MMSEA Section 111
Medicare Secondary Payer
Mandatory Reporting

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

Version 2.0
July 31, 2009

MMSEA Section 111
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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.

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1 Summary of Version 2.0 Updates

- Section 2 was updated to further define the term Total Payment Obligation to Claimant (TPOC).
- Various sections were updated to reflect that TPOC information needs only be reported for TPOC dates as of January 1, 2010 and subsequent.
- Sections 5.4 and 19 were updated to add a link to the CMS Medicare Manuals at www.cms.hhs.gov/manuals/IOM .
- Section 7.1 was updated with the following note: *An updated version of section 7.1 is being published separately as an ALERT, in draft, for public comment.*
- A note was added to Section 8.2 stating that if no domestic, US address and/or TIN is available for the RRE, contact the COBC EDI Department (646-458-6740). This matter will be referred to CMS to obtain instructions on how to complete registration information on the COBSW and submit the TIN Reference File.
- Sections 11.2.5 and 11.2.6 were added to provide requirements related to ICD-9-CM diagnosis codes and foreign addresses.
- Changes were made throughout the guide and Section 11.4 was added to incorporate the information regarding the interim reporting thresholds described in "MMSEA 111 – March 20, 2009 – Alert for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation" posted to www.cms.hhs.gov/MandatoryInsRep/Downloads/Allert_UserGuideSupp_NGHP.pdf. Subsequent sections were renumbered accordingly. **Note that the dates for the reporting thresholds have been modified to extend the period of times the thresholds will remain in effect and the threshold for reporting Workers' Compensation ORM was raised.**
- Changes were made, and Section 11.5 was added, to incorporate the information in the alert titled "MMSEA 111 – April 7, 2009 – Alert for Reporting Multiple Total Payment Obligation to the Claimant (TPOC) Amounts" posted to www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPAlertTPOC.pdf. Subsequent sections were renumbered accordingly.
- Sections 11.7 and 11.10.1 were updated to note that a process will be added to the Section 111 COBSW application that will allow a user associated with the RRE ID to indicate that the RRE has nothing to submit for a particular quarter in lieu of submitting an actual empty file.
- Sections 11.7.3 and 11.7.4 were updated to add the ORM Termination Date (Field 99) to the list of fields that would trigger an update record submission.
- Section 12.3.2 was updated to change the delete threshold error to "more than 4%" from "10% or more".
- Section 13 was updated to provide a link to the X12 270/271 companion guide for the Query Files and information on the HEW software processing environment requirements.
- Section 15.3 was updated to further clarify the SFTP transmission method and directory structure.
- Section 17 was updated to provide a list of emails generated by the system for Section 111 COBSW processes.
- The following changes were made to the Claim Input File Detail Record Layout in Appendix A:

    - A value of ‘FC’ was added for the State of Venue (Field 17) for use in cases where the incident occurred outside the United States.
    - Clarification was added for requirements related to the ICD-9-CM diagnosis codes to be used in Fields 15 and 19-55.
    - The description for Field 99, ORM Termination Date was updated to indicate that dates in the future may be reported in this field.
    - Additional values were added to the Claimant 1 Relationship (Field 104).
    - A new field, Claimant 1 Entity/Organization Name was added as a redefinition of the Claimant 1 Last Name and First Name fields to allow for submitting a claimant name other than that for a specific individual. All subsequent fields on the record were renumbered accordingly.
    - A default value of ‘FC’ was added for all claimant and representative address state codes to be used in the event that no US address is available. If contact information is needed for these individuals subsequent to the claim report, CMS will contact the RRE using the information supplied on the TIN Reference File. No international/foreign addresses are allowed on the TIN Reference File. Contact the COBC EDI Department if there is no domestic, US address for the RRE.
    - Representative, Claimant and Claimant Representative sections of the record layout were updated to indicate that if those sections are not used, each field should be set to its appropriate default value (spaces or zeroes).
- The Claim Input File Auxiliary Record layout in Appendix A was updated for the following:
    - Additional values were added to Claimant 1-4 Relationship fields.
    - New fields for Claimant 2-4 Entity/Organization Name were added as redefinition of the Claimant 2-4 Last Name and First Name fields to allow for submitting claimant names other than those for specific individuals.
    - Four additional sets of TPOC fields were added to allow for reporting of separate, additional TPOCs related to each claim report as needed.
    - All fields on the record were renumbered as needed for the changes above.
    - A default value of ‘FC’ was added for all claimant and claimant representative address state codes to be used in the event that no US address is available.
    - Claimant and Claimant Representative sections of the record layout were updated to indicate that if those sections are not used, each field should be set to its appropriate default value (spaces or zeroes).
- The Claim Response File record layouts in Appendix C were changed to:
    - Increase the length of the Header, Detail and Trailer records to **460 bytes**.
    - New fields were added on the detail response record for the Submitted Policy Number and Submitted Claim Number.
    - Field numbers and starting and ending positions were adjusted accordingly.
- The Error Code Table in Appendix E was updated to add error codes for edits to new fields and modify others to be in line with the updated field descriptions.
- A new Appendix H was added that includes a list of Insufficient ICD-9 Diagnosis Codes that will be used in edits related to the Alleged Cause of Injury, Incident, or Illness and ICD-9 Diagnosis Codes on the Claim Input File Detail Record.

- A new Appendix I was added with a list of acronyms commonly used in Section 111 reporting requirements.

2 Introduction and Important Terms

This guide provides information and instructions for the Medicare Secondary Payer (MSP) liability insurance (including self-insurance), no-fault insurance and workers' compensation reporting requirements mandated by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173). Entities responsible for complying with Section 111 are referred to as "Responsible Reporting Entities" or "RREs". An overview of Section 111 related legislation, MSP rules, and the reporting process is followed by detailed instructions and process requirements. Explanations regarding who is an RRE and how this reporting will be implemented are included in this guide. File specifications are located in appendices to this guide for easy reference.

This guide is for use by all Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation RREs.

Please note that the Centers for Medicare & Medicaid Services (CMS) is implementing the Section 111 requirements in phases. As time passes and we gain experience with Section 111 reporting, the data exchange requirements will continue to be refined and new processes added when necessary. CMS will issue revised versions of this Section 111 User Guide from time to time. Section 111 RREs will be notified when new versions are available. Please check the CMS Section 111 Web page often at www.cms.hhs.gov/MandatoryInsRep for the latest version of this guide and for other important information.

Important Terms Used in Section 111 Reporting

In addition to understanding the term RRE (see further explanation in Section 7) there are several other terms which are critical to understanding the Section 111 reporting process. These terms are frequently referred to throughout this guide:

- 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 associated with a claim. This typically only applies to no-fault and workers' compensation claims. Please see Section 11.8 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/apart from ORM. A TPOC generally reflects a "one-time" or "lump sum" payment of a settlement, judgment, award, or other payment intended to resolve/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. Please refer to the definition of the TPOC Date and TPOC Amount in Fields 100 and 101 of the Claim Input File Detail Record in Appendix A.

- The definition of the CMS Date of Incident (DOI) differs from the definition of that generally used by the insurance industry under specific circumstances. Please see the definition of the Fields 12 and 13 of the Claim Input File Detail Record in Appendix A for an explanation.

3 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 as well as 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 are 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 Appendix F of this guide. Section 111 authorizes CMS implementation by program instruction or otherwise. All implementation instructions, including this User Guide, are/will be available on (or through a download at) CMS' dedicated Web page: www.cms.hhs.gov/MandatoryInsRep.

Section 111:

- Adds reporting rules; it does not eliminate any existing statutory provisions or regulations.
- Does not eliminate CMS' existing processes, including for example, CMS' process for self-identifying pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation claims to CMS' Coordination of Benefits Contractor (the COBC) or the processes followed by CMS' Medicare Secondary Payer Recovery Contractor (the MSPRC) for MSP recoveries, where appropriate.
- Includes penalties for noncompliance.
- Who Must Report:
    - "[A]n applicable plan."
    - "[T]he 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 to enable an appropriate determination concerning

coordination of benefits, including any applicable recovery claim. Data elements 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.

NOTE: 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. See Attachment A in order to determine if you are an RRE for purposes of these new provisions. See also section 7.1 of this guide for further discussion of who is an RRE. The statutory language, the PRA Notice and the PRA Supporting Statement with Attachments are all available as downloads at www.cms.hhs.gov/MandatoryInsRep. Attachment A to the Supporting Statement provides details on definitions and exactly which entities must report. Attachment A is also available in Appendix G of this guide.

4 Medicare Entitlement, Eligibility, and Enrollment

This section provides a general overview of Medicare entitlement, eligibility and enrollment. Please refer to www.cms.hhs.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 (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.

5 MSP Overview

Note: The following paragraphs provide only a very high level overview of the MSP provisions related to liability insurance (including self-insurance), no-fault insurance and workers' compensation. Medicare beneficiaries, attorneys, insurers, self-insured entities, third party administrators and their agents are always responsible for understanding when there is coverage primary to Medicare, notifying Medicare when applicable, and for paying appropriately.

"Medicare Secondary Payer" (MSP) is the term used when the Medicare program does not have primary payment responsibility (that is, 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 (including as subsequently amended), Medicare is a secondary payer to group health plan coverage in certain situations and is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

Policies or self-insurance allegedly "supplemental" to Medicare -- By statute, Medicare is secondary to liability insurance (including self-insurance), no-fault insurance, and workers' compensation. An insurer or workers' compensation cannot, by contract or otherwise, supersede federal law.

The data collected under Section 111 reporting will be used by CMS in processing claims billed to Medicare for reimbursement for items and services furnished to Medicare beneficiaries and for MSP recovery efforts, as appropriate.

The Section 111 reporting responsibilities are an additional, more comprehensive method for obtaining information regarding situations where Medicare is appropriately a secondary payer. They do 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 associated conditional payments within 60 days of receipt of such settlement, judgment, award, or other payment. The Section 111 reporting requirements do not eliminate this obligation.

5.1 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*."

See Appendix G for the CMS definition of "self-insurance." Essentially, individuals/entities engaged in a business, trade, or profession are self-insured to the extent they have not purchased liability insurance coverage. This includes responsibility for deductibles.

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'', 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' 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.

5.2 Workers' Compensation

Workers' compensation is a law or plan of the United States, or any state, that compensates employees who get sick or injured on the job. Most employees are covered under workers' compensation plans. 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.

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 otherwise 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" for workers' compensation.)

5.3 Roles of CMS' Coordination of Benefits Contractor (COBC) and CMS' Medicare Secondary Payer Recovery Contractor (MSPRC)

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

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

The MSPRC is 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.

5.4 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' manuals and Web pages for further detail. For Section 111 reporting purposes, use of the "Definitions and Reporting Responsibilities" document provided in Appendix G is critical.

Additional information can be found at www.cms.hhs.gov/manuals/IOM. The MSP Manual can be found at www.cms.hhs.gov/manuals/downloads/msp105c02.pdf.

6 Process Overview

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 by determining primary versus secondary payer responsibility. Section 111 requires RREs to submit information specified by the Secretary 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. RREs will 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 will take place between the RREs and the CMS Coordination of Benefits Contractor (the COBC). The COBC will manage the technical aspects of the Section 111 data submission process for all Section 111 RREs.

For purposes of RRE submissions, the term "**claim**" is used to refer to the overall claim for liability insurance (including self-insurance), no-fault insurance or workers' compensation rather than a single claim for a particular medical item or service. Claim information is to be submitted 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.

Section 111 RREs are required to register with the COBC and fully test the data submission process before submitting production Claim Input Files. RREs will be assigned a quarterly file submission timeframe during which they are to submit Claim Input Files. Once in a production mode, RREs will submit their initial claim files containing information for all liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims involving a Medicare beneficiary as the injured party where the settlement, judgment, award or other payment date is **January 1, 2010**, or subsequent, and which meet the reporting thresholds described later in this guide. In addition, initial claim files must include claims on which ongoing responsibility for medical payments exists as of **July 1, 2009** and subsequent, regardless of the date of an initial acceptance of payment responsibility (see the Qualified Exception in Section 11.9). Subsequent quarterly file submissions are to contain only new or changed claim information using add, delete and update transactions.

An RRE electronically transmits a claim data file to the COBC. The COBC processes the data in this *input file* by first editing the incoming data and then determines whether the submitted information identifies the injured party as a Medicare beneficiary. Other insurance information for Medicare beneficiaries derived from the input file is posted to other CMS databases by the COBC. This is then used by other Medicare contractors for claims processing to make sure Medicare pays secondary when appropriate and/or is passed to the CMS Medicare Secondary Payer Recovery Contractor (MSPRC) for recovery efforts. When this processing is completed or the prescribed time for response file generation has elapsed, the COBC electronically transmits a *response file* back to the RRE. 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.

RREs must implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary and gather the information necessary for

Section 111 reporting. Either the Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) must be included on Section 111 record submissions for each injured party. The CMS is allowing RREs to submit a query to the COBC to determine Medicare status of the injured party prior to submitting claim information for Section 111 reporting. This query will assist the RRE in determining whether the claim must be reported under Section 111. The query record must contain the SSN or HICN, name, date of birth and gender of the injured party. On the query response record, the COBC will return information on whether the individual was identified as a Medicare beneficiary based upon the information submitted and if so, provide the HICN and other updated information for the individual found on the Medicare Beneficiary Database. The reason for Medicare entitlement and the actual dates of Medicare entitlement and enrollment (coverage under Medicare) are not returned on the query file response.

The COBC is implementing a new application on the COB Secure Web site (COBSW) for Section 111 processing. RREs will use this application on the COBSW to register and set up reporting account information for Section 111. Statistics related to file processing will be displayed in this application and RREs may also choose to exchange Section 111 files with the COBC via the COBSW.

Detailed specifications for the Section 111 reporting process are provided in the following sections of this guide. A description of each file is provided in the table below.

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

File Type	Description
Claim Input File	This is the data set transmitted from a MMSEA Section 111 RRE to the COBC that is used to report applicable liability insurance (including self-insurance), no-fault insurance and workers' compensation claim information where the injured party is a Medicare beneficiary. This file is transmitted in a flat file format (there is no applicable HIPAA-compliant standard.)
Claim Response File	This is the data set transmitted from the COBC to the MMSEA Section 111 RRE after the information supplied in the RRE's Claim Input File has been processed. This file is transmitted in a flat file format.

File Type	Description
TIN Reference File	The TIN Reference File consists of a listing of the RRE's federal tax identification numbers (TINs) reported on the Claim Input File records and the business mailing address that is linked to the TIN and Office Code/Site ID combinations for the purposes of coordination of benefits and recovery. This file is transmitted in a flat file format.
Query Input File	This is an optional query file that can be used by an RRE to determine whether an injured party/claimant is a Medicare beneficiary. This file is transmitted using the ANSI X12 270/271 Entitlement Query transaction set.
Query Response File	After the COBC has processed the Query Input File it will return the Query Response File with a determination as to whether the information submitted for the queried injured party/claimant identifies the individual as a Medicare beneficiary. This file is transmitted using the ANSI X12 270/271 Entitlement Query transaction set.

7 Responsible Reporting Entities (RREs)

7.1 Who Must Report

NOTE: An updated version of Section 7.1 is being published separately as an ALERT, in draft, for public comment.

- 42 U.S.C. 1395y(b)(8) provides that the "applicable plan" is the RRE and defines "applicable plan" as follows:

  > "APPLICABLE PLAN- In this paragraph, 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."

- As stated, 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 in order to determine if you are a RRE for purposes of these new provisions. The statutory language, the PRA Notice and the PRA Supporting Statement with Attachments are all available as downloads at www.cms.hhs.gov/MandatoryInsRep. "Attachment A -- Definitions and Reporting Responsibilities" to the Supporting Statement provides details on definitions and exactly which entities must report. Attachment A can also be found in Appendix G of this guide.

- CMS is aware that the industry generally does not use the term "plan" or some other CMS definitions such as the definitions for "no-fault insurance" or "self-insurance". However, CMS is constrained by the language of the applicable statute and CMS' regulations. **It is critical that you understand and utilize CMS' definitions for purposes of Section 111 when reviewing and implementing Section 111 instructions**.

- Third party administrators (TPAs) as defined by CMS for purposes for 42 U.S.C. 1395y(b)(7) & (8) are never RREs for purposes of 42 U.S.C. 1395y(b)**(8)** [liability (including self-insurance), no-fault, and workers' compensation reporting] **based *solely* upon their status as this type of TPA.** (Note that for purposes of 42 U.S.C. 1395y (b)**(7)** reporting for group health plan arrangements, this type of TPA is automatically an RRE.)

  However, while entities which meet this definition of a TPA generally only act as agents for purposes of the liability insurance (including self-insurance), no-fault insurance, or workers' compensation reporting they may, under specified

circumstances, also be an RRE. See, for example, the discussion of RREs for workers' compensation.

The RRE is limited to the "applicable plan" and may not by contract or otherwise limit its reporting responsibility although it may contract with a TPA or other entity for actual file submissions for reporting purposes. The applicable plan must either report directly or contract with the TPA or some other entity to submit data as its agent. Where an RRE uses another entity for claims processing or other purposes, it may wish to consider contracting with that entity as its agent for reporting purposes.

- Where an entity is self-insured for a deductible but the payment of that deductible is done through the insurer, then the insurer is responsible for including the deductible amount in the amount it reports as a settlement, judgment, award or other payment.

- Where there are multiple defendants involved in a settlement, an agreement to have one of the defendant's insurers issue any payment in obligation of a settlement, judgment, award or other does not shift RRE responsibility to the entity issuing the payment. All RREs involved in the settlement remain responsible for their own reporting.

- For re-insurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds, patient compensation funds, etc. which have responsibility beyond a certain limit, the key in determining whether or not reporting for 42 U.S.C. 1395y(b)(8) is required for these situations is whether or not the payment is to the injured claimant/representative of the injured claimant vs. payment being made to self-insured entity to reimburse the self-insured entity. Where payment is being made to reimburse the self-insured entity, the self-insured entity is the RRE for purposes of the payment made to the injured individual and no reporting is required by the insurer reimbursing the self-insured entity.

- RRE for liability self-insurance pools -- Entities self-insured in whole or in part with respect to liability may elect, where permitted by law, to join with other similarly situated entities in a self-insurance pool (e.g., joint powers authority). If the self-insurance pool (1) is a separate legal entity (2) with full responsibility to resolve and pay claims using pool funds (3) without involvement of the participating entity, the self-insurance pool is the responsible reporting entity. If all three aforementioned characteristics are not applicable to the self-insurance pool, the participating self-insured entity is the responsible reporting entity.

- RRE for a State established "assigned claims fund" which provides benefits for individuals injured in an automobile accident that do not qualify for personal injury protection/medical payments protection from an automobile insurance carrier:

    - Where there is a State agency which resolves and pays the claims using State funds or funds obtained from others for this purpose, the established agency is the RRE.

- Where there is a State agency which designates an authorized insurance carrier to resolve and pay the claims using State-provided funds without State agency review and/or approval, the designated carrier is the RRE.
- Where there is a State agency which designates an authorized insurance carrier to resolve and pay the claims using State-provided funds but the State agency retains review or approval authority, the State agency is the RRE.

- **RRE for Workers' Compensation:**

  Attachment A – "Definitions and Reporting Responsibilities" for the Revised Supporting Statement to the Paperwork Reduction Act Notice published in the Federal Register on February 12, 2009" provides, in part: *"For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), 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. Where such a plan is directly funded by the employer, the employer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). Where such a plan is indirectly funded by the employer, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8)."* The following bullets provide more specific guidance regarding who is the RRE for workers' compensation laws or plans.

  - Where the applicable law or plan authorizes an employer to purchase insurance from an insurance carrier and the employer does so, the insurance carrier is the RRE.
  - Where the applicable law or plan authorizes an employer to self-insure and the employer does so independently of other employers, the self-insuring employer is the RRE.
  - Where the applicable law or plan authorizes employers to join with other employers in self-insurance pools (e.g., joint powers authorities) and the self-insurance pool (1) is a separate legal entity (2) with full responsibility to resolve and pay claims using pool funds (3) without involvement of the participating employer, the self-insurance pool is the RRE.
  - Where the applicable law or plan authorizes employers to join with other employers in self-insurance pools but any of the above delineated requirements are not satisfied, the participating employer is the RRE.
  - Where the applicable law or plan establishes a State/Federal agency with sole responsibility to resolve and pay claims, the established agency is the RRE.
  - Applicable law or plan authorizes employers to self-insure or to purchase insurance from an insurance carrier and also establishes a State/Federal agency to assume responsibility for situations where the employer fails to obtain insurance or to properly self-insure --

- Where such State/Federal agency itself resolves and pays the claims using State/Federal funds or funds obtained from others for this purpose, the established agency is the RRE.
- Where such State/Federal agency designates an authorized insurance carrier to resolve and pay the claim using State/Federal-provided funds without State/Federal agency review and/or approval, the designated carrier is the RRE.
- Where such State/Federal agency designates an authorized insurance carrier to resolve and pay the claim using State/Federal-provided funds but State/Federal agency retains review or approval authority, the State/Federal agency is the RRE.

7.2 Use of Agents

Agents are not RREs for purposes of the MSP reporting responsibilities for 42 U.S.C. 1395y(b)(7) & (8). However, the applicable RRE may contract with an entity to act as an agent for reporting purposes. Agents may include, but are not limited to, data service companies, consulting companies or similar entities that can create and submit Section 111 files to the COBC on behalf of the RRE.

Registration for reporting and file submission with the COBC must be completed by the RRE. During registration, the RRE may designate an agent. An agent may not register on behalf of an RRE. However an agent may complete some steps of the registration process with RRE approval and oversight (see Section 8).

An RRE may not shift its Section 111 reporting responsibility to an agent, by contract or otherwise. The RRE remains solely responsible and accountable for complying with CMS instructions for implementing Section 111 and for the accuracy of data submitted.

CMS does not sponsor or partner with any entities that can be agents. CMS has not and will not endorse any entity as an agent for Section 111 reporting purposes and has no approved list of agents. Entities that are potential agents do not register with CMS or pay CMS a fee in order to become an agent.

As stated previously, agents do not register for Section 111 reporting with the COBC. Instead they are named and invited to participate by their RRE customers. Agents must exchange separate files for each RRE ID that they represent. Agents must test each RRE ID file submission process separately. Agent representatives may be Account Managers and Account Designees for the RRE on the COB Secure Web site (COBSW) as described later in this guide. However, agents may not be named as the RRE's Authorized Representative. See Section 8 Registration and Account Setup.

All communications regarding Medicare recovery will be directed to the RRE, not the agent. However, please note that CMS is not changing its MSP recovery processes. For example, demands involving liability insurance recoveries against a settlement, judgment, award, or other payment are routinely issued to the Medicare beneficiary.

8 Registration and Account Setup

8.1 Overview

The registration process requires RREs to provide notification to the COBC of their intent to report data to comply with the requirements of Section 111 of the MMSEA. Registration *of the RRE* is required and must be completed before testing between the RRE (or its agent) and the COBC can begin. Through the registration process, the COBC will obtain the information needed to:

- Validate information provided by the RRE registrant
- Assign a Section 111 Responsible Reporting Entity Identification Number (RRE ID) to each RRE
- Develop a Section 111 reporting profile for each entity including estimates of the volume and type of data to be exchanged for planning purposes
- Assign a production live date and ongoing file submission timeframe for Claim Input File submission to each entity
- Establish the necessary file transfer mechanisms
- Assign a COBC Electronic Data Interchange Representative (EDI Rep) to each entity to assist with ongoing communication and data exchange and
- Assign Login IDs to individual users associated with each RRE ID account.

Section 111 Liability, No-Fault and Workers' Compensation RREs register on the Section 111 COB Secure Web site (COBSW) using a new, interactive, Web portal designed for this purpose.

The website URL is www.Section111.cms.hhs.gov. Once you click on the "I Accept" link and accept the terms of the Login Warning, the homepage will display. Information on the New Registration and Account Setup processes can be found under the "How To" menu option. A Login ID is not needed to access this menu option. Click on the menu option and a drop-down list will appear. Then click on the item desired in the list. In particular, please read the documents found under "How to Get Started" and "How to Invite Designees". Once you have begun the registration process on the Section 111 COBSW, you will have access to "Help" information on each page displayed. By clicking on the link for the Help page, a new window will open with instructions and information needed to complete the page you are working on. Once you have finished the New Registration and Account Setup steps and obtain a Login ID for the Section 111 COBSW, you may log into the application using the Login fields displayed on the right side of the homepage. After login, a detailed Section 111 COBSW User Guide is available under the "Reference" menu option. You must be logged into the application to gain access to the COBSW User Guide.

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

expectation of having claims to report, **must** register in time to allow a full quarter for testing if they have future situations where they have a reasonable expectation of having to report. Once registered, an RRE must submit a Claim Input File once per quarter for each RRE ID during the assigned file submission timeframe.

8.2 Registration and Account Setup Process

Section 111 registration and account setup is a five step process.

Step 1: Identify an Authorized Representative, Account Manager and other COBSW Users

Each RRE must assign or name an Authorized Representative. This is the individual in the RRE organization who has the legal authority to bind the organization to a contract and the terms of MMSEA Section 111 requirements and processing. This is normally a person at the executive level of the organization. The Authorized Representative has ultimate accountability for the RRE's compliance with Section 111 reporting requirements. Please refer to the Data Use Agreement in Section 16 to make sure the person you name as your Authorized Representative has the authority to sign this agreement.

The Authorized Representative:

- Cannot be a user of the Section 111 COBSW for any RRE ID.
- Cannot be an agent of the RRE.
- May perform the initial registration on the COBSW or delegate this task to another individual, but will not be provided with a Login ID.
- Will designate the Account Manager.
- Must approve the account setup, by physically signing the profile report including the Data Use Agreement, and returning it to the COBC.
- Will be the recipient of COBC notifications related to non-compliance with Section 111 reporting requirements.

Each RRE must assign or name an Account Manager. 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 be an RRE employee or agent. 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, 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 COBC mailing. This would 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 or TPA as its Account Manager.

- Can invite other users to register on the COBSW and function as Account Designees.
- Can manage the RRE's profile including selection of a file transfer method.
- 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 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 or an Account Designee for the same RRE ID.

At the RRE's discretion, the Account Manager may designate other individuals to register as users of the COBSW associated with the RRE's account, known as Account Designees. 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 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 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 review file transmission history.
- Can review file-processing statuses and file statistics.
- Can change his/her personal information.
- Cannot be an Authorized Representative for any RRE ID or the Account Manager for the same RRE ID.
- Cannot invite other users to the account.
- Cannot update RRE account information.

Note: Each user of the Section 111 application on the COBSW will have only one Login ID and password. With that Login ID and password, you 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.

Step 2: Determine Reporting Structure

Before beginning the registration process, an RRE must also determine how the RRE will submit its Section 111 files to the COBC and how many Section 111 Responsible Reporting Entity Identification Numbers (RRE IDs) will be needed. Only one Claim Input

File may be submitted on a quarterly basis for each RRE ID. Due to corporate organization, claim system structures, data processing systems, data centers and agents that may be used for file submission, you may want to submit more than one Claim Input File to the COBC on a quarterly basis and therefore will need more than one RRE ID in order to do so.

For example, if an RRE will use one agent to submit workers' compensation claims and another agent to submit liability and no-fault claims, the RRE must register on the COBSW twice to obtain two RRE IDs that will be used by each agent respectively. Likewise, if you have two or more subsidiary companies that process workers' compensation claims using different claims systems and you will not combine the claim files for Section 111 reporting, you must register for each claim file submission to obtain separate RRE IDs in order to submit multiple claim files in one quarter.

Alternatively, you may use one agent to report Claim Input Files and another agent to report Query Input Files using the same RRE ID. In addition, the RRE may choose to report one file type (claim or query) and have an agent report the other under the same RRE ID.

You may name the same Authorized Representative and Account Manager for each RRE ID or use different individuals.

You may **not** set up a separate RRE ID for submission of the Query Input File only. You **must** submit a quarterly Claim Input File for every RRE ID you establish.

You must complete the New Registration and Account Setup steps on the Section 111 COBSW for ***each*** RRE ID you want, so careful consideration must be given to the number of RRE IDs you request. Once logged into the Section 111 COBSW, most functions are performed by each RRE ID. Your Account Manager must invite and identify Account Designees that will need access to multiple accounts by RRE ID. File transmission and viewing the results of file processing is done by RRE ID. So to ease the management of reporting, account maintenance and user access, we suggest that fewer RRE IDs are better than many.

The registration process will remain available indefinitely. You may alter your reporting structure subsequently if needed. You may request one or more additional RRE IDs in the future if changes in your business operations require changes in your data reporting requirements. If you register and obtain an RRE ID that you later determine you will not need or no longer use, contact your EDI Rep to have it disabled.

You are not required to obtain an RRE ID for each subsidiary separately but you must do so if separate input files will be submitted for each or if each/any subsidiary is handling its own reporting. Alternatively, the parent organization may register, obtain one RRE ID and report for all applicable subsidiaries under that RRE ID.

If you register for multiple RRE IDs:

- You can use the same TIN for each or different TINs for each. No matching is done between the TINs supplied at registration and the TINs supplied on your input files.
- You can name the same Authorized Representative for each or a different Authorized Representative for each.

- You can name the same Account Manager for each or a different Account Manager for each.
- You can invite the same Account Designee to be associated with multiple RRE IDs or invite different Account Designees to different RRE IDs.
- The system randomly assigns EDI Representatives to RRE IDs. If you register for multiple RRE IDs and want them all assigned to one EDI Representative, then contact one of the assigned EDI Representatives and request a reassignment of all RRE IDs to one EDI Rep.

The RRE TIN supplied during registration is used by the COBC to authenticate the RRE prior to establishing the reporting account. The RRE TINs supplied on Claim Input Files are used to associate the claim record to contact information for the RRE that is used by Medicare for coordination of benefits and recovery efforts as needed.

Step 3: RRE Registration on the COBSW – New Registration

An individual assigned by the RRE must go to the Section 111 COBSW URL (www.Section111.cms.hhs.gov), click on the "New Registration" button, complete and submit the registration for the RRE. The registration step is for the RRE, that is, it is for RRE information; it is not for information regarding an agent of the RRE. The RRE's Authorized Representative may complete this task or delegate it to an individual of his/her choosing. The New Registration step on the COBSW must be performed for each RRE ID needed for Section 111 reporting.

The application will require that you submit:

- A Federal Tax Identification Number (TIN) for the RRE
- Company name and address
- Company **Authorized Representative** contact information including name, job title, address, phone and e-mail address
- National Association of Insurance Commissioners (NAIC) company codes, if applicable. If you organization does not have NAIC company codes, you may default this field to all zeroes.
- Reporter Type - Select the Liability Insurance (Including Self-Insurance)/No-Fault Insurance/Worker's Compensation option, **not** GHP
- Subsidiary company information to be included in the file submission for the registration. Subsidiary information is optional during the registration process and may be supplied at a later date. TINs supplied for subsidiaries must be unique and not match the RRE TIN or TINs supplied for other subsidiaries in this step.

It is critical that you provide contact information for your Authorized Representative in this step regardless of who is actually performing this task on the Section 111 COBSW. The Authorized Representative cannot be a user of the Section 111 COBSW for any RRE ID. If you need to change your Authorized Representative after completing this step, you must contact your assigned EDI Representative.

When a registration application is submitted, the information provided will be validated by the COBC. Once this is completed, the COBC will send a letter via the US Postal

Service to the named Authorized Representative with a personal identification number (PIN) and the COBC-assigned RRE ID associated with the registration. PIN letters will be sent to the Authorized Representative within 10 business days.

The Authorized Representative must give this PIN and RRE ID to their Account Manager to use to complete the Account Setup step.

If you need more than one RRE ID for Section 111 reporting, this step must be repeated for each.

The RRE TIN provided during registration is used to authenticate the RRE for Section 111 reporting. You are asked to provide TINs for subsidiaries of the RRE that will be included in reporting under the RRE ID. Doing so will assist CMS in its efforts to help assure that you are in compliance with the Section 111 reporting requirements. Further, CMS may require this information at a later date. However, this subsidiary information is optional during registration. You do **not** have to provide all of the TINs during registration that you might later use on your Claim Input File and TIN Reference File submissions. The TINs provided on the Claim Input File and TIN Reference File will be used by Medicare for coordination of benefits and recovery efforts related to particular claim reports as needed. No comparison is done between those TINs and the RRE TIN and subsidiary TINs provided during registration.

If no domestic, US address and/or TIN is available for the RRE, contact the COBC EDI Department (646-458-6740). This matter will be referred to CMS to obtain instructions on how to complete this information on the COBSW.

Step 4: RRE Account Setup on the COBSW – Account Manager

In order to perform the RRE account setup tasks, the RRE's Account Manager must go to the Section 111 COBSW URL (www.Section111.cms.hhs.gov) with the PIN and RRE ID and click on the "Account Setup" button.

The Account Manager will:

- Enter the RRE ID and associated PIN
- Enter personal information including name, job title, address, phone and e-mail address
- Create a Login ID for the COBSW
- Enter account information related to expected volume of data to be exchanged under this RRE ID (estimated number of annual paid claims for the lines of business that will be reported under the RRE ID)
- Enter applicable reporting agent name, address, contact e-mail and TIN. If using one agent for Claim Input File reporting and another agent for Query Input File Reporting, then provide the agent that will be doing your Claim Input File reporting. Individuals from both agents may be invited later to be Account Designees associated with the RRE ID.
- Select a file transmission method
- Provide file transmission information needed if the Connect:Direct transmission method is selected. See the later section on the Connect:Direct method for what information will be collected. ***You must have complete file transmission***

information available if the Connect:Direct method is selected or this step cannot be completed and all the other data you provided will be lost.

Once the Account Manager has successfully obtained a COBSW Login ID, he/she may log into the application and invite Account Designees to register for Login IDs. In addition, after completing Account Setup for his/her first RRE ID, since only one Login ID is required per user, the Account Manager will bypass the steps for creating another Login ID and password when setting up subsequent RRE IDs.

The Account Setup step must be completed by your Account Manager. In this step, the Account Manager will obtain a Login ID and must personally agree to the terms of the User Agreement. If you need to change your Account Manager after completing this step, contact your assigned EDI Rep.

This step must be repeated for each RRE ID.

Step 5: Return Signed RRE Profile Report – Authorized Representative

Once account setup has been completed on the COBSW (including file transmission details for Connect:Direct if that method is selected) and processed by the COBC, a profile report will be sent to the RRE's Authorized Representative and Account Manager via e-mail. Profile report e-mails will be transmitted within 10 business days upon completion of the Account Setup step on the COBSW.

The Profile Report contains:

- A summary of the information you provided on your registration and account setup
- Important information you will need for your data file transmission
- Your RRE ID that you will need to include on all files transmitted to the COBC
- Your quarterly file submission timeframe for the Claim Input File
- Contact information for your COBC EDI Representative who will support you through testing, implementation and subsequent production reporting.

The RRE's Authorized Representative must review, sign and return the profile report to the COBC. Once your profile report has been marked as received by the COBC, you may begin testing your Section 111 files. The COBC will send an email to your Account Manager indicating that testing can begin.

9 File Format

9.1 General File Standards

The Claim Input File and TIN Reference Files are transmitted in a flat, ASCII file format. The Connect:Direct file transmission method will convert files into EBCDIC. The Query Files are transmitted using the ANSI X12 270/271 Entitlement Query transaction set. However, the COBC will supply each RRE software to translate flat file formats to and from the X12 270/271 on request. As will be described further in a later section, the Query File formats documented in Appendix D represent the flat file input and output to the translator software supplied by the COBC and the remainder of this section assumes the RRE will use that software. If you are using your own X12 translator, the necessary mapping documentation can be downloaded from www.cms.hhs.gov/MandatoryInsRep. Note that the COBC is using the 4010A1 version of the X12 270/271. An upgrade to the 5010 version is planned for a later as yet undetermined date.

With the exception of the X12 270/271, all input files submitted for Section 111 must be fixed width, flat files. All records in the file must be the same length as specified in the file layouts. All data fields on the files are of a specified length and should be filled with the proper characters to match those lengths. No field delimiters, such as commas between fields, are to be used. Detailed record and field specifications are found in the appendices of this guide. When information is not supplied for a field, provide the default value per the specific field type (fill numeric and numeric date fields filled with zeroes; alphabetic, alphanumeric and “Reserved for Future Use” fields filled with spaces).

Each input file format contains at least three record types. The file begins with a header record. Header records identify the type of file being submitted and will contain your Section 111 RRE ID. You will receive your RRE ID on your profile report after your registration for Section 111 is processed. Detail records represent claim information where the injured party is a Medicare beneficiary or query requests for individual people on the Query Input File. Each file always ends with a trailer record that marks the end of the file and contains summary information including counts of the detail records for validation purposes. Each header record must have a corresponding trailer record. Each trailer record must contain the proper count of detail records. **Do not include the header and trailer records in these counts.** If the trailer record contains invalid counts, your file will be rejected.

9.2 Data Format Standards

The table below defines the formatting standard for each data type found in the Section 111 files, both input and response.

Conventions for Describing Data Values

Data/Field Type	Formatting Standard	Examples
Numeric	Zero through nine (0 - 9) Padded with leading zeroes. Do not include decimal point. See individual field descriptions for any assumed decimal places. Default to all zeroes unless otherwise specified in the record layouts.	Numeric (5): "12345" Numeric (5): "00045"
Alphabetic	A through Z Left justified. Non-populated bytes padded with spaces. Alphabetic characters sent in lower case will be converted and returned in upper case. Default to all spaces unless otherwise specified in the record layouts. Embedded hyphens (dashes), apostrophes and spaces will be accepted in alphabetic name fields.	Alpha (12): "TEST EXAMPLE" Alpha (12): "EXAMPLE " Alpha (12): "SMITH-JONES " Alpha 12): "O'CONNOR "
Alphanumeric	A through Z (all alpha) + 0 through 9 (all numeric) + special characters: Comma (,) Ampersand (&) Space ( ) Hyphen/Dash (-) Period (.) Single quote (') Colon (:) Semicolon (;)	Text (8): "AB55823D" Text (8): "XX299Y " Text (18): "ADDRESS@DOMAIN.COM" Text (12): " 800-555-1234" Text (12): "#34 "

Data/Field Type	Formatting Standard	Examples
	Number (#) Forward slash (/) At sign (@) Left justified Non-populated bytes padded with spaces Alphabetic characters sent in lower case will be converted and returned in upper case. Default to all spaces unless otherwise specified in the record layouts.	
Numeric Date	Zero through nine (0 - 9) formatted as CCYYMMDD. No slashes or hyphens. Default to zeroes unless otherwise specified in the file layouts (no spaces are permitted).	A date of March 25, 2011 would be formatted as "20110325" Open ended date: "00000000"
Reserved for Future Use	Populate with spaces. Fields defined with this field type may not be used by the RRE for any purpose. They must contain spaces.	
The above standards apply unless otherwise noted in layouts.		

10 File Submission Timeframe

Claim Input Files must be submitted on a quarterly basis during your assigned, 7-day file submission timeframe. TIN Reference Files must be submitted with your initial production file. They are optional with subsequent production files absent any changes to the TIN Reference Files. You will receive your Claim Input File submission timeframe assignment on your profile report which is sent after the COBC has processed your Section 111 registration and account setup. Each 3-month calendar quarter of the year has been divided into 12 submission periods as shown in the chart below. For example, if you have been assigned to Group 7, you will submit your Claim Input and associated TIN Reference File from the 15th through the 21st calendar day of the second month of each calendar year quarter; February 15th and February 21st for the first quarter, May 15th and May 21st for the second quarter, August 15th and August 21st for the third quarter and November 15th and November 21st for the fourth quarter of each year.

Note: Your Claim Input File receipt date will be set by the COBC system. There may be a slight delay between the actual time the file is submitted and when it is picked up and marked as received by the COBC. RREs should send their files as close to the first calendar day of their submission timeframe as possible in order to have the file receipt date fall safely within their submission timeframe.

There is no submission timeframe associated with Query Input Files. You may start sending test and production Query Input Files as frequently as once per calendar month, after your RRE ID is in a testing status, on any day of the month.

As of this writing:

- RREs in a testing status may submit test and production Query Input Files beginning on July 1, 2009.
- RREs in a testing status may submit test Claim Input Files beginning on January 1, 2010.
- RREs in a production status (see testing requirements in Section 14) **may** submit production Claim Input Files during their assigned file submission timeframe after January 1, 2010 once testing is complete.
- RREs **must** submit their initial production Claim Input File during their assigned file submission timeframe during the second calendar quarter (April – June) 2010.

Quarterly Claim Input File Submission Timeframes

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

11 Claim Input File

11.1 Overview

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

Claim information is reported after ORM has been assumed by the RRE or after a TPOC settlement, judgment, award or other payment has occurred. Records with claim information are to be transmitted for claims that are addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award or other payment on or after **January 1, 2010** that meet the reporting thresholds described later in this guide. A TPOC single payment obligation is reported only once regardless of whether it is funded through a single payment, an annuity or a structured settlement. RREs must also report claim information where ongoing responsibility for medical services (ORM) related to a claim was assumed by the RRE on or after **July 1, 2009**. In addition, records with claim information are to be transmitted for claims for which ORM exists on or through July 1, 2009, regardless of the date of an initial acceptance of payment responsibility (see the Qualified Exception in Section 11.9). Refer to the "MSP Overview" section, the "What Claims Are Reportable/When Are Such Claims Reportable?" section and Appendix G ("Definitions and Reporting Responsibilities") for further guidance on the types of claims that must be reported.

This file is transmitted in a fixed-width, flat file format. The file layout is provided in Appendix A of this guide.

The Claim Input File is submitted on a quarterly basis during the RRE's assigned file submission timeframe. The COBC will use this file 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).

To determine whether an injured party is a Medicare beneficiary, the COBC must match your data to Medicare's. You are required to send either a Medicare Health Insurance Claim Number (HICN) or the injured party's Social Security Number (SSN) on your Claim Input File records. For matching an individual to determine if they are a Medicare beneficiary the COBC uses:

- HICN or SSN
- First initial of the first name
- First 6 characters of the last name
- Date of birth (DOB)
- Gender

First the COBC must find an exact match on the SSN or HICN. Then at least three out of the four remaining criteria must be matched exactly. If a match is found, you will always be returned the correct HICN. You should store this HICN on your internal files and use it on future transactions. The COBC 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.

If the information provided passes the COBC edit process and is applicable to Medicare coverage, it is then passed to other Medicare systems and databases including those used by the CMS MSPRC and Medicare claims processing contractors. The COBC 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 is returned within 45 days of 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 COBC when a file has been received and when response files are available. File processing status may also be viewed on the Section 111 COBSW.

In the case of a settlement, judgment or award, or other payment without separate ongoing responsibility for medicals at any time, only **one** report record is required is to be submitted per liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim where the injured party is a Medicare beneficiary. An RRE is to report the assumption or termination of "ongoing responsibility for medicals" situations along with the one-time reporting of payments where ongoing responsibility is not assumed. When reporting ongoing responsibility for medicals (ORM), you are **not** to report individual payments for each medical item or service. You are **not** to report a previously submitted and accepted record each quarter. However, if an RRE has accepted ongoing responsibility for medicals on a claim (as is the case with many workers' compensation and no-fault claims), then the RRE must report **two** events; an initial (add) record to reflect the acceptance of ongoing payment responsibility and a second (update) record to reflect the end date of ongoing payment responsibility with the corresponding end date reflected in the ORM Termination Date (Field 99). Please note, when termination of ongoing responsibility for medicals is reported, the ORM Indicator in Field 98 must remain as 'Y' (for yes); do not change it to 'N'. The 'Y' indicates current ongoing responsibility for medicals only until a termination is reported. Once the termination date is reported, the 'Y' reflects the existence of ongoing responsibility for medicals prior to the termination date. Because reporting is done only on a quarterly basis, there may be some situations in which the RRE reports both the assumption of ongoing responsibility in the same record as the termination date for such responsibility. RREs are **not** to submit a report on the Claim Input File every time a payment is made 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 81) when reporting the assumption of ORM and the Exhaust Date for the Dollar Limit for No-Fault Insurance (Field 82) when ORM is terminated as applicable.

RREs must implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary. RREs must submit either the Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) 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 CMS is unable to validate a particular SSN or HICN 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 indicate the reason for rejection. Complete response file processing is covered in a later section.

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

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

The file structure will be explained in subsequent sections. The following table provides a high-level picture of what a Claim Input File and associated TIN Reference File would look like:

Sample Claim Input/TIN Reference File Structure
Header Record for Claim Input for RRE ID
Detail Record for Claim/DCN 1
Detail Record for Claim/DCN 2
Auxiliary Record for Claim/DCN 2
Detail Record for Claim/DCN 3
Trailer Record for Claim Input for RRE ID
Header Record for TIN Reference File for RRE ID
TIN/Office Code 1 Combination
TIN/Office Code 2 Combination
Trailer Record for TIN Reference File for RRE ID

11.2 Data Elements

Detailed record layouts and data element descriptions for the Claim Input File can be found in Appendix A of this guide.

11.2.1 Header

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

11.2.2 Detail Claim Record

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

Each detail record on the Claim Input File must contain a unique DCN generated by the RRE. This DCN is required so that response records can be matched and issues with files more easily identified and resolved. It can be any format of the RREs choosing as long as it is not more than 15 characters as defined in the record layout. The DCN only needs to be unique within the current file being submitted.

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

11.2.3 Auxiliary Record

The Auxiliary Record is used to report information only if there is more than one "claimant" or if there is information related to additional Total Payment Obligation to Claimant (TPOC) amounts. It is only required if there are additional claimants to report for the associated Detail Claim Record and/or if there is more than one TPOC Amount to report. Do not include this record with the claim report unless one or both of these situations exist(s). (Remember that the "claimant" fields on the Claim Input File Detail Record (Fields no. 104 – 132) are only used if the injured party/ Medicare beneficiary is deceased and the claimant is the beneficiary's estate or another individual/entity.) Claimant 1 on the Detail Claim Record must be completed in order for information concerning additional claimants to be accepted. Additional claimants are reported only in the event of a deceased beneficiary (injured party) when another entity or individual has taken the Medicare beneficiary's place as the "Claimant" (Estate, Family, Other).

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

Note: Once an Auxiliary Record has been submitted and accepted with a claim report, you must continue to send this record with any subsequent update record for the claim unless the information it contains no longer applies to the claim (the RRE wishes to remove information reported for Claimants 2-4 and TPOC 2-5 Fields).

11.2.4 Trailer

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

11.2.5 ICD-9-CM Codes

Add and update records on Claim Input Files submitted on or after January 1, 2011 must include International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes in the Detail Record Alleged Cause of Injury, Incident or Illness (Field 15) and the ICD-9 Diagnosis Codes 1-19 beginning in Field 19. Field descriptions are provided in the record layout in Appendix A. This section provides more information concerning the requirements for these fields.

To allow RREs and their agents more time to incorporate the use of ICD-9 codes in their Section 111 reporting process, an interim requirement has been made available. If an RRE is unable to supply valid ICD-9 codes in the Cause and Diagnosis fields, the Description of Illness/Injury (Field 57) may be used. This field may be supplied in lieu of the Cause and Diagnosis codes prior to 2011. It is a free-form, alphanumeric text field that must contain a description of the major body part(s) injured (e.g. head, arm, leg, etc.) and cause of illness/injury. The COBC will use this information to map the description to an ICD-9 diagnosis code for use by other Medicare contractors in claim processing and recovery efforts. If this field cannot be mapped, the RRE may be contacted to provide more information. The Description of Illness/Injury will only be available for use on files submitted prior to January 1, 2011. After that, all add and update detail records must contain both a valid Alleged Cause of Injury, Incident or Illness and at least one valid ICD-9 Diagnosis Code.

Prior to 2011, if a code is supplied in the Alleged Cause or ICD-9 Diagnosis Code fields, those fields will be fully edited by the system according to the field descriptions provided in the record layout even if text is provided in the Description of Illness/Injury field. A record will be rejected with an associated error code if the field requirements are not met. So these fields should be filled with spaces until an RRE has fully tested the submission of ICD-9 codes. Please refer to the section on testing in this guide. Test files may be submitted even after an RRE has begun submitting production files. An RRE may start submitting production files using the Description of Illness/Injury and continue to test the submission of ICD-9 codes.

CMS publishes a list of valid ICD-9 diagnosis codes once per year at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Use the current version download published once per year (e.g. V26 I-9 Diagnosis.txt effective 10/1/2008). Throughout this guide the term "valid ICD-9 diagnosis code" refers to any ICD-9 code that exactly matches the first 5 bytes or characters of a record in this file. Decimal points are not to be included.

CMS has determined that certain valid ICD-9 diagnosis codes do not provide enough information related to the cause and nature of an illness, incident or injury to be complete, useful, and/or adequate for Section 111 reporting. A list of these codes is provided in Appendix H and is referred to as the list of "Insufficient ICD-9 Diagnosis Codes". These codes will NOT be accepted in the Alleged Cause of Injury, Incident or Illness (Field 15). These codes WILL be accepted in the ICD-9 Diagnosis Codes beginning in Field 19. However, at least one valid numeric ICD-9 Diagnosis Code that is NOT on this list and NOT an E code and NOT a V code (not beginning with the letter 'E' and not beginning with the letter 'V') must be provided in any one of the ICD-9 Diagnosis Code fields in order for the record to be accepted. If these requirements are not met, the record will be rejected. Again, these requirements apply prior to 2011 if the RRE attempts to provide codes in the Alleged Cause or any ICD-9 Diagnosis code fields. If those fields are left blank prior to 2011 the edits will not be applied. All edits apply to these fields on add and update records beginning with files submitted January 1, 2011 and subsequent.

CMS encourages RREs to supply as many valid ICD-9 Diagnosis Codes as possible as that will lead to more accurate coordination of benefits, including facilitating accurate claims payment and/or the determination of recovery amounts, where applicable.

Requirements

- ICD-9 codes are to be submitted with no decimal point. Codes must be left justified and any remaining unused bytes filled with spaces. Leading zeroes must be included as applicable (see below).
- The list of ICD-9 codes considered valid by CMS for Section 111 reporting can be found on www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Use the current version download published once per year (e.g. V26 I-9 Diagnosis.txt effective 10/1/2008). The submitted code must ***exactly*** match the first 5 bytes/characters of a record on this file. For example, '81000' is valid, but '810 ' is not. A value of '0010 ' is valid, but a value of '10 ' is not.
- Prior to January 1, 2011, RREs must provide either:

  Alleged Cause of Injury, Incident, or Illness (Field 15) and at least one diagnosis code in the ICD-9 Diagnosis Code 1 (Field 19)

  OR

  Description of Illness/Injury (Field 57).

- With files submitted on January 1, 2011 and subsequent, RREs must provide the Alleged Cause of Injury, Incident, or Illness (Field 15) and at least one diagnosis code in the ICD-9 Diagnosis Code 1 (Field 19) in add and update records.

- To be considered valid, the Alleged Cause of Illness/Injury must begin with an 'E' (be an "E code") and be on the list of valid ICD-9 codes for Section 111 reporting. In addition, the E code supplied must ***NOT*** be on the list of Insufficient ICD-9 Diagnosis Codes provided in Appendix H. Prior to 2011, it may be filled with spaces.
- To be considered valid, an ICD-9 Diagnosis Code must be on the list of valid ICD-9 codes for Section 111 reporting. It may begin with a number, the letter 'E' or the letter 'V'. Prior to 2011, all ICD-9 Diagnosis Codes may be filled with spaces.
- With files submitted January 1, 2011 and subsequent, at least one ICD-9 Diagnosis Code must be provided on add and update records.
- Regardless of the submission date, if any number of ICD-9 Diagnosis Codes is provided, at least one must NOT begin with 'E' and NOT begin with 'V' and NOT be on the list of Insufficient ICD-9 Diagnosis Codes provided in Appendix H. Additional ICD-9 Diagnosis Codes can (and should) be provided as long as they are on the list of valid codes.
- If these requirements are not met, the record will be rejected and an 'SP' disposition code and associated error code will be returned on the corresponding Claim Response File record.

More information related to ICD-9-CM may be found at:
http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf and
http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm.

The CMS plans to implement the new ICD-10-CM diagnosis codes by October 2013. Filler has been reserved on the Claim Input File Detail Record layout to make room for these codes as they are defined with up to seven bytes rather than the five bytes used for ICD-9 diagnosis codes. Complete instructions and requirements for the use of ICD-10 codes will be provided at a later date. At this time ICD-10 codes will not be accepted. Further information can be found at http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf and http://www.cms.hhs.gov/ICD10/.

11.2.6 Foreign Addresses

CMS recognizes that in certain rare, unique situations, the RRE may be an entity with no associated Federal Tax Identification Number (TIN), United States address and/or US telephone number. In order to register for Section 111 reporting and submit the TIN Reference File, a TIN, and US address and telephone number are required. RREs must provide a TIN and US address/phone if available. If none is available, contact the COBC EDI Department at 646-458-6740. The matter will be referred to CMS for resolution. In some cases, CMS may allow the RRE to register under information for their US-based "managing agency company", but do not do so unless CMS approval has been received.

Contact information outside the United States may not be provided in any address or telephone number field on Section 111 files. See the previous instructions provided above for submission of the applicable TIN Reference File fields. On the Claim Input File Detail and Auxiliary Records, the RRE must supply a domestic, US address and telephone number for Claimant and Representative fields if possible. If none is available, then supply a value of 'FC' in the associated State Code field and default all other fields

to spaces or zeroes as specified in the record layouts in Appendix A. If US contact information is not supplied for a Claimant or Representative, then the RRE may be contacted directly to supply additional information. So it is recommended that an RRE make every effort to supply US contact information to avoid further contact regarding address information.

11.3 TIN Reference File

The TIN submitted in Field 72 of each Claim Detail Record is an IRS-assigned, federal tax identification number for the RRE. It may also be known as the RRE's federal employer identification number (FEIN or EIN). For those who are self-employed, their TIN may be an Employer Identification Number (EIN) or Social Security Number (SSN) depending upon their particular situation. The TINs in field 72 must match the TINs in your TIN Reference File. However, depending on the circumstances, you may submit the same or different TINs in Field 72 and TIN Reference File than you provided for the RRE ID during registration. All claims should be reported with the RRE TIN associated with the entity that currently has payment responsibility for the claim. As described in a later section, updates may be submitted to change the TIN associated with a previously reported claim if needed.

Other TINs for injured parties, other claimants and attorneys or representatives are submitted on the Claim Detail Record but only the RRE TINs submitted in Field 72 are to be included on the TIN Reference File. The TIN Reference File is to be submitted with a record for each RRE (Plan) TIN and Office Code (Site ID) combination reported in Fields 72 and 73 of your Claim Input File Detail Records.

The TIN Reference File is submitted with the Claim Input File so that RRE name and address information associated with each TIN used does not have to be repeated on every Claim Input Record. The TIN, name and mailing address used on the TIN Reference File record should be those associated to the TIN and address to which healthcare claim insurance coordination of benefits and notifications related to Medicare's recovery efforts, if contact is necessary, should be directed. An RRE may use more than one TIN for Section 111 claim reporting. For example, an insurer may have claims operations defined for various regions of the country or by line of business. Because they are separate business operations, each could have its own TIN and each TIN may be associated with a distinct name and mailing address.

To allow for further flexibility, CMS has added an optional field called the Office Code (or Site ID) as Field 73 of the Claim Detail Record. This is an RRE-defined field that can be used when the RRE has only one TIN but wishes to associate claims and the corresponding mailing address for the RRE to different offices or sites. If you do not need this distinction, you may leave the Office Code field blank on each Claim Detail Record and TIN Reference File records.

For example, an RRE may use only one TIN ('123456789') but have two office codes; '000000001' for workers' compensation claims and '000000002' for commercial liability claims. Two records will be reported on the TIN Reference File. One record with TIN of '123456789' and Office Code of '000000001' and a second record with the same TIN of '123456789' but Office Code of '000000002'. Different mailing addresses may be

submitted on the TIN Reference File record for each of these combinations. In this example, the RRE would submit '123456789' in Field 72 of each Claim Detail Record, '000000001' in Field 73 of each workers' compensation Claim Detail Record, and '000000002' in Field 73 of each commercial liability Claim Detail Record.

The TIN Reference File may be submitted with your Claim Input File as a logically separated file within the same physical file, or in a completely separate physical file. It has its own header and trailer records. It must be sent at the same time as your first Claim Input File.

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

Any TIN/Office Code combination submitted on a Claim Detail Record must be included in the TIN Reference File in order for the detail record to process.

There is no response file specifically associated with the TIN Reference File. If your TIN Reference File is not processed successfully, records on your Claim Input File will be rejected with errors associated with TIN/insurer-related fields.

The TIN Reference File layout and field descriptions can be found in Appendix B.

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

11.3.1 TIN Validation

This section outlines the steps the COBC will take to validate TINs on the Claim Input File and associated TIN Reference File. Note that full Claim Response File processing and compliance flags are explained in more detail in a later section of this guide.

- A TIN/Office Code combination in Fields 72 and 73 of the Claim Input File Detail Record must match a TIN/Office Code combination on a current or previously submitted TIN Reference File record. (The Office Code can be left blank if it is not used.)
- If no match is found, the Claim Input File Detail Record will be rejected with an 'SP' disposition code and a 'CP02' error code associated with invalid TIN/insurer information.
- If a match is found, then the TIN must be a valid IRS-assigned tax ID. If the TIN is not valid, then the Claim Input record will be accepted and processed but a compliance flag will be set with a value of '02' on the corresponding

Claim Response File record. The RRE must resubmit the correct TIN and any associated Office Code on an update record in the next quarterly Claim Input File along with an associated TIN Reference File record.

11.4 Interim Reporting Thresholds

The following interim reporting thresholds have been established for Section 111 reporting. RREs must adhere to these requirements when determining what claim information should be submitted on initial and subsequent quarterly update Claim Input Files. These thresholds are solely for purposes of the required reporting responsibilities for purposes of 42 U.S.C. 1395y(b)(8) (that is, the Section 111 MSP reporting requirements for liability insurance (including self-insurance), no-fault insurance, and workers' compensation). These thresholds are not exceptions/do not act as a "safe harbor" with respect to any other obligation or responsibility of any individual or entity with respect to the Medicare Secondary Payer provisions. These thresholds are **interim** thresholds while CMS is implementing the Section 111 reporting process. CMS reserves the right to change these thresholds and will provide appropriate advance notification of any changes.

No-Fault Insurance ORM and TPOC Amounts

- For no-fault insurance, there is ***NO*** de minimus dollar threshold for reporting the assumption/establishment of ORM or for reporting TPOC.

Liability Insurance ORM

- For liability insurance (including self-insurance), there is ***NO*** de minimus dollar threshold for reporting the assumption/establishment of ORM. However, thresholds for TPOC amounts apply as outlined below.

Workers' Compensation ORM

- For workers' compensation ORM, claims meeting ***ALL*** of the following criteria are excluded from reporting for file submissions due through December 31, 2011:
    - The claim is for "medicals only" and
    - The associated "lost time" for the worker is no more than the number of days permitted by the applicable workers' compensation law for a "medicals only" claim (or 7 calendar days if the applicable law has no such limit) and
    - All payment(s) has/have been made directly to the medical provider and
    - Total payment for medicals does not exceed $750.00.

Liability Insurance and Workers' Compensation TPOC Amounts

- For liability insurance (including self-insurance) and workers' compensation (Plan Insurance Type = 'E' or 'L') TPOCs, the following requirements and dollar thresholds apply:
    - RREs are not required to adhere to the TPOC thresholds for claims reported with ORM (ORM Indicator = 'Y'). RREs are only required to report a TPOC on a claim with ORM if over the TPOC threshold, but may report TPOCs under the threshold at the RRE's discretion. In other words,

the COBC will not apply the TPOC threshold edit criteria to claims reported with ORM.

- TPOC threshold checks will only be applied to initial claim reports (add records).
- Initial claim reports (add records) which have no ORM and do not meet the total TPOC threshold amount will be rejected with an associated error code. In other words, claims reported below the specified thresholds for the applicable date range will be considered to be reported in error. Subsequent update records that remove or otherwise lower the total TPOC amount reported will be accepted regardless of the thresholds.
- Where there are multiple TPOCs associated with the same claim record, the combined, cumulative TPOC amounts must be considered in determining whether or not the reporting threshold is met. However, multiple TPOCs must be reported in separate TPOC fields as described later in this guide.
- RREs are only required to report TPOCs with dates of January 1, 2010 and subsequent. Therefore, only TPOCs with dates of January 1, 2010 and subsequent need to be included in the total for the threshold check. However, TPOCs with dates prior may be included at the RRE's discretion. **The COBC will add all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.**
- The threshold dollar and date ranges apply to the date when the threshold is met (the most recent TPOC Date). The COBC will use the most recent TPOC Date supplied on the claim report when checking the threshold ranges. Timeliness of reports will be determined based upon the applicable date for the TPOC which caused the threshold to be met (the last, latest, most recent TPOC Date reported on the claim record.)
- For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the TPOC amount includes the total of these two figures which in turn is included in the total TPOC amount used for the threshold check.
- Claim reports where the last (most recent) TPOC Date is **January 1, 2010 through December 31, 2011** with TPOC Amounts totaling $0.00 - **$5,000.00**, are exempt from reporting. Initial claim reports (add records) with no ORM (ORM Indicator = 'N') where the most recent TPOC Date is prior to January 1, 2012 with a total TPOC amount less than $5000.00 will be rejected.
- Claim reports where the last (most recent) TPOC Date is **January 1, 2012 through December 31, 2012** with TPOC Amounts totaling $0.00 - **$2000.00**, are exempt from reporting. Initial claim reports (add records) with no ORM (ORM Indicator = 'N') where the most recent TPOC Date is prior to January 1, 2013 with a total TPOC amount less than $2000.00 will be rejected.
- Claim reports where the last (most recent) TPOC Date is **January 1, 2013 through December 31, 2013**, with TPOC Amounts totaling $0.00 - **$600.00** are exempt from reporting. Initial claim reports (add records) with no ORM (ORM Indicator = 'N') where the most recent TPOC Date is prior to January 1, 2014 with a total TPOC amount less than $600.00 will be rejected.

- No threshold applies to claims where the last (most recent) TPOC Date is January 1, 2014 and subsequent.

11.5 Reporting Multiple TPOCs

This section provides information on how RREs will report multiple TPOC Dates and Amounts on the Claim Input File for Section 111 reporting. For example, if an RRE negotiates separate, different settlements at different times for a liability claim, each settlement amount is to be reported and maintained ongoing in separate fields. There are five sets of TPOC fields available – one on the Claim Input File Detail Record and four on the Claim Input File Auxiliary Record. These sets of fields include the associated TPOC Date, TPOC Amount, and "Funding Delayed Beyond TPOC Start Date" for each separate TPOC associated with a claim report. Please see the field descriptions in the file layouts in Appendix A for the Detail and Auxiliary Records. Additional TPOC fields only need to be submitted if the RRE has more than one, distinct, additional TPOC to report for a claim. Please refer to later sections of this guide which provide more information for reporting using add, delete and update transactions.

The TPOC fields will be "positional" in the sense that the first settlement/judgment/award/other payment TPOC Amount should be reported on the Detail Record in Fields 100-102, the second settlement/judgment/award/other payment TPOC Amount should be placed in the first available TPOC Date and Amount on the Auxiliary Record starting at Field 93, and so on. All subsequent reports for the claim should maintain all previously reported data in its original position/field, except for fields being updated.

RREs only need to report the Auxiliary Record if they have more than one "claimant" or if they have more than one distinct TPOC to report for the claim. (Remember that the "claimant" fields on the Claim Input File Detail Record (Fields 104 – 132) are only used if the injured party/ Medicare beneficiary is deceased and the claimant is the beneficiary's estate or another individual/entity.) The Auxiliary Record must always directly follow the corresponding Detail Record for the claim report in the Claim Input File. The Detail Record is always required for a claim report on the Claim Input File. The Auxiliary Record is only included if needed. ***Once an RRE has submitted an Auxiliary Record and it has been accepted by the COBC for a claim report, the RRE must continue to include the Auxiliary Record with all subsequent update transactions for that claim unless there are no additional claimants to report and the second through fifth TPOC Amounts are subsequently zeroed out (reported previously but the RRE wishes to rescind the previous report of any TPOC 2-5 Amounts).***

To report only one TPOC Amount on an initial claim report, submit an add transaction with a '0' in the Action Type (Field 3) of the Detail Record, place the TPOC Date and Amount in Fields 100 and 101 of the Detail Record and do not include an Auxiliary Record. (To report only one TPOC Amount on an existing record (the record was already submitted with ORM information), the transaction would be submitted with a '2' in the Action Type as an update rather than an add.)

To report more than one TPOC Amount on an initial claim report, submit an add transaction with a ‘0’ in the Action Type of the Detail Record, place the first TPOC Date and Amount in Fields 100 and 101 of the Detail Record, and place the second and subsequent TPOC Dates and Amounts in the corresponding TPOC fields on the Auxiliary Record. (To report more than one TPOC Amount on an existing record (the record was already submitted with ORM information), the transaction would be submitted with a ‘2’ in the Action Type as an update rather than an add.)

To report a new, additional second TPOC Date and Amount after the first TPOC Amount has been reported, submit an update transaction with ‘2’ in the Action Type of the Detail Record, place the previously reported first TPOC Date and Amount in Fields 100 and 101 of the Detail Record, include an Auxiliary Record and place the second TPOC Date and Amount in Fields 93 and 94 on the Auxiliary Record.

To report a new, additional third TPOC Date and Amount after a previous claim submission, submit an update transaction with ‘2’ in the Action Type of the Detail Record, place the previously reported first TPOC Date and Amount in Fields 100 and 101 of the Detail Record, and place the second previously reported TPOC Date and Amount in Fields 93 and 94 on the Auxiliary Record, and place the new, additional third TPOC Date and Amount in Fields 95 and 96 on the Auxiliary Record. Each subsequent TPOC added will follow the same guidelines.

To correct a previously submitted TPOC Amount or Date, you will submit an update transaction with a value of ‘2’ in the Action Type on the Detail Record and place the corrected TPOC Amount and/or Date in the same field it was reported previously, in a sense overlaying what was reported before on the Detail or Auxiliary Record. All other TPOCs reported previously for the claim should be reported with their original values and in their original locations on the Detail or Auxiliary Records as applicable.

In the case where an RRE has previously reported a TPOC, to remove a TPOC previously reported due to erroneous information on a prior submission (in essence, deleting that one TPOC but keeping any others), you will submit an update transaction with a value of ‘2’ in the Action Type on the Detail Record and place zeroes in the TPOC Date and Amount in the same fields they were reported previously on the Detail or Auxiliary Record. Subsequent submissions for the claim report should continue to preserve the positional nature of these fields so that TPOC should continue to be reported with zeroes on any subsequent report for the claim.

If more than five TPOCs need to be reported for a single claim, then please contact your EDI Representative for assistance.

11.6 Initial File Submission

This section describes requirements for your initial file submission which is the first Claim Input File you will submit for Section 111 on or about your production live date after testing has successfully been completed. To begin reporting for Section 111, you must create and send a file that contains information for all claims, where the injured party is/was a Medicare beneficiary and medicals are claimed and/or released (or the settlement, judgment, ward, or other payment had the effect of releasing medicals) and which are addressed/resolved (or partially addressed/resolved) through a settlement, judgment, award or other payment on or after January 1, 2010, regardless of the assigned date for your first submission. A "Total Payment Obligation to the Claimant" (or TPOC) single payment obligation is reported only once regardless of whether it is funded through a single payment, an annuity or a structured settlement and the TPOC amount is determined without regard to the "ongoing responsibility for medicals" (or ORM) if the RRE has assumed ORM. In other words, for claims only involving payment due to a TPOC settlement, judgment or award, or other payment (that is a single payment obligation – regardless of how the payout is actually structured – with no separate assumption of ongoing responsibility for medicals) the report is only needed if the settlement, judgment, award, or other payment date for purposes of Section 111 reporting is on or after January 1, 2010. See the Claim Input File Detail Record Layout, Field 100 in Appendix A for an explanation of how to determine the TPOC Date.

You must also report on claims for which the RRE **has** ongoing responsibility for medicals (ORM) as of July 1, 2009 and subsequent, even if the assumption of responsibility occurred prior to July 1, 2009. Where the assumption of ongoing responsibility for medicals occurred prior to July 1, 2009, and continued on or through July 1, 2009, reporting is required.

See Sections 11.8, 11.9, and 11.10 for specific exceptions or extensions related to Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, or workers' compensation. See Section 11.4 for Interim Reporting Threshold requirements.

INITIAL FILE SUBMISSION EXAMPLES				
No.	**Situation**	**Additional Facts**	**Section 111 Report**	**Rationale**
1A	A Medicare beneficiary is injured by slipping and falling in a retail store. The owner of the store is covered by a general liability policy. A one-time payment is made to the Medicare beneficiary and the insurer has no ongoing obligation for additional medical payments for the beneficiary.	The beneficiary files a claim with the insurer of the liability policy. A settlement is signed by both parties on June 3, 2009; there is no court involvement.	No report of settlement for Section 111	The "Total Payment Obligation to the Claimant" (TPOC) Date is prior to January 1, 2010. See Field 100 on the Input File Detail Record for further information on the TPOC Date. Remember that the TPOC date/information is reportable without regard to responsibility/lack of responsibility for ongoing medicals.
1B	Same basic facts as 1A	The beneficiary sues. A settlement for $10,000 is signed by both parties on June 3, 2009. However, the settlement requires court approval, which is not obtained until January 10, 2010.	Report settlement for Section111	The "Total Payment Obligation to the Claimant" (TPOC) Date is on or after January 1, 2010 and the TPOC Amount meets the reporting threshold for the TPOC Date timeframe (greater than $5000). See Field 100 and 101 on the Claim Input File Detail Record layout for further information on the TPOC Date and Amount. Remember that the TPOC date/information is reportable without regard to responsibility/lack of responsibility for ongoing medicals.

INITIAL FILE SUBMISSION EXAMPLES				
No.	**Situation**	**Additional Facts**	**Section 111 Report**	**Rationale**
2A	A Medicare beneficiary is injured on the job on February 15, 2009, and files a workers' compensation claim. Workers' compensation assumes responsibility (including a requirement to pay pending investigation) for the associated medicals.	The claim is still open; workers' compensation continues to have responsibility for the medicals on and after July 1, 2009. There is no settlement, judgment, award, or other payment aside from the assumption of responsibility for medicals.	Report ongoing responsibility for medicals for Section 111	Ongoing responsibility for medicals exists as of July 1, 2009, or later. See sections 11.8 and 11.9 for extensions, exceptions, and information regarding termination of workers' compensation ORM.
2B.	Same basic facts as 2A	There was a judgment or award for $50,000 by the WC court issued on June 23, 2009. This judgment or award left the medicals open.	Report the ongoing medicals responsibility for Section111. Do not report the judgment or award. (However, if a TPOC prior to 1/1/2010 is reported in conjunction with a reportable ORM, the TPOC will not be rejected.)	See 2A for why the ongoing medicals responsibility is reported. The settlement, judgment, award, or other payment which was separate from the ongoing medicals responsibility is not reported because the applicable TPOC date is prior to January 1, 2010.

INITIAL FILE SUBMISSION EXAMPLES				
No.	**Situation**	**Additional Facts**	**Section 111 Report**	**Rationale**
3A	A Medicare beneficiary is injured in an automobile accident on February 15, 2009. The beneficiary files a claim with the other driver's insurer (or with his own if it is a no-fault state). The insurer opens a claim and assumes responsibility for ongoing medicals associated with the claim under the "med pay" portion of the policy (which has a cap of $5,000). The med pay cap is reached as of June 15, 2009.		Do not report the ongoing responsibility for medicals information for Section 111.	ORM terminated prior to July 1, 2009.
3B	Same basic facts as 3A	The beneficiary's medicals exceed the cap and/or he/she has other alleged damages. The insurer settles with the beneficiary for $50,000 on July 3, 2010.	Do not report the ongoing responsibility for medicals information for Section 111. Report the $50,000 TPOC information.	ORM terminated prior to July 1, 2009. TPOC date on or after January 1, 2010 and exceeds the reporting threshold.

INITIAL FILE SUBMISSION EXAMPLES				
No.	**Situation**	**Additional Facts**	**Section 111 Report**	**Rationale**
3C	Same basic facts as 3A/3B **except that state law requires life-time medicals.**	Same additional facts as 3B	Report both the ongoing responsibility for medicals and the settlement.	ORM continued in effect July 1, 2009. TPOC date on or after January 1, 2010 and exceeded the reporting threshold.

Your initial Claim Input File may be larger than your subsequent update files since it will contain “retroactive” reporting for all TPOC dates on or after January 1, 2010 and assumptions of ongoing responsibility for medicals on or after July 1, 2009 as well as initial reports where ongoing responsibility for medicals was assumed prior to July 1, 2009, and continued at least through July 1, 2009. Assuming a steady claim volume at the RRE, the Section 111 file size should level off in subsequent quarters. All records on your initial file will be “add” records and have a value of zero (‘0’) in the Action Type (Field 3).

Section 111 liability insurance (including self-insurance), no-fault insurance, and workers’ compensation RREs must submit their initial production Section 111 Claim Input File during the **second calendar quarter (April - June) of 2010** during their assigned submission timeframe. When you register for Section 111 reporting, you will be assigned a 7-day window for your quarterly file submission. The production live date is the first day of your first quarterly submission timeframe and your initial Claim Input File must be received inside that 7 day window.

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

11.7 Quarterly File Submissions

Subsequent, quarterly Claim Input File submissions must include records for any new claims as “add” records, where the injured party is a Medicare beneficiary, reflecting settlement, judgment, award, other payment (including assumption of ORM) since the last file submission.

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

If a record was submitted and accepted by the COBC on a previous file submission, but the claim record never should have been sent in the first place and the RRE submitted it in error (e.g. there was no settlement, judgment, award, or other payment (including assumption of ORM)) then you must submit a “delete” record on your next quarterly Claim Input File to remove that claim information from the Medicare systems and databases.

Quarterly update files must contain resubmission of any records found in error on the previous file, with corrections made. No interim file submissions will be accepted. Since the claim record was not accepted by the COBC on the previous file, these corrected records are to be sent with the same action type as the original record.

Response file processing will be discussed in a later section of this guide but please note that a record is considered accepted by the COBC if the corresponding response record is returned with a disposition code of ‘01’, ‘02’, or ’03’.

If the individual was not a Medicare beneficiary at the time responsibility for ongoing medicals was assumed, the RRE must monitor the status of that individual and report when that individual becomes a Medicare beneficiary unless responsibility for ongoing medicals has terminated before the individual becomes a Medicare beneficiary. Please refer to the section describing the Query File that can be used to monitor an injured party’s Medicare coverage.

If you are reporting any new TINs or Office Codes on your Claim Input File, submit a TIN Reference File with records for each new TIN/Office Code combination with your quarterly Claim Input File submission.

If you have no new information to supply on a quarterly update file, you must submit an “empty” Claim Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count. Note that a process will be added to the Section 111 COBSW application that will allow a user associated with the RRE ID to indicate that the RRE has nothing to submit for a particular quarter in lieu of submitting an actual empty file.

See also, Sections 11.8, 11.9, and 11.10 for specific exceptions or extensions related to Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, or workers’ compensation. See Section 11.4 for Interim Reporting Threshold requirements.

11.7.1 Add

An “add” record or transaction is defined with a ‘0’ (zero) in the Action Type (Field 3) of a Claim Detail Record. An add is a record submitted to the COBC for a new claim that was either not previously submitted or was submitted but not accepted with an ’01 or ‘02’ disposition code. An add transaction could be for a new claim settled since your last quarterly report, a claim resubmitted due to errors, or a claim where the RRE assumed ongoing responsibility for medicals previously but the injured party has just become covered by Medicare.

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

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

Example 3: An RRE has begun submitting production Section 111 Claim Input Files and received and processed the last quarter’s responses from the COBC. The RRE determines that an injured party on a claim where the RRE has ongoing responsibility for medicals under Section 111 becomes covered by Medicare. The RRE determines this through its monitoring process (which may include, for example, notification from the injured party or information through the Section 111 query process). The RRE submits the claim as an add record on the next quarterly file submission.

11.7.2 Delete

A “delete” record or transaction is defined with a ‘1’ in the Action Type (Field 3) of a Claim Detail Record. A delete transaction is sent to remove information previously sent for Section 111 to the COBC. Records accepted by the COBC receive an ‘01’ or ‘02’ disposition code in your Claim Response File you receive back from the COBC. If your add transaction did not result in one of these disposition codes, there’s no need to delete it even if it was previously sent in error. There is no need to send a delete record for a record for which you previously received an ‘03’. Delete records should be needed only under rare circumstances. If you discover a severe error that affected many records on a file previously transmitted to the COBC for Section 111, then please contact your EDI Rep to discuss the steps that should be taken to correct it.

Because Medicare stores information on claims submitted previously by certain key information, the following fields on a delete record must match the add record sent previously in order for the delete to be successful:

- Injured Party HICN or SSN (Fields 4 or 5)*
- CMS Date of Incident (Field 12)

- Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 71)
- ORM Indicator (Field 98)

*Note: As described in the Overview section, the COBC uses either the reported injured party's HICN or SSN, the first initial, the first 6 characters of the last name, date of birth and gender to match to a Medicare beneficiary. You should send the most recent, most accurate information you have in your system for name, date of birth and gender. The COBC will provide updated, "applied" values for these fields, according to what Medicare has on file, on response records when a match is found to a Medicare beneficiary. Medicare's files are updated by a feed from the Social Security Administration (SSA) so if a beneficiary updates his information with SSA, it will be fed to the COBC and used in the matching process. See the discussion of the matching process in Section 11.1 and the description of fields returned on the response record in Section 12. RREs are strongly encouraged to use the Medicare HICN assigned to the injured party whenever made available by the injured party or as returned by the COBC on query and claim response records as this is the official individual identifier used by Medicare for Medicare beneficiaries.

RREs are to send separate records for different policy and claim numbers. Medicare does maintain information with policy and claim numbers submitted. However, these are not considered key fields. Delete records should be submitted with the same policy and claim numbers as submitted on the original add record for the claim.

Delete records are used in two situations. First, if the original record should never have been sent in the first place.

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

The other case when a delete record will be sent is when you need to change a key field submitted previously. In these situations, the RRE must send a delete record with the key information that matches the previously accepted add record followed by a new add record with the changed information.

Example 2: A claim record was submitted for a liability claim with a settlement, judgment, award, or other payment on a RRE's previous quarterly file submission and was accepted with an '01' disposition code. Subsequently, the RRE changes the CMS date of incident (DOI) in its internal system. On its next Claim Input File, the RRE sends a delete record for the claim, with the values for the key fields listed above, all other claim information submitted previously on the original record, and places a '1' in the Action Type. In the same Claim Input File, the RRE sends an add record for the claim with the changed information including the new DOI and a '0' in the Action Type. The COBC processes both records and returns a record for each on

the response file with the applicable disposition code. The original record will be deleted from the COBC system and then added back with the new DOI supplied.

11.7.3 Update

An “update” record or transaction is defined with a ‘2’ in the Action Type (Field 3). An update transaction with an Action Type of ‘2’ is sent when you need to change information on a record previously submitted and accepted by the COBC for which you received an ‘01’ or ‘02’ disposition code in your Claim Response File. An update transaction with an Action Type of ‘2’ is also sent when you need to submit a new, additional TPOC Amount and Date. See the section on Multiple TPOCs in this guide.

Because Medicare stores information on claims submitted previously by certain key information, the following fields on an update record must match the add record sent previously in order for the update to be successful:

- Injured Party HICN or SSN (Fields 4 or 5)*
- CMS Date of Incident (Field 12)
- Plan Insurance Type (Liability, No-Fault, Workers’ Compensation in Field 71)
- ORM Indicator (Field 98)

*Note: As described in the Overview section, the COBC uses either the reported injured party’s HICN or SSN, the first initial, the first 6 characters of the last name, date of birth and gender to match to a Medicare beneficiary. You may send the original values submitted for name, date of birth and gender or the updated, “applied” values the COBC returned on the previous response record when applicable. See the discussion of the matching process in Section 11.1 and the description of fields returned on the response record in Section 12. RREs are strongly encouraged to use the Medicare HICN assigned to the injured party whenever made available by the injured party or as returned by the COBC on query and claim response records as this is the official individual identifier used by Medicare for Medicare beneficiaries.

RREs are to send separate records for different policy and claim numbers. Medicare does maintain information with policy and claim numbers submitted. However, these are not considered key fields. Update records should be submitted with the same policy and claim numbers as submitted on the original add record for the claim. Multiple update records with matching key fields but different policy/claim numbers will be accepted and processed.

Update records are submitted under three circumstances. The first is when an RRE needs to send the ORM Termination Date to indicate that the responsibility for ongoing medicals has ended (this may be a simple termination or it might be associated with the reporting of a settlement, judgment, award, or other payment TPOC amount/date). The second is when a report of ongoing responsibility for medicals has already been submitted and accepted and there is a separate settlement, judgment, award, or other payment TPOC amount/date but the RRE continues to retain ongoing responsibility for medicals. The third circumstance is to change information critical for use by Medicare in its claims payment and recovery processes. See the Event Table for additional information.

If you need to update one of the key fields listed above, follow the process described in the previous section where a delete and add record are required. See the Event Table for additional information.

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

- ICD-9 Diagnosis Codes 1-19 (starting at Field 19 on the Detail Record)
- Description of Illness/Injury (Field 57 of the Detail Record)
- TIN (Field 72 of the Detail Record)
- TPOC Date1 (Field 100 of the Detail Record)
- TPOC Date 2 -5 (Fields 93, 96, 99, 102 of the Auxiliary Record)
- TPOC Amount 1 (Field 101 of the Detail Record)
- TPOC Amount 2 – 5 (Fields 94, 97, 100, 103 of the Auxiliary Record)
- Claimant 1 Information (Fields 104 – 115 of the Detail Record)
- ORM Termination Date (Field 99)

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

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

Example 1: An initial claim record was previously submitted by an RRE and accepted by the COBC for a workers' compensation claim where the RRE assumed ongoing responsibility for medicals (the ORM Indicator Field 98 was submitted with a 'Y'). The RRE's ongoing responsibility for medicals subsequently terminated. In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a '2' in the Action Type (Field 3) and an ORM Termination Date (Field 99) reflecting when the RRE's ongoing responsibility for medicals ended. All other data elements are submitted as they were on the original report, including a 'Y' in the ORM Indicator.

Example 2: An initial claim record was previously submitted by an RRE and accepted by the COBC for a no-fault claim where the RRE assumed ongoing responsibility for medicals (the ORM Indicator Field 98 was submitted with a 'Y'). The limit on the no-fault portion of the policy applicable to the claim was provided in the No-Fault Insurance Limit (Field 81). Subsequently, the no-fault limit was reached and the RRE's ongoing responsibility for medicals ended. In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a '2' in the Action Type (Field 3), an ORM Termination Date (Field 99) reflecting when the RRE's ongoing responsibility for medicals ended, and the date the no-fault limit was reached in the Exhaust Date for Dollar Limit for No-Fault Insurance (Field 82). All other data elements are submitted as they were on the original report, including a 'Y' in the ORM indicator.

Example 3: A claim record was previously submitted by the RRE and accepted by the COBC for a liability claim with a settlement, judgment, award, or other payment information in TPOC Date 1 (Field 100) and TPOC Amount 1 (Field 101). Subsequently, the RRE corrects the TPOC Date 1 (Field 100) in its claim system since an incorrect date was entered initially. In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a '2' in the Action Type (Field 3) and the corrected TPOC Date 1 (Field 100). All other data elements are submitted as they were on the original report.

Example 4: A claim record was previously submitted by the RRE and accepted by the COBC for a liability claim with a settlement, judgment, award, or other payment TPOC. The Claim Detail Record submitted reflected ongoing responsibility for medicals (ORM Indicator = 'Y') and included a TPOC Date 1 and TPOC Amount 1 (Fields 100 and 101). Subsequently, an additional settlement, judgment, award, or other payment TPOC is reached with respect to the same claim record. In the next quarterly Claim Input File submission, the RRE sends an update record for the claim with a '2' in the Action Type (Field 3) the same amounts submitted previously in TPOC Date 1 and TPOC Amount 1 on the detail record and the **new, additional** TPOC date and amount in TPOC Date 2 and TPOC Amount 2 (Fields 93 and 94) on an Auxiliary Record immediately following the Detail Record. All other data elements are submitted as they were on the original report, including a 'Y' in the ORM Indicator on the detail record.

11.7.4 Event Table

This table is to be used by RREs and their agents to determine when and how to send records on the Claim Input File. The RRE Action reflects Claim Input File record submissions to be included in the next quarterly submission after the event occurs. Please see the Claim Input File record layouts in Appendix A for the requirements for each specific field on the record as this table describes the record submission only in general terms. No report is made for liability insurance (including self-insurance), no-fault insurance, or workers' compensation claims in which the injured party is a Medicare beneficiary until there is a settlement, judgment, award, or other payment (either ORM or TPOC or both). The phrase "previously reported and accepted" means that a claim record was previously submitted and the COBC sent back a disposition code of '01' or '02' on the corresponding Claim Response File record. See also the definition of the Total Payment Obligation to Claimant (TPOC) Amount and Date in Fields 100 and 101 of the Claim Input File Detail Record in Appendix A which also applies to the TPOC Date and Amount fields on the Auxiliary Record.

Event	RRE Action
Single Report – No ORM • Claim with settlement, judgment, award or other payment TPOC date on or after **1/1/2010** • Total TPOC Amount reaches/meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 11.4). TPOCs with dates prior to 1/1/2010 may be included at the RREs discretion. • No ORM	Send Add Record: • '0' (add) in the Action Type • 'N' in the ORM Indicator • TPOC Dates and Amounts

Event	RRE Action
Initial Report – with ORM and TPOC • Claim with settlement, judgment, award or other payment TPOC date on or after **1/1/2010** • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 11.4). TPOCs with dates prior to 1/1/2010 may be included at the RREs discretion. Total TPOC Amount may be less than the threshold at the RREs discretion since ORM is being reported in this case. • RRE has or had ORM on or after **7/1/2009** and meets the Workers' Compensation reporting threshold for ORM if applicable (that is, the ORM does not meet one or more of the specified criteria for it to be excluded from reporting).	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • TPOC Dates and Amounts
Initial Report – with ORM, no TPOC • Claim with no settlement, judgment, award, or other payment TPOC but the RRE has or had ORM on or after **7/1/2009** and meets the Workers' Compensation reporting threshold for ORM if applicable	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • Zeroes in TPOC Date and Amount
Termination of ORM – No TPOC • Claim with ORM previously reported and accepted by the COBC • ORM ends and there is no settlement, judgment, award or other payment TPOC Amount.	Send Update Record: • '2' (update) in the Action Type • '**Y' in the ORM Indicator** • Zeroes in TPOC Date and Amount • Date ORM ended in ORM Termination Date • Include Auxiliary Record if previously submitted and information on it still applies

Event	RRE Action
Termination of ORM – with TPOC • Claim with ORM previously reported and accepted by the COBC • ORM is ended and there is also a settlement, judgment, award or other payment TPOC Amount • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 11.4). TPOCs with dates prior to 1/1/2010 may be included at the RREs discretion. Total TPOC Amount may be less than the threshold at the RREs discretion.	Send Update Record: • '2' (update) in the Action Type • '**Y' in the ORM Indicator** • TPOC Date and Amount • Date ORM ended in ORM Termination Date • Include Auxiliary Record if previously submitted and information on it still applies
Initial Report and ORM Termination in One Report – No TPOC • Claim with no settlement, judgment, award, or payment TPOC amount • With ORM assumed on or after **7/1/2009** and meets the Workers' Compensation reporting threshold for ORM if applicable • Claim **not** previously reported and accepted • ORM has ended prior to the initial report of the ORM	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • Zeroes in TPOC Date and Amount • Date ORM ended in ORM Termination Date

Event	RRE Action
Initial Report and ORM Termination in One Report – with TPOC • Claim with settlement, judgment, award or other payment TPOC amount • With ORM assumed on or after **7/1/2009** and meets the Workers' Compensation reporting threshold for ORM if applicable • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 11.4). TPOCs with dates prior to 1/1/2010 may be included at the RREs discretion. Total TPOC Amount may be less than the threshold at the RREs discretion. • Claim **not** previously reported and accepted • ORM has ended prior to initial report but on or after **7/1/09**. (ORM could have ended because no-fault benefits were exhausted or termination in connection with the TPOC, etc.)	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • TPOC Date and Amount • Date ORM ended in ORM Termination Date

Event	RRE Action

Key Field Change – Delete/Add
 	
• Claim record was previously reported and accepted
 	
• One or more of the following **Key** fields was changed after the initial claim record was submitted and accepted:
 	
  • Injured Party SSN or HICN (wrong person sent as injured party)
  • CMS Date of Incident (Field 12)
  • Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 71)
  • ORM Indicator (Field 98)
	Send a Delete Followed by an Add
	
	Send Delete Record:
	
	• '1' (delete) in the Action Type
	• All other fields with matching values sent on the original record
	
	Send Add Record:
	
	• '0' (add) in the Action Type
	• Corrected/updated information for all other fields
	• Include Auxiliary Record if previously submitted and information on it still applies
	• All other information previously submitted as required

Event	RRE Action

Changed Information (other than Key Field information)
 	
• Claim previously submitted and accepted
 	
• One or more of the following fields has changed after the initial claim record was submitted and accepted:
 	
  • ICD-9 Diagnosis Codes 1-19
  • Description of Illness/Injury (Field 57)
  • TIN (Field 72)
  • TPOC Dates 1 - 5
  • TPOC Amounts 1 - 5
  • Claimant 1 Information (Fields 104 - 115)
  • ORM Termination Date (Field 99)
	Send Update Record:
	
	• '2' (update) in the Action Type
	• Include Auxiliary Record if previously submitted and information on it still applies
	• Changed values for
	  • ICD-9 Diagnosis Codes 1-19
	  • Description of Illness/Injury (Field 57)
	  • TIN (Field 72)
	  • TPOC Dates 1 - 5
	  • TPOC Amounts 1 – 5
	  • Claimant 1 Information (Fields 104 - 115)
	• Same values previously reported for
	  • Injured Party SSN/HICN (Fields 4/5)
	  • CMS Date of Incident (Field 12)
	  • Plan Insurance Type (Field 71)
	  • ORM Indicator and Termination Date (Fields 98 and 99)
	  • Same or updated information for all other fields

Delete/Cancel Prior Record Submission • Claim record was previously reported and accepted • Record was submitted in error – it should not have been sent due to an RRE system problem or other issue	Send Delete Record • '1' (delete) in the Action Type • All other fields with matching values sent on the original record
Record Rejected with Errors • Submitted claim record returned with an 'SP' disposition code in the corresponding response file record (not accepted, rejected by the COBC due to errors)	Correct errors Send record with previously submitted Action Type (Add, Update or Delete)

Event	RRE Action
Record in Process at COBC • Submitted claim record returned with a '50' disposition code in the corresponding response file record (still being processed by the COBC)	Resubmit same record with most current claim information
Ongoing Monitoring – Injured Party Becomes Covered by Medicare • Claim record previously submitted and rejected by the COBC with a '51' or '03 disposition code • RRE continues to have ORM • Injured party becomes covered by Medicare	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • TPOC Dates and Amounts as applicable

Reporting Additional TPOC Amounts
 	
• Claim record was previously reported and accepted (including a TPOC amount)
• With or without ORM
• An ***additional*** settlement, judgment, award or other payment TPOC is reached with respect to the same Section 111 claim record. If, for example, a claim to an insurer includes both no-fault insurance (as defined by CMS) and liability insurance, TPOCs associated with the no-fault and liability insurance would be reported on separate add records with different Plan Insurance Types (Liability, No-Fault, Workers' Compensation in Field 71). This instruction only applies where there are multiple TPOCs for the same record, for the same insurance type, etc.
	Send Update Record
	
	• '2' in the Action Type
	• New/additional TPOC Date and Amount in the next available set of TPOC fields on the Auxiliary Record (not cumulative amount but rather the amount of the additional TPOC)
	• Same values previously reported for
	  • Injured Party SSN/HICN (Fields 4/5)
	  • CMS Date of Incident (Field 12)
	  • Plan Insurance Type (Field 71)
	  • ORM Indicator and Termination Date (Fields 98 and 99)
	• Same or updated information for all other fields
	• See the Section 11.5 on Reporting Multiple TPOCs for more information

Event	RRE Action

ORM Reopens or Change in ORM Termination Date
 	
• Claim previously submitted with ORM Indicator (Field 98) = 'Y', non-zero ORM Termination Date (Field 99) and accepted
• RRE reopens or reassumes ORM or otherwise changes ORM Termination Date
	Send Update Record
	
	• '2' in the Action Type
	• Same values previously reported for
	  • Injured Party SSN/HICN (Fields 4/5)
	  • CMS Date of Incident (Field 12)
	  • Plan Insurance Type (Field 71)
	  • ORM Indicator (Field 98)
	• Zeroes in the ORM Termination Date (Field 99) if no ORM Termination Date established (to "reopen" the ORM on the record) or submit new/corrected date in ORM Termination Date. An ORM Termination Date in the future may be submitted if known and firmly established.
	• Same or updated information for all other fields

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

Information regarding an RRE's reporting for the assumption of ongoing responsibility for medicals (ORM) has been presented in other sections of this guide. The section provides additional information and clarity on the topic.

First, it's important to understand the reference to "ongoing" is not related to "ongoing reporting" or repeated reporting of claims under Section 111 but rather the RRE's responsibility to pay on an ongoing basis for the injured party's (Medicare beneficiary's) medicals associated with the claim. This typically only applies to no-fault and workers' compensation claims.

The trigger for reporting ORM is the assumption of ORM by the RRE – when the RRE has made a determination to assume responsibility for ORM or is otherwise required to assume ORM – not when or after the first payment for medicals under ORM has actually been made. Medical payments do not actually have to be paid on the claim for ORM reporting to be required.

If an RRE has assumed ORM, the RRE is reimbursing the provider of services (doctor, hospital, etc.) or injured parties for specific medical procedures, treatment, services, or devices like a doctor's visit, surgery, ambulance transport, and the like. These medicals are being paid by the RRE as they come in. Payments like these are NOT reported individually under Section 111 as TPOCs. When ORM ends (a no-fault limit is reached, the injured worker is healed, back to work and the RRE no longer has ORM. etc.) then the RRE reports an ORM termination date. If there was no settlement, judgment, award, or other TPOC payment made related to the claim (i.e. an actual settlement for medicals and/or lost wages, etc.), **you may never need to report a TPOC amount on a claim with ORM**. You may just need to send the termination date.

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

It is critical to report ORM claims with specific and complete information regarding the cause and nature of the illness, injury or incident associated with the claim. Medicare uses the information submitted in the Alleged Cause of Injury, Incident or Illness (Field 15), the ICD-9 Diagnosis Codes (starting in Field 19) and the Description of Illness/Injury (Field 57) to determine what specific medical services claims, submitted to Medicare, should be paid first by the RRE and considered only for secondary payment by Medicare.

For claims where the injured party is a Medicare beneficiary and there has been a settlement, judgment, award, or other payment, and the RRE has not assumed ORM, only **one** Section 111 claim report is required after the TPOC Date. The TPOC is defined as the Total Payment Obligation to the Claimant without regard to ongoing medical services. The TPOC Date is the date the obligation was established. Please see the

description of these fields in the Claim Input File Detail and Auxiliary Record layouts and further explanation in Section 2. The RRE provides the TPOC Date (as defined in Field 100 of the Claim Input File Detail Record) and the TPOC Amount (as defined in Field 101 of the Claim Input File Detail Record) when such a settlement, judgment, award, or other payment occurs. The field descriptions in the record layout explain how to calculate the TPOC Date and TPOC Amount. Note there is one set of TPOC fields provided on the Detail Record and four more sets of TPOC fields provided on the Auxiliary Record to allow for reporting of multiple TPOC settlements, judgments, awards, or other payments. See also Sections 11.4 Interim Reporting Thresholds and 11.5 Reporting Multiple TPOCs for more information on TPOC reporting requirements.

For claims where there is no TPOC settlement, judgment, award, or other payment (which is essentially a single payment obligation, regardless of how the actual payout is structured) but the liability insurance (including self-insurance), no-fault insurance, or workers' compensation has assumed ongoing responsibility for medicals associated with the claim (ORM) for the injured party, **two** reports under Section 111 are required. The first report is when the RRE assumes the ORM and the second is when ORM terminates. The RRE provides basic information about the claim in the first report including a 'Y' in the ORM Indicator and the no-fault insurance policy limit (if applicable). On the second report, the RRE provides the ORM Termination Date (date when ongoing responsibility for medicals ended) and, if a no-fault case, the date the no-fault policy limit was exhausted (if applicable). The first report will be an add record and the second report will be an update record. The second report will have a 'Y' in the ORM Indicator too. The RRE does not provide a TPOC Date and TPOC Amount on either report of ongoing responsibility for medicals unless there was a settlement, judgment, award, or other payment TPOC amount in addition to the termination of the ORM. If ORM is started and ended within the same calendar quarter or prior to the current reporting quarter before the initial report of ORM was made, all of this information may be reported on one record. For example, suppose a workers' compensation claim is opened for an employee/injured party who is a Medicare beneficiary in January and the injury is relatively minor such that ORM terminates in March. Depending upon its specific quarterly submission date, the RRE may end up only needing to report the claim once if the claim is closed and ORM has ended. This record would include a "Y" in the ORM Indicator and an ORM Termination Date. A TPOC Date and Amount would also be included in this single report if there was also a separate settlement, judgment, award, or other payment outside of the termination of the ORM.

A value of 'Y' in the ORM Indicator means that the claim currently has or at one time had ORM. The COBC posts these records for Medicare claims processing use so that claims for the same incident are checked and not paid primary by Medicare if there is other insurance that should pay first. CMS' key for claims processing actions related to these records is knowing a record has or had ORM -- hence the ORM Indicator being key to Section 111 processing. The ORM Indicator is not an on/off switch. Once "on" (a value of 'Y'), it stays "on" unless the RRE erroneously reported ORM and never had ORM. To turn ORM "off" as of a certain date, the RRE sends an ORM Termination Date on an update record but leaves the ORM Indicator set to 'Y". This will indicate that the RRE had ORM from the date of the incident through the ORM Termination date submitted. Zeroes in the ORM Termination Date indicate that there is no established end date as of yet for the ORM.

For claims with ORM, the RRE is NOT to report each time they pay for a medical service for the injured party. The actual amounts paid for specific medical services under the assumption of ORM are not reported, just the fact that ORM has been assumed for a particular claim for a particular period of time. In addition, RREs are NOT to report the same claim information each quarter. Once they make the first report and get a positive response that the record was accepted they do not report again until the ORM has terminated or there is separate TPOC information to be reported.

The only exception to two claim reports for ORM (as described above) will be when assumption and termination of ORM are reported in the same record or when the RRE needs to update or delete previously submitted information and correct records due to a change in important information sent on the prior record. Please refer to the Event Table to determine what would trigger an additional update or delete. One example may be that the RRE reported an incorrect diagnosis or description of injury. Since this could have a material effect on Medicare's claims processing and/or recovery efforts, the RRE will likely have to submit an update record to change that field. A delete transaction would be sent only if the original record was sent entirely in error and the information previously submitted needs to be removed from Medicare databases/systems.

With respect to ongoing responsibility for medicals, a determination that a case is "closed" or otherwise inactive does not automatically equate to a report terminating the ORM. If the ORM is subject to reopening or otherwise subject to a further request for payment, the record submitted for ORM should remain open. (Medicare beneficiaries have a continuing obligation to apply for all no-fault or workers' compensation benefits to which they are entitled.) Similarly, if a file is "closed" due to a "return to work" and no additional anticipated medicals, a report terminating the ORM should not be submitted as long as the ORM is subject to reopening or otherwise subject to an additional request for payment. For certain states which require a workers' compensation claim be left open for ORM indefinitely, the second report may never be submitted.

Note: **"Special Exception" regarding reporting termination of ORM:**

- Assumption of ORM typically occurs with respect to no-fault insurance (as defined by CMS – see Record Layout descriptor for CMS' definition) or workers' compensation. Because this may involve all levels of injury, the above rule could result in the continuation of open ORM records even where, as a practical matter, there is no possibility of associated future treatment. An example might be a relatively minor fully healed flesh wound in a State where workers' compensation requires life-time medicals. To address this situation, RREs may submit a termination date for ORM if they have a signed statement from the injured individual's treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or otherwise subject to a claim for further payment.

- If, in fact, there is a subsequent reopening of the claim and further ORM, the RRE must report this as an update record with zeroes or a new date in the ORM Termination Date (Field 99).

CMS uses information regarding ongoing responsibility for both claims processing and potential recoveries. Providers, physicians, and other suppliers are to bill primary payers

such as liability insurance (including self-insurance), no–fault insurance, and workers' compensation prior to billing Medicare although Medicare may pay conditionally if "prompt payment' as defined by CMS rules is not made by the liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Conditional payments are subject to recovery if primary payment responsibility is subsequently established.

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

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

See Section 11.4 for temporary thresholds related to exemptions for reporting workers' compensation claims with ORM.

11.9 Special Reporting Extension for ORM and Special Qualified Reporting Exception for ORM Assumed Prior to July 1, 2009 Where Such ORM Continues as of July 1, 2009.

EXTENSION -- Where ORM was assumed prior to July 1, 2009, and continues as of July 1, 2009, the RRE must report this individual. As RREs may not have collected the necessary data elements for individuals (such as the SSN) for whom responsibility was assumed prior to July 1, 2009, CMS is permitting RREs to delay reporting for these individuals until the RRE's assigned submission in the third calendar quarter (July – October) of 2010. The extension is intended to allow RREs time to go back and determine the Medicare status of individuals for whom there is pre-existing ORM which continues as of July 1, 2009. This extension does not apply to claims which are addressed/resolved (partially addressed/resolved) on or after July 1, 2009. The extension applies only to claims where the RRE has accepted ongoing responsibility for medicals with the claim potentially subject to further payment for items or services with dates of services on or after July 1, 2009, but the original resolution (partial resolution) date is prior to July 1, 2009. If an RRE has the information that such a claimant is a Medicare beneficiary and the RRE has the SSN or HICN, it is to send the record with its initial production file. If the RRE does not have this information, it may delay reporting on these claims until its third calendar quarter 2010 file submission.

QUALIFIED EXCEPTION -- The general rule is that aside from the "'Special Exception' regarding reporting termination of ORM" discussed in Section 11.8, a report terminating the ORM should not be submitted as long as the ORM is subject to reopening or otherwise subject to an additional request for payment. However, for ORM assumed prior to July 1, 2009, if the claim was actively closed or removed from current claims records prior to January 1, 2009, the RRE is not required to identify and report that ORM

under the requirement for reporting ORM assumed prior to July 1, 2009. If such a claim is later subject to reopening with further ORM, it must be reported with full information, including the original DOI (as defined by CMS). This means that when looking back through claims history to create your initial Claim Input File report to include claims with ORM that was assumed prior to July 1, 2009, the RRE needs only look back to the status of claims as of January 1, 2009. If the claim was removed from the RRE's current/active claim file prior to January 1, 2009, it does not need to be reported unless it is reopened.

ORM Assumed Prior to July 1, 2009 Qualified Exception Examples

Claim Example	**Reporting Requirement**
RRE assumed ORM March 5, 2008 and is still making payments for medicals as of 7/1/09.	Report this claim since payment for medicals continues as of July 1, 2009. The claim is on the active claim file as of January 1, 2009 and subsequent.
RRE assumed ORM March 5, 2008, is not making payments as of July 1, 2009 but didn't consider the claim "closed" until after January 1, 2009. As of July 1, 2009 and subsequent, the claim is still "technically" open and ORM continues, but the RRE hasn't made a payment since August of 2008. The RRE considers this claim closed and moved it off their file of current open/active claims ***on February 15, 2009.***	Report this claim since the claim was not actively closed or removed from current claim records until ***after*** January 1, 2009. The claim was on the active claim file as of January 1, 2009.
RRE assumed ORM March 5, 2008, is not making payments as of July 1, 2009 and considered the claim "closed" prior to January 1, 2009. As of July 1, 2009 and subsequent, the claim is still "technically" open and ORM continues, but the RRE hasn't made a payment since August of 2008. The RRE considers this claim closed and moved it off their file of current open/active claims ***on October 1, 2008.***	Do not report this claim since it was actively closed or removed from current claims records prior to January 1, 2009. The claim was not on the active claim file as of January 1, 2009.

11.10 Additional Requirements

11.10.1 Technical Requirements

- Claim Input Files must include properly formatted header, detail and trailer records as defined in the file layouts provided.

- Claim Input Files must be submitted on a quarterly basis, four times a year.

- Files must be submitted within an assigned, 7-day submission period each quarter. File submission timeframes will be assigned after successful registration for Section 111 reporting.

- 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 EDI Rep intervention.

- RREs must register on the Section 111 COB Secure Web site (COBSW) from May 1, 2009 through September 30, 2009, and complete testing prior to submission of production Claim Input Files. After the registration has been processed by the COBC, the RRE will receive an e-mail with a profile report. The profile report will contain information submitted during registration for verification purposes, the assigned 7-day file submission timeframe, and the assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). The last page of the profile report must be signed by the RRE's Authorized Representative and returned to the COBC before testing can begin. Once testing requirements have been passed, the RRE ID status will be updated by the COBC to "production" and production Claim Input File submission may commence.

    - NOTE: Entities who are RREs for purposes of the Section 111 liability insurance (including self-insurance), no-fault insurance, or workers' compensation are not required to register if they will have nothing to report. For example, if an entity is self-insured (as defined by CMS) solely for the deductible portion of a liability insurance policy but it always pays any such deductible to its insurer, who then pays the claim, it may not have anything to report. However, those who do not register initially because they have no expectation of having claims to report, **must** register in time to allow a full quarter for testing if they have future situations where they have a reasonable expectation of having to report.

- RREs will be assigned a Section 111 RRE ID during registration which is to be used on all submitted files.

- Claim Input File testing begins on January 1, 2010.

- Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation RREs must submit their initial production Section 111 Claim Input File during the **second calendar quarter (April - June) of 2010** during their assigned submission timeframe.

- Group Health Plan (GHP) file submissions for Section 111 may not be mixed with liability, no-fault, and workers' compensation Claim Input File submissions.

- An RRE or agent may not mix data for multiple RRE IDs (multiple RRE IDs for a single RRE or RRE IDs for separate RREs) in the RRE's or agent's file submission. A separate quarterly Section 111 file must be submitted for each RRE ID, and no more than one file may be submitted for each RRE ID.

- All reporting is to be through electronic file exchanges as described in this guide.

- Files may be submitted via the Section COBSW user interface using Hypertext Transfer Protocol over Secure Socket Layer (HTTPS) or the Section 111 SFTP server via Secure File Transfer Protocol (SFTP). As an alternative, RREs with large amounts of data may submit via Connect:Direct (formerly known as NDM) via the AT&T Global Network System (AGNS). See Section 15 for details.

- RREs must implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary. RREs must submit either the Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) 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 cannot be identified as a Medicare beneficiary based upon the information submitted, CMS will reject the record for that individual. The Applied Disposition Code (Field 27) on the corresponding Claim Response File Detail Record will indicate the reason for rejection. It is not acceptable for an RRE to send information on every claim record 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.

- CMS recommends that RREs send an injured party's HICN on Claim Input File records whenever it is available instead of the SSN. The HICN is CMS' Medicare identifier for Medicare beneficiaries and is the preferred data element for matching purposes. RREs are encouraged to obtain HICNs from injured parties who are Medicare beneficiaries (printed on their Medicare card) and to use the HICNs passed back to them by the COBC on Claim and Query Response Files.

- A TIN Reference File must be submitted with the initial Claim Input File containing records for each plan TIN submitted in Field 72 of Claim Input File Detail Records. All combinations of Plan TIN and Office Code/Site ID submitted in Fields 72 and 73 of the Claim Input File Detail Records must have a corresponding TIN/Office Code combination on the TIN Reference File.

Subsequent Claim Input Files do not need to be accompanied by a TIN Reference File unless changes to previously submitted TIN/Office Code information must be submitted or new TIN/Office Code combinations have been added.

- Quarterly Claim Input Files must include records for any new claims, where the injured party is a Medicare beneficiary, reflecting settlement, judgment, award, or other payment since the last file submission. However, if the settlement, judgment, award or other payment is within 45 days prior to the start of the 7-day file submission timeframe, then an RRE may submit that claim on the next quarterly file. This grace period allows the RRE time to process the newly addressed/resolved (partially addressed/resolved) claim information internally prior to submission for Section 111. For example, if there is a reportable TPOC with a TPOC Date of May 1, 2010, and the file submission period for the second calendar quarter of 2010 is June 1-7, 2010, then the RRE may delay reporting that claim until the third calendar quarter file submission during September 1-7, 2010. However, if the TPOC Date is April 1, 2010, then the RRE must include this claim on the second calendar quarter file submission during June 1-7, 2010. Records not received timely will be processed but marked as late and used for subsequent compliance tracking. A code indicating 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. See Section 12.4 for more information on timeliness and compliance flags.

- Subsequent quarterly update files must include pertinent updates/corrections/deletions to any previously submitted records per instructions in the Event Table.

- Quarterly update files must contain resubmission of any records found in error on the previous file with corrections made. No interim file submissions will be accepted.

- If you have no new information to supply on a quarterly update file, you must submit an “empty” Claim Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count. As an alternative to submitting an empty file, a process will be added to the Section 111 COBSW application that will allow a user associated with the RRE ID to indicate that the RRE has nothing to submit for a particular quarter in lieu of submitting an actual empty file.

- E-mail notifications will be sent to the RRE’s Account Manager after a file has been received by the COBC and when a response file has been transmitted or is available for download. All users with login IDs associated to the RRE ID may monitor the status of submitted files on the Section 111 COBSW.

- Each Detail Record on the Claim Input File must contain a unique Document Control Number (DCN) generated by the RRE. This DCN is required so that response records can be matched and issues with files more easily identified and resolved. It can be any format of the RREs choosing as long as it is not more than 15 alpha-numeric characters as defined in the record layout. Most of CMS’

current data exchange partners use some form of a Julian date and a counter as their DCN. The DCN only needs to be unique within a single file. The same DCN does not need to be maintained and submitted on subsequent update or delete records for a claim report. A new DCN may be generated for the claim report each time it is submitted in subsequent files.

- The COBC will return response files to the RRE within 45 days of the receipt date posted for the input file.

11.10.2 What Claims Are Reportable/When Are Such Claims Reportable?

- RREs' initial file submissions must report on all claims, where the injured party is/was a Medicare beneficiary that are addressed/resolved (or partially addressed/resolved) through a settlement, judgment, award or other TPOC payment on or after January 1, 2010, that meet the interim reporting thresholds, regardless of the assigned date for a particular RREs first submission. A TPOC is reported only once regardless of whether it is funded through a single payment, an annuity or a structured settlement. See Section 11.4 for interim TPOC reporting thresholds.

- RREs must report claim information where ongoing responsibility for medicals (ORM) related to a claim was assumed on or after July 1, 2009. In addition, RREs must report claim information for claims where ongoing responsibility for medicals exists on or through July 1, 2009, regardless of the date of an initial assumption of ORM (the assumption of ORM predates July 1, 2009). See Sections 11.4, 11.8 and 11.9 for special exemptions, exceptions and extensions for reporting claims with ORM.

- RREs are to report after there has been a TPOC settlement, judgment, award or other payment and/or after ORM has been assumed.

    - Notice to CMS of a pending claim or other pending action by an RRE or any other individual or entity does not satisfy an RRE's reporting obligations with respect to 42 U.S.C. 1395y(b)(8).

    - Notice to CMS by the RRE of a settlement, judgment, award or other payment by any other means than the established Section 111 reporting process does not satisfy an RRE's reporting obligations with respect to 42 U.S.C. 1395y(b)(8).

    - Notice to CMS of a settlement, judgment, award, or other payment by an individual or entity other than the applicable RRE does not satisfy an RRE's reporting obligations with respect to 42 U.S.C. 1395y(b)(8).

- Records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by RRE, etc. Consequently, it is possible that an RRE will submit more than one record for a particular individual in a particular quarter's submission window. For example, if there is an automobile accident with both drivers insured by the same company and both drivers' policies are

making a payment with respect to a particular Medicare beneficiary, there would be a record with respect to each policy. There could also be two records with respect to a single policy if the policy were reporting a med pay (considered to be no-fault) assumption of ongoing responsibility for medicals and/or exhaustion/termination amount as well as a liability settlement/judgment/award/other payment in the same quarter.

- Joint settlements, judgments, awards, or other payments – Each RRE reports its ongoing medical responsibility and/or settlement/judgment/award/other payment responsibility without regard to ongoing medicals. Each RRE would also report any responsibility it has for ongoing medicals on a policy-by-policy basis. Again, depending on the number of policies at issue for an RRE and or the type of insurance or workers' compensation involved, an RRE may be submitting multiple records for the same individual.

- Multiple settlements involving the same individual -- Each RRE must report appropriately. There will be multiple records submitted for the same individual but they will be cumulative rather than duplicative. Additionally, if more than one RRE has assumed responsibility for ongoing medicals, Medicare would be secondary to each such entity.

- Med Pay and Personal Injury Protection (PIP) are both considered no-fault insurance by CMS (Field 71 Plan Insurance Type = 'D'). RREs must combine PIP/Med Pay limits for one policy when they are separate coverages and being paid out on claims for the same injured party and same incident under a **single** policy and not terminate the ORM until both the PIP and Med Pay limits are exhausted. If PIP and Med Pay are coverages under separate policies then separate records with the applicable no-fault policy limits for each should be reported.

- Re-insurance, stop loss insurance, excess insurance, umbrella insurance guaranty funds, patient compensation funds which have responsibility beyond a certain limit, etc. -- The key in determining whether or not reporting for 42 U.S.C. 1395y(b)(8) is required for these situations is whether or not the payment is to the injured claimant/representative of the injured claimant vs. payment being made to the self-insured entity to reimburse the self-insured entity. Where payment is being made to reimburse the self-insured entity, the self-insured entity is the RRE for purposes of the payment made to the injured individual and no reporting is required by the insurer reimbursing the self-insured entity.

- One-time payment for defense evaluation - A payment made specifically for this purpose directly to the provider or other physician furnishing this service does not trigger the requirement to report.

- Where there is a settlement, judgment, award or other payment with no establishment/acceptance of responsibility for ongoing medicals, the RRE is not required to report for purposes of 42 U.S.C. 1395y(b)(8) (Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, or workers' compensation) if the individual is <u>not</u> a Medicare beneficiary.

- RREs must report settlements, judgments, awards, or other payments **regardless of whether or not there is an admission or determination of liability**. Reports are required with either partial or full resolution of a claim.

    - For purpose of the required reporting for 42 U.S.C. 1395y(b)(8), the RRE does not make a determination of what portion of any settlement, judgment, award, or other payment is for medicals and what portion is not. The RRE reports responsibility for ongoing medicals separately from any other payment obligation but does not separate medical vs. non-medical issues if medicals have been claimed and/or released or the settlement, judgment, award, or other payment otherwise has the effect of releasing medicals.

    - "No medicals" – If medicals are claimed and/or released, the settlement, judgment, award or other payment must be reported regardless of any allocation made by the parties or a determination by the court.

        - The CMS is not bound by any allocation made by the parties even where a court has approved such an allocation. The CMS does normally defer to an allocation made through a jury verdict or after a hearing on the merits. However, this issue is relevant to whether or not CMS has a recovery claim with respect to a particular settlement, judgment, award, or other payment and does not affect the RRE's obligation to report.

        - RREs are not required to report liability insurance (including self-insurance) settlements, judgments, awards or other payments for "property damage only" claims which did not claim and/or release medicals or have the effect of releasing medicals.

    - RREs must report the full amount of any settlement, judgment, award or other payment amount (the TPOC amount) without regard to any amount separately obligated to be paid as a result of the assumption/establishment of responsibility for ongoing medicals.

- The date of incident does not affect the RRE's reporting responsibilities for workers' compensation.

- In situations where the applicable workers' compensation law or plan requires the RRE to make regularly scheduled periodic payments to, or on behalf of, the claimant, and the applicable workers compensation law or plan specifically precludes these periodic payments from including any direct or indirect payment for past, present, or future medical expenses; the RRE does not report these periodic payments (they are not reportable as either TPOCs or ORM). Otherwise, these payments are considered to be part of and are reported as ORM.

- RREs generally are not required to report liability insurance (including self-insurance) or no-fault insurance settlements, judgments, awards or other payments where the date of incident (DOI) **as defined by CMS** was prior to December 5, 1980. (See exception in discussion below of cases involving "exposure.")

- For claims involving “exposure”, this means that there was no exposure on or after December 5, 1980, alleged, established, and/or released. If any exposure for December 5, 1980 or a subsequent date was claimed and/or released, then Medicare has a potential recovery claim and the RRE must report for Section 111 purposes.

    - For example, if the date of 1st exposure is prior to December 5, 1980, but that exposure continues on or after December 5, 1980; Medicare has a potential recovery claim.

    - Additionally, please note that application of the December 5, 1980, is specific to a particular claim/defendant. For example, if an individual is pursuing a liability insurance (including self-insurance) claim against “X”, “Y” and “Z” for asbestos exposure and exposure for “X” ended prior to December 5, 1980, but exposure for “Y” and “Z” did not; a settlement, judgment, award or other payment with respect to “X” would not be reported.

- The liability insurance (including self-insurance) and no-fault insurance MSP provisions were effective December 5, 1980. CMS has determined as a matter of policy that it will not recover under the MSP provisions with respect to liability insurance (including self-insurance) or no-fault insurance settlements, judgments, awards or other payments where the DOI **as defined by CMS** was prior to December 5, 1980 unless the claim involves exposure continuing on or after December 5, 1980.

  Please note that the term “exposure” is being used here in the sense of physical exposure, not legal exposure. If “x” is sued for permitting or causing toxic exposure on a particular piece of property but sold the property prior to December 5, 1980, Medicare still has a potential recovery claim against any settlement, judgment, award, or other payment as long as the alleged injured party’s exposure to the toxic property continued on or after December 5, 1980.

- Policies or self-insurance which allege that they are “supplemental” to Medicare -- By statute, Medicare is secondary to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation. An insurer or self-insured entity cannot, by contract or otherwise supersede federal law.

- There is no Medicare beneficiary age threshold for reporting for Section 111 liability insurance (including self-insurance), no-fault insurance, and workers’ compensation.

- The geographic location of the incident, illness, or injury is not determinative of the RRE’s reporting responsibility as Medicare beneficiaries who are injured or become ill outside of the United States often return to the U.S. for medical care.

- Where there is no settlement, judgment, award or other payment, including no assumption of responsibility for ongoing medicals, there is no Section 111 report required. As indicated

earlier, the fact that there is no admission or determination of liability does not exempt an RRE from reporting.

- If there are multiple TPOCs for the same individual for the same claim, each new TPOC must be reported as a separate settlement, judgment, award, or other payment. This applies to liability insurance (including self-insurance), no-fault insurance, and workers' compensation. Remember that a single payment obligation is reported only once regardless of whether it is funded through a single payment, an annuity or a structured settlement. However the sum of all TPOC amounts must be used when determining whether the claim meets the applicable reporting threshold. Use the most recent, latest TPOC Date associated with the claim when determining whether the claim meets the interim reporting thresholds defined in Section 11.4.

- When to report claims involving appeals --

    - If there is an assumption of ORM due to a judgment or award but the liability insurance (including self-insurance), no-fault insurance, or workers' compensation is appealing this judgment or award:

        - If payment is being made, pending results of the appeal, the ORM must be reported.
        - If payment is not being made pending results of the appeals, the ORM is not reported until the appeal is resolved.

    - If there is a TPOC date/amount due to a judgment, award, or other payment but the liability insurance (including self-insurance)/no-fault insurance/workers' compensation or claimant is appealing or further negotiating the judgment/award/other payment:

        - If payment is being made, pending results of the appeal/negotiation, the TPOC must be reported.
        - If payment is not being made pending results of the appeals/negotiation, the TPOC is not reported until the appeal/negotiation is resolved.

12 Claim Response File

For every Claim Input File you send to the COBC for Section 111 reporting the COBC will send you a Claim Response File in return. The Claim Response File specifications are in Appendix C. The response file will be transmitted back to you within 45 days of receipt of your input file in the same manner you used to send your input file (HTTPS, SFTP, or Connect:Direct). The response file contains a header record, followed by detail records for each record you submitted on your input file, followed by a trailer record that contains a count of the detail records supplied. This count does not include the header and trailer records. The detail response record contains “supplied” data elements which are what the RRE submitted on the corresponding input record. It also contains “applied” data elements which reflect values for certain data elements according to information on Medicare’s files and some derived fields that pertain to Medicare’s secondary payment status.

If the COBC can match the submitted injured party to a Medicare beneficiary based upon the information submitted on the input record, then the response record will always contain the Medicare HICN for that individual. You should save the HICN returned for Medicare beneficiaries and submit it on any subsequent Claim Input File records for that injured party/beneficiary. This is CMS’ official identifier for the beneficiary and is the preferred data element for matching records to Medicare beneficiaries.

The Claim Response File Detail Records contain:

- The same DCN submitted on the corresponding Claim Input File record for matching purposes (Submitted DCN Field 2)

- The information the RRE supplied on the input record for the injured party and RRE TIN/Office Code:
    - Submitted Action Type (Field 3)
    - Injured Party HICN (Field 4)
    - Submitted Injured Party SSN (Field 5)
    - Submitted Injured Party Last Name (Field 6)
    - Submitted Injured Party First Name (Field 7)
    - Submitted Injured Party Middle Initial (Field 8)
    - Submitted Injured Party Gender (Field 9)
    - Submitted Injured Party DOB (Field 10)
    - Submitted Plan TIN (Field 11)
    - Submitted Plan Office Code/Site ID (Field 12)
    - Submitted Policy Number (Field 13)
    - Submitted Claim Number (Field 14)

- Applied information for the injured party, if identified as a Medicare beneficiary based upon the information submitted, and fields that indicate when and why Medicare is secondary to the other insurance reported on the input record (disposition of ‘01’, ‘02’, and ‘03’):
    - Applied Injured Party HICN (Field 16)
    - Applied Injured Party Last Name (Field 18)
    - Applied Injured Party First Name (Field 19)

- Applied Injured Party Middle Initial (Field 20)
- Applied Injured Party Gender (Field 21)
- Applied Injured Party DOB (Field 22)
- Applied MSP Effective Date (Field 23)
- Applied MSP Termination Date (Field 24)
- Applied MSP Type Indicator (Field 25)

You may (but are not required to) use the Applied Injured Party Name, Gender and DOB fields to update your internal system and submit these values on any subsequent transactions for that injured party/Medicare beneficiary.

- An Applied Disposition Code (Field 27) that indicates the results of processing

- Error codes indicating why the record was rejected for errors (