix A). Field descriptions in Appendix A apply to both file submission and the information submitted via DDE.

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**Slide notes**

An RRE may include liability insurance (including self-insurance), no-fault insurance, and Workers' Compensation Claim Detail Records in a single file submission, if it has responsibility for multiple lines of business. However, there is no requirement to do so.

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**Slide notes**

If the RRE will submit separate files by line of business, subsidiary, agent submissions, claim processing systems, or other reason, then the RRE must register and obtain an RRE ID for each quarterly Claim Input File submission, as described in the Registration and Account Setup section of the Section 111 NGHP User Guide.

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Claim Input File Submission

- Must be submitted prior to or with the initial Claim Input File
- Used to report name and address associated with RRE TIN reported on Claim Input File in Field 72
- Does not need to accompany subsequent Claim Input Files unless there are changes or additions

Slide notes

A Federal Tax Identification Number (TIN) Reference File must be submitted prior to or with the initial Claim Input File.

The TIN Reference File is used to report the full name and address associated with each plan or RRE TIN reported on the Claim Input File in Field 72.

Subsequent Claim Input Files do not need to be accompanied by a TIN Reference File, unless the RRE is modifying information for a previously submitted TIN and Office Code/Site ID or adding new TIN and Office Code/Site ID combinations.

However, if you choose, you may submit a TIN Reference File with every quarterly Claim Input File submission. Additional information on the TIN Reference File can be found in the TIN Reference File CBT and in the NGHP User Guide.

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Claim Input File Submission

File Submitters

- Claim Input File submitted quarterly (four times a year)
- Within the RRE's assigned 7-day submission period each quarter, unless an RRE has nothing to report
 - File submission timeframes assigned after successful registration for Section 111

DDE Submitters

- Enter claim information manually for Section 111 COBSW
 - Anytime, but at least within 45 days of establishing a TPOC or assuming ORM

Slide notes

The Claim Input File is submitted on a quarterly basis, four times a year. Claim Input Files must be submitted within the RRE's assigned, 7-day submission period each quarter, unless an RRE has nothing to report for a particular quarter.

File submission timeframes will be assigned after successful registration for Section 111 reporting.

Note: DDE submitters will enter claim information manually on the Section 111 COBSW at any time but at least within 45 days of establishing a TPOC or assuming ORM.

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Claim Input File Submission

Claim Input File submitted within 14 calendar days before the start of a submission period

- Considered early submission for the quarter
 - File held until the start of the submission period
 - Files submitted more than 14 days prior will be suspended with the assumption they were submitted in error

Slide notes

Claim Input Files submitted within 14 calendar days before the start of a submission period are considered early submissions for that quarter. The file will be held until the start of the submission period.

Files submitted more than 14 days prior will be suspended with the assumption they were submitted in error and will require Electronic Data Interchange (EDI) Representative intervention.

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Claim Input File Submission

Records not received timely are processed, but marked as late

- Compliance Code of 01 placed in Compliance Flag

Settlement, judgment, award, or other payment within 45 days prior to submission timeframe, may be reported on next quarterly file

- Grace period provides time for RRE to process internally

Slide notes

Claim Detail Records not received timely will be processed, but marked late. A compliance code of 01, indicating that a late submission was received, will be placed in the first available Compliance Flag (Fields 38-47) of the corresponding Claim Response File Detail Record.

However, if the settlement, judgment, award, or other payment (including assumption of ORM) is within 45 days before the start of the 7-day file submission timeframe, then an RRE may submit that Claim Detail Record on the next quarterly file.

This grace period allows the RRE time to process the newly resolved (partially resolved) claim information internally, prior to submission for Section 111.

