

Section 111 Non-Group Health Plan (NGHP) Reporting Webinar



August 13, 2020

- Section 111 Reporting Tips, Best Practices and Reminders
- Medicare Secondary Payer Recovery Portal (MSPRP) Enhancements
- Questions and Answers

Presentation Overview

Changing Reporting Agents (1 of 2)

- If a Responsible Reporting Entity (RRE) is changing reporting agents, the new agent should continue to submit files under the RRE's existing RRE ID(s).
- It is the RRE's responsibility to coordinate the transition of reporting from the former agent to the new agent and to notify your Electronic Data Interchange (EDI) Representative of the change. Individuals from the new reporting agent should be given access to the RRE ID on the Section 111 Coordination of Benefits Secure Website (COBSW).
- <https://www.cob.cms.hhs.gov/Section111/>

Changing Reporting Agents (2 of 2)

RRE Listing

This page lists all the Responsible Reporting Identification Numbers (RRE IDs) with which you are associated. You can select from the Actions available in the drop-down menu next to each RRE ID. Click on the down arrow, select an Action from the list and then click on the Go button.

To search for a specific RRE enter the RREID and click on the Search button. To refresh the complete list of RREs with which you are associated, click on the Refresh RRE Listing button.

The RRE Listing is sorted by RRE ID.

RRE ID

items found, displaying all items: 1

RRE ID	Name	Status	Submission Period	Reporting Options	EDI Representative Name	EDI Phone Number	EDI Email	Actions
123456	AAAAAAAAAAAA	Setup	01	Expanded	Mike Jones	2813308004	mike@whomikejones.com	Designee Maintenance  <input type="button" value="Go"/>

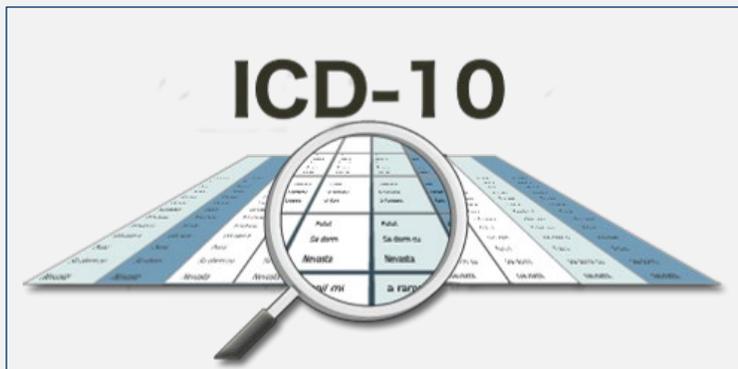
Recovery Agent Information and Tax Identification Number (TIN) Reference File Reminders (1 of 2)

- Some NGHP RREs use recovery agents to perform or assist with tasks related to Medicare Secondary Payer (MSP) demands or potential demands.
- For the purposes of Section 111 NGHP submission of Recovery Agent information only, the Centers for Medicare & Medicaid Services (CMS) uses the designation of an agent and submission of that agent's name and address on the TIN Reference File or Direct Data Entry (DDE) submission as an authorization by the RRE for the agent to resolve any recovery correspondence related to claim submissions.

Recovery Agent Information and TIN Reference File Reminders (2 of 2)

- RREs should submit recovery agent information in the dedicated Recovery Agent fields.
- The most current matching TIN/Office Code information submitted will be the information used for future recovery.
- If you need to change TIN information, you must resubmit the TIN record with the new information and the matching claim record.

- When reporting dates of incident/discharge dates prior to 10/1/2015, you may use International Classification of Diseases, Ninth Revision (ICD-9) or ICD-10 codes.
- When reporting date of incident/discharge dates on or after 10/1/2015 use ICD-10 codes only.
- It is not necessary to change previously accepted dates of incident prior to 10/1/2015 to ICD-10 codes.



Diagnosis Codes (1 of 3)

- Accurate reporting of diagnosis codes is critical for accurate recovery.
- Only report relevant injury information.
- Partial codes will not be accepted and must exactly match the first 5 positions of a code on the list of valid ICD-9/ICD-10 diagnosis codes.

Diagnosis Codes (2 of 3)

- Retain the leading and trailing zeros if they are part of the valid code but do not add any additional leading or trailing zeros.
- Do not include the decimal point but do include any digits that follow the decimal point.
 - For example: ICD-9 code 038.42 should be submitted as 03842

Diagnosis Codes (3 of 3)

Using the NOINJ Code (1 of 2)

- NOINJ - Default diagnosis code that may be used under limited and specific circumstances when reporting liability insurance (including self-insurance).
- Used when 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.



Using the NOINJ Code (2 of 2)

- The code of “NOINJ” may not be submitted on claim reports reflecting Ongoing Responsibility for Medicals (ORM).
- The default code of “NOINJ” may only be used when reporting liability insurance.
- “NOINJ” will only be accepted in Fields 15 and 18 on the Claim Input File Detail Record.
- If “NOINJ” is submitted in Field 18, then ‘NOINJ’ (or all spaces) must be submitted in Field 15; and vice versa.
- If “NOINJ” is submitted in Field 18, then all remaining ICD Diagnosis Codes 2-19 (Fields 19-36) must be filled with spaces.
- If a “NOINJ” code is incorrectly or inappropriately used, or the above-mentioned requirements for using it are not met, then the record will be rejected.

Submission Timeframes

- Claim Input Files must be submitted quarterly during the RRE's assigned submission timeframe.
- RREs may submit multiple files in a single quarter but:
 - Subsequent file submissions will not be processed until the prior file processing has been completed and the response file generated.
 - RREs will be limited to one file submission every fourteen days.



- Mandatory reporting thresholds have been defined by CMS.
- A Total Payment Obligation to Claimant (TPOC) generally reflects a “one-time” or “lump sum” settlement, judgment, award, or other payment intended to resolve or partially resolve a claim.
- These TPOC dollar thresholds apply only to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation records that do not have ORM.



Reporting Thresholds (1 of 3)

Reporting Thresholds (2 of 3)

Insurance Type	Reporting Required for Cumulative Total TPOC Amount(s)	Most Recent TPOC Date is on or between	Reporting Required Quarter Beginning
No-Fault	Greater than \$750	October 1, 2016 or after	January 1, 2017
Liability insurance (including self-insurance)	Greater than \$750	January 1, 2017 or after	April 1, 2017
Workers' Compensation	Greater than \$750	October 1, 2016 or after	January 1, 2017

- When there are multiple TPOCs reported by the same RRE on the same record, the combined TPOC amounts must be considered in determining whether the reporting threshold is met.
- 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.
- ORM must always be reported but payments made due to ORM are NOT TPOCs.
- Non-trauma liability reporting for exposure, ingestion, and implantation must be reported.

Reporting Thresholds (3 of 3)

- 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
- TPOC amount or No-Fault Insurance Limit exceeds 100 million dollars.
- The Account Manager will be notified for any of these errors.
- The Account Manager **MUST** contact their EDI Representative to resolve.

Threshold Errors

Med Pay/PIP Reminder

- Both Med Pay and Personal Injury Protection (PIP) coverage should be included when reporting the No-Fault Insurance Limit (Field 61 of the Claim Input File).
- Both Med Pay and PIP limits should be combined for a policy when they are separate coverages being paid out on claims for the same party and incident under a single policy.
- If both are not reported the amount reported is not an accurate reflection of the policy limit.
- ORM should not terminate until both coverage limits are exhausted.

TIN Reference Response File (1 of 2)

- Submitted TIN Reference Files will generate a corresponding TIN Reference Response File.
- 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 TIN Reference Response File.
- RREs must make the necessary corrections to their TIN Reference File Detail Records and submit these corrections.

TIN Reference Response File (2 of 2)

- The TIN Reference File does not need to be submitted with each Claim Input File. Only submit when updates are necessary.
- Updates to the TIN Reference file will update all records with a corresponding TIN on previously submitted files.

Error Codes

Error Codes beginning with

Relate to

CB	Claim Beneficiary Information
CC	Claim Claimant Information
CI	Claim Injury Information
CJ	Claim Ongoing Responsibility for Medicals (ORM) or Total Payment Obligation to Claimant (TPOC) Information
CP	Claim Plan Information
CR	Claim Representative Information
CS	Claim Self-Insurance Information
CT	Claim Auxiliary TPOC Information
SP	Errors returned by CWF
TN	TIN Reference File Errors

Common Error Codes (1 of 2)

Error Code	Record	Field Name	Field Required	Common Clause
CI04	Claim Input File Detail Record	State of Venue (Field 16)	Yes	Field 16 is left blank
CI05	Claim Input File Detail Record	ICD Diagnosis Code 1 (Field 18)	Yes, if Action Type (Field 3) =0 (Add) or if Action Type (Field 3) =2 (Update)	Field 18 is left blank or the code is invalid
CJ01	Claim Input File Detail Record	ORM Indicator (Field 78)	Yes	Field is left blank

Common Error Codes (2 of 2)

Error Code	Record	Field Name	Field Required	Common Clause
CJ07	Claim Input File Detail Record	TPOC Threshold	N/A	ORM Indicator= "N" and the cumulative total of all submitted TPOC Amounts is zero
TN99	Claim Input File Detail Record	TIN/Office Code (Field 52 & 53)	Yes for Field 52	TIN Reference File Errors were not corrected

Escalation Process

- Contact your EDI Representative at the BCRC.
- If your Section 111 EDI Representative does not respond to your inquiry or issue within two business days, you may contact the EDI Director, Angel Pagan, at 646-458-2121 or apagan@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, at 646-458-6682 or JBrady@ehmedicare.com.



MSPRP Enhancements

Recent:

- Addition of a “Previous” button to more screens for ease of use.
- When logged in with Multi-Factor Authentication (MFA), the ability to view and reprint correspondence from the Letter Activity tab.
- Also when logged in with MFA, the ability to see ICD code descriptions when hovering over the codes on the MSPRP Claims Listing page and the ability to view the ICD code(s) submitted via Section 111 reporting on this same page.
- Changes to the Case Information page to provide additional information about conditional payments, treasury referrals, and reported ORM.

Resources

- The EDI Department is available for assistance at (646) 458-6740.
- For additional information, please also see the following resources:

[Section 111 NGHP User Guide](#)

[Section 111 COBSW MRA User Guide](#)

[MSPRP User Guide](#)

[Section 111 NGHP Training Materials](#)

[MSPRP Training Materials](#)

[Section 111 Mailbox](#)

Questions & Answers



Title: Section 111 Non-Group Health Plan (NGHP) Reporting Webinar**Slide 1: Presentation Overview**

No slide notes available.

Slide 2: Changing Reporting Agents (1 of 2)

Today we would like to begin by covering instances when changes to reporting agents need to be made by a Responsible Reporting Entity (RRE). We want to ensure that everyone is aware of what is needed in order to make that change.

If an RRE is changing reporting agents, the new agent should continue to submit files under the RRE's existing RRE ID(s). There is no need to go through the registration process to create a new RRE ID when changing reporting agents.

It is the RRE's responsibility to coordinate the transition of reporting from the former agent to the new agent and to notify your Electronic Data Interchange (EDI) Representative of the change. Individuals from the new reporting agent should be given access to the RRE ID on the Section 111 COBSW (<https://www.cob.cms.hhs.gov/Section111/>).

Next, we will show you how to update the information.

Slide 3: Changing Reporting Agents (2 of 2)

Changing reporting agents can be done by the Account Manager by logging into the COBSW and using the Designee Maintenance Action located on the RRE Listing page to invite these individuals as Account Designees.

Select Designee Maintenance from the Actions drop-down menu for the RRE ID you wish to change agents for, then select Go. Follow the instructions on the Designee Listing page to add and delete designees as needed.

The new agent may then use their COBSW login IDs for access to the RRE ID on the COBSW as well as for the HTTPS and SFTP file transmission methods.

If you have questions regarding your specific circumstances related to ceasing or transitioning reporting, please contact your EDI Representative. You will also need to contact your EDI Representative if you need to change your Authorized Representative or Account Manager for the COBSW as those cannot be changed online.

Slide 4: Recovery Agent Information and Tax Identification Number (TIN) Reference File Reminders (1 of 2)

When you are using a recovery agent to assist with MSP recovery demands or potential demands it is important to correctly report the Recovery Agent information. For Section 111 NGHP submissions, the Centers for Medicare & Medicaid Services (CMS) will use your designation of a recovery agent on the TIN Reference File as an authorization for that agent to resolve recovery correspondence related to claim submissions.

Slide 5: Recovery Agent Information and TIN Reference File Reminders (2 of 2)

RREs should be submitting recovery agent information in the dedicated Recovery Agent fields.

The recovery process will always use the most current matching TIN/office code info submitted regardless of when the claim detail record was submitted.

RREs don't have to resubmit all the matching claim detail records after submitting a new TIN record. The RRE, however, will have to resubmit the TIN record and the matching claim records.

Slide 6: Diagnosis Codes (1 of 3)

Now let's talk about more about specific Section 111 reporting topics, starting with diagnosis codes. The topic of diagnosis codes comes up frequently in questions to the Section 111 mailbox and the EDI Department. So here are some things to remember.

When reporting ICD-9 or ICD-10 diagnosis codes, the requirement from CMS is that reporters must report for dates of incident/discharge (DOS) on and after October 1, 2015 with ICD-10 codes. Any date of incident before that date can be reported using ICD-9 or ICD-10.

This application functionality was implemented as part of the ICD-10 transition to reject ICD-9 codes submitted for dates of incident after 10/1/2015. If reports were made for a date of incident prior to 10/1/2015, they should not be updated to change a previously accepted ICD-9 code to an ICD-10 code, and there should be no reports after 10/1/2015 with ICD-9 codes.

Slide 7: Diagnosis Codes (2 of 3)

We also wanted to mention some best practice tips for reporting diagnosis codes. In order to accurately identify claims for recovery purposes and to prevent Medicare from paying primary in the case of Ongoing Responsibility for Medicals (ORM), it is critical to submit all diagnosis codes that pertain to the injury but not codes for pre-existing or unrelated conditions. The more accurate your reporting of diagnosis codes, the more accurate the recovery process will be.

With that in mind:

Only report relevant injury information. As previously mentioned, you should not report diagnosis codes for pre-existing conditions if included in the initial ER visit.

Be sure to submit ICD diagnosis codes that exactly match the first 5 positions of a code on the list of valid ICD-9 and ICD-10 codes. Partial codes are not accepted.

Slide 8: Diagnosis Codes (3 of 3)

You should also be sure to:

Retain leading and trailing zeroes, but do not add leading or trailing zeroes if they are not shown for the code.

Do not include the decimal point but be sure to include any digits that may follow the decimal point. For example, ICD-9 code 038.42 should be submitted as 03842.

You should reference the list of valid ICD-9 and ICD-10 codes as well as the list of excluded codes that are available in the NGHP User Guide, as well as on the Section 111 COBSW.

Slide 9: Using the NOINJ Code (1 of 2)

Our next topic is use of the NOINJ code.

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.

Current instructions require the RRE to report claim information in these circumstances. However, in these very limited circumstances, when no valid ICD-10 diagnosis code can be associated with the claim, 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).

Slide 10: Using the NOINJ Code (2 of 2)

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.
- 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).
- “NOINJ” will only be accepted in Fields 15 and 18 on the Claim Input File Detail Record.
- If “NOINJ” is submitted in Field 18, then “NOINJ” (or all spaces) must be submitted in Field 15; and vice versa.
- If “NOINJ” is submitted in Field 18, then all remaining ICD Diagnosis Codes 2-19 (Fields 19-36) must be filled with spaces.
- If an “NOINJ” code is incorrectly or inappropriately used, or the above-mentioned requirements for using it are not met then the record will be rejected.

Slide 11: Submission Timeframes

Another question that we get often is about file submission timeframes.

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. RREs are assigned their quarterly file submission timeframe at the completion of the registration process.

However, we want to clarify that 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.

The two limitations that apply to this are:

Subsequent file submissions will not be processed until the prior file submission has completed and a response file has been generated. RREs should not submit a subsequent file until the prior file's response file has been received.

RREs will be limited to only one file submission every fourteen days.

Slide 12: Reporting Thresholds (1 of 3)

Let's also take a look at reporting thresholds.

CMS has defined mandatory reporting thresholds solely for purposes of the required Section 111 Medicare Secondary Payer (MSP) reporting requirements. These thresholds are not exceptions for any other obligation or responsibility of any individual or entity with respect to the MSP provisions.

A Total Payment Obligation to Claimant (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.

Remember that for reporting purposes the TPOC date is the date the payment obligation is established and not the actual date the payment is released.

RREs are required to report liability insurance (including self-insurance), no-fault insurance, and workers' compensation TPOCs only if the cumulative TPOC Amount exceeds the reporting threshold for the most recent TPOC date.

Slide 13: Reporting Thresholds (2 of 3)

For Section 111 reporting, the current minimum reportable TPOC amounts for liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims is \$750. For Liability – TPOC dates as of 1/1/2017 and subsequent, for No-Fault and Workers' Compensation – TPOC dates as of 10/1/2016 and subsequent.

TPOC amounts that exceed these thresholds must be reported. However, TPOC amounts less than the specified threshold may be reported and will be accepted.

The CJ07 error will be returned for a liability, workers' compensation, or no-fault claim report where the ORM Indicator is set to "N" and the cumulative TPOC amount is zero.

Slide 14: Reporting Thresholds (3 of 3)

When there are multiple TPOCs reported by the same RRE on the same record, the combined TPOC Amounts must be considered in determining whether the reporting threshold is met.

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.

ORM must always be reported however payments made due to ORM are not TPOCs.

And also note that non-trauma liability reporting for exposure, ingestion, and implantation must be reported.

Slide 15: Threshold Errors

We also would like to mention threshold errors.

After completion of data quality edits, the Benefits Coordination & Recovery Center (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:

- If 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
- TPOC amount or No-Fault Insurance Limit exceeds 100 million dollars

A file that exceeds the threshold error checks will be suspended from further processing until the suspension is overridden by your EDI Representative.

An email will be sent to the Account Manager to inform him or her of this suspension. You must contact your assigned EDI Representative to analyze and resolve file threshold errors. Once you have contacted your assigned EDI Representative, your file may be released for processing. Or, if it was sent in error, it will be deleted, in which case you may need to resend a corrected file, as instructed by your EDI Representative.

Slide 16: Med Pay/PIP Reminder

We recently put out a Section 111 Alert regarding PIP/Med Pay, so we think mentioning it again in this forum will be beneficial.

When reporting the No-Fault Insurance limit on the Claim Input File, it is important to remember that both Med Pay and Personal Injury Protection (PIP) coverage should be included when reporting the No-Fault Insurance Limit, which is Field 61 of the Claim Input File.

RREs must combine both Med Pay and PIP coverage limits for a policy when they are separate coverages being paid out on claims for the same injured party and incident under a single policy.

Recently it has come to our attention that some NGHP RREs are only including Med Pay when reporting the No-Fault Insurance Limit.

If both Med Pay and PIP coverage limits are not reported, then the amount reported is not an accurate reflection of the policy limit. Ongoing responsibility for medicals should not terminate until both the Med Pay and PIP coverage limits are exhausted.

Slide 17: TIN Reference Response File (1 of 2)

We would also like to talk about TIN Reference Response Files. A submitted TIN Reference File will generate a corresponding TIN Reference Response File. Let's take a closer look at the response file returned.

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 TIN Reference Response File. The response file will include a 'TN' disposition code and error codes specific to the errors identified.

RREs must make the necessary corrections to their TIN Reference File Detail Records and submit these corrections.

Slide 18: TIN Reference Response File (2 of 2)

We also want to remind you that the TIN Reference File doesn't need to be submitted with every Claims Input File. It only needs to be submitted if there are updates. Be aware that an update on the TIN Reference file will update all records with a corresponding TIN on previously submitted files.

The full listing of the TIN Response File error codes are available in the TIN Response File Error Codes table in the NGHP User Guide Appendices Chapter 5.

Slide 19: Error Codes

We have seen some trends when it comes to error codes recently. We hope that by pointing these out the BCRC will see less of them in the future and your files will process more smoothly.

Each error code begins with a two-letter prefix which helps you to quickly determine what the error code is related to. For example, if you see an error code that begins with CB it is referencing Claim Beneficiary Information while an error code beginning with TN is referring to TIN Reference File errors. You can also find this list and a breakdown of all the error codes in Chapter 5 of the NGHP User Guide.

Slide 20: Common Error Codes (1 of 2)

These are the most common error codes that we have been noticing on a regular basis.

CI04- The issue we see with most commonly is that RRE's are leaving field 16, the State of Venue, blank and it is a required field.

CI05- We see this error for a few common reasons. RRE's often leave field 18, the first diagnosis code, blank or provide invalid ICD codes. Another error we see that triggers this is when an RRE indicates an ICD indicator of 9 or 0 and provides an ICD code that contradicts that ICD indicator.

CJ01- This one is straight forward; RRE's often leave field 78, the ORM Indicator, blank and it is a required field. If an RRE has or had ongoing responsibility for medicals related to the claim, then this field should be Y. If not, an "N" must be submitted in the ORM indicator. The ORM Indicator cannot be blank or spaces. It must have a value of Y or N.

Slide 21: Common Error Codes (2 of 2)

CJ07- For this one RRE's will indicate ORM=No, but they fail to provide a valid TPOC amount.

TN99- We see this one because there are errors on the TIN Reference File and those were not corrected. TIN Reference Files need to be corrected and submitted with the Claim Input File.

Slide 22: Escalation Process

Now that we have talked through a lot of tips and reminders, we also want to just mention that CMS and the BCRC place great importance in providing exceptional service to our customers.

To that end, we have an escalation process that we want to be sure you are aware of. This process helps to ensure our customers' needs are met.

It is important that RREs and their reporting agents follow this process so that BCRC Management can address and prioritize issues appropriately.

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.

If your Section 111 EDI Representative does not respond to your inquiry or issue within two business days, you may contact the EDI Director, Angel Pagan, at 646-458-2121. Mr. Pagan's email is apagan@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 email address is JBrady@ehmedicare.com. Please contact Mr. Brady only after attempting to resolve your issue following the escalation protocol provided above.

Slide 23: MSPRP Enhancements

Now that we have covered all of our reporting tips and reminders, we just wanted to let everyone know about recent enhancements to the Medicare Secondary Payer Recovery Portal (MSPRP).

In April we implemented the addition of a "Previous" button to more screens for ease of use.

We also just implemented some additional enhancements in July including:

- The ability to view and reprint correspondence from the Letter Activity tab if you are logged in to the Portal with Multi Factor Authentication (MFA).
- The ability to see diagnosis code descriptions when hovering over the codes on the MSPRP Claims Listing page and the ability to view the ICD code(s) submitted via Section 111 reporting on this same page if you are logged into the Portal with MFA.

And, we will be making some changes to the Case Information page to provide additional information about conditional payments, treasury referrals, and reported ORM.

Slide 24: Resources

Lastly, today we want to remind everyone of the various resources that are available to you.

The EDI Department is available for assistance at 646-458-6740.

You can always reference the NGHP, COBSW and MSPRP user guides, as well as training materials which are available on CMS.gov. And if you haven't already, you can also sign up to receive notifications on CMS.gov from the Section 111 NGHP pages. You can do this using the "Sign Up" box at the bottom of any CMS.gov page and selecting which pages you want to receive updates on. That will allow you to receive notices when materials are updated, or new information is posted.

Lastly, you may always submit reporting questions to the Section 111 mailbox.

Slide 25: Questions & Answers

No slide notes available.

Acronyms

BCRC	Benefits Coordination & Recovery Center
CMS	Centers for Medicare & Medicaid Services
COBSW	Coordination of Benefits Secure Website
DDE	Direct Data Entry
EDI	Electronic Data Interchange
ICD	International Classification of Diseases
MFA	Multi-Factor Authentication
MSP	Medicare Secondary Payer
MSPRP	Medicare Secondary Payer Recovery Portal
NGHP	Non-Group Health Plan
ORM	Ongoing Responsibility for Medicals
PIP	Personal Injury Protection
RRE	Responsible Reporting Entity
TIN	Tax Identification Number
TPOC	Total Payment Obligation to Claimant