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Claim Input File Submission

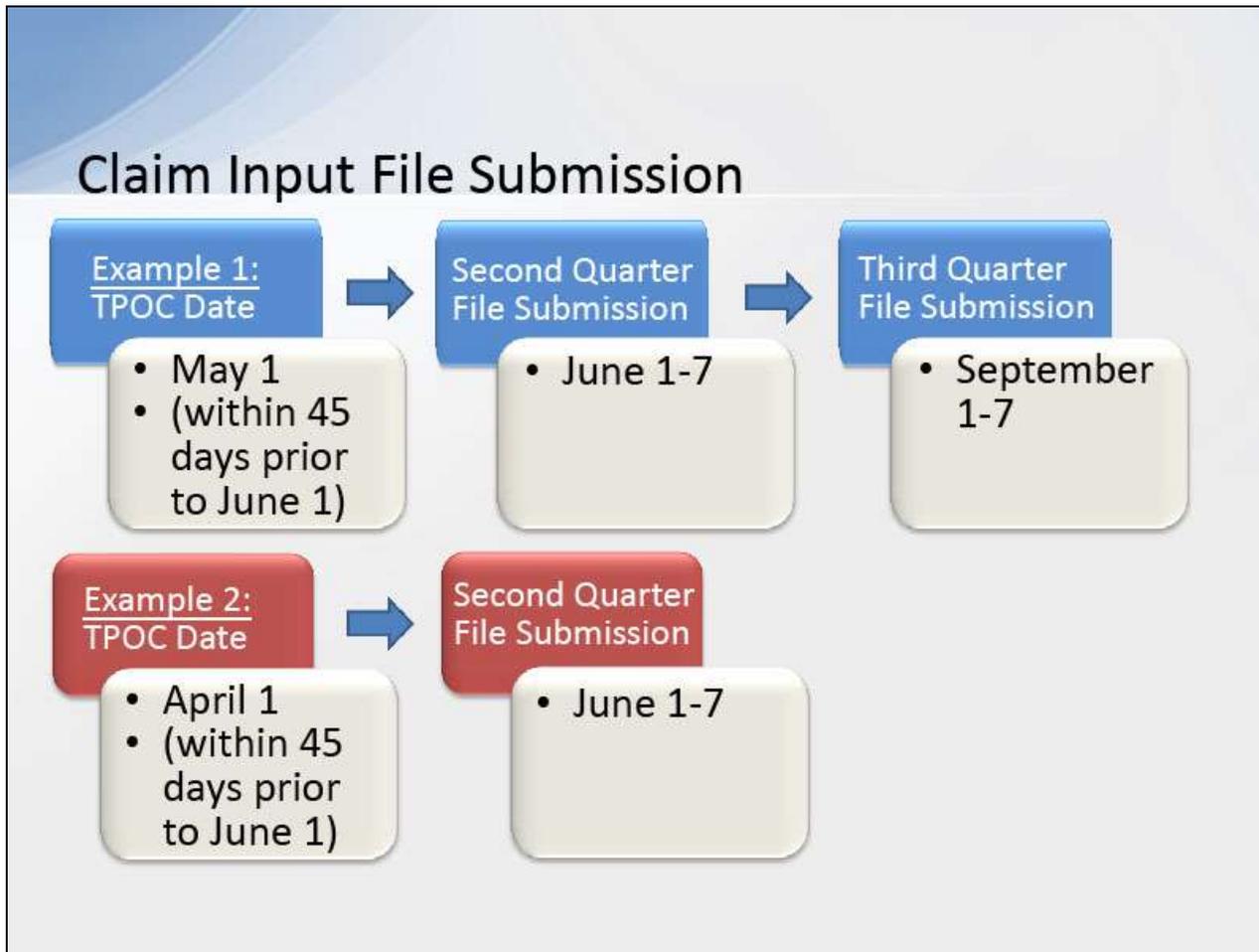
- RREs must contact their EDI Representative if they cannot submit during their assigned timeframe for the quarter in question
- EDI Representative can approve a file submission off-schedule depending on the circumstances
- File may suspend, but your EDI Representative will release it for processing if arrangements were previously made
- Any time you cannot submit your file during your assigned file submission timeframe, contact your EDI Representative immediately

Slide notes

If you cannot submit during your assigned timeframe for the quarter in question, contact your EDI Representative for guidance. Your EDI Representative can approve a file submission off-schedule depending on the circumstances.

The file may suspend, but your EDI Representative will release it for processing if arrangements have been previously made. At any time, if you will not be able to submit your file during your assigned file submission timeframe, contact your EDI Representative immediately.

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**Slide notes**

If a claim has a TPOC Date of May 1, 2011, and file submission period for the second calendar quarter of 2011 is June 1-7, 2011, then the RRE may delay reporting this claim until the third calendar quarter file submission because the TPOC Date is within 45 days of the June 1-7 file submission period.

The grace period gives the RRE the option of submitting this claim during their June 1-7, 2011 file submission period, or they can delay reporting until the third calendar quarter of 2011 (September 1-7).

However, if the TPOC Date for a record is April 1, 2011, and the file submission period for the second calendar quarter of 2011 is June 1-7, 2011, then the RRE must include this record on the second calendar quarter file submission. In this case, the TPOC Date is outside the 45-day window of reporting and therefore, no grace period applies.

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Claim Input File Submission

Used by the BCRC to determine

- If injured party can be identified as a Medicare beneficiary based on information submitted and
- Whether the beneficiary's coverage under Medicare continued or commenced on or after CMS DOI
- Note: Definition of CMS DOI differs from Industry DOI
 - CMS DOI is 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 any medical practitioner
 - See definitions in Appendix A of the [NGHP User Guide](#)

Slide notes

The BCRC will use the submitted claim information to determine if the injured party reported can be identified by CMS as a Medicare beneficiary, based upon the information submitted and whether the beneficiary's coverage under Medicare continued or commenced on or after the date of incident (DOI) as defined by CMS.

Please note: The definition of the CMS Date of Incident (DOI) differs from the definition of that generally used by the insurance industry under specific circumstances.

For MMSEA Section 111, the CMS required DOI for a cumulative injury is 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 any medical practitioner.

Please see the definition of the CMS DOI (Field 12) and Industry DOI (Field 13) of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter V (Appendix A) for an explanation.

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Claim Response File

If claim information passes the BCRC edit process and is applicable to Medicare coverage

- Passed to other Medicare systems and databases

The BCRC will return a response file for each Claim Input File

- Response File
 - Contains a response record for each input record
 - Includes information on errors found, disposition codes and MSP information as prescribed by the response file format
 - Created as soon as all submitted records have finished processing but no later than 45 days after file submission
 - RREs must react and take action on information returned
 - Account Managers will receive e-mail notifications when file is ready
 - File processing status may also be viewed on the Section 111 COBSW

Slide notes

If the claim information provided on the Claim Input File passes the BCRC edit process and is applicable to Medicare coverage, it is then passed to other Medicare systems and databases including those used by the BCRC and Medicare claims processing contractors.

The BCRC will return a response file for each Claim Input File. This response file will contain a response record for each input record, indicating the results of processing.

The response file 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.

The BCRC will commence creation of the response file as soon as all submitted records have finished processing but no later than 45 days after file submission. RREs must react and take action on the information returned in the response file.

For example, if a response record indicates that the Claim Input record was not accepted due to errors, then the RRE must correct the record and resend it on their next quarterly file submission.

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 status may also be viewed on the Section 111 COBSW.

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DDE Responses

If claim information passes the BCRC edit process and is applicable to Medicare coverage

- Passed to other Medicare systems and databases

The BCRC will return a response file for submitted DDE

- Displayed on the Claim Listing page of the Section 111 COBSW
- RREs must react and take action on the information

Slide notes

If the claim information submitted via DDE passes the BCRC edit process and is applicable to Medicare coverage, it is then passed to other Medicare systems and databases including those used by the BCRC and Medicare claims processing contractors.

The BCRC will return a response for each claim submitted via DDE. DDE responses are displayed on the Claim Listing page of the Section 111 COBSW. RREs must react and take action on the information returned on the DDE Claim Listing page.

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You have completed the Claim Input File Overview course. Information in this presentation can be referenced by using the NGHP User Guide's table of contents and any subsequent alerts. These documents are available for download at the following link:
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Slide notes

If you have any questions or feedback on this material, please go the following URL:
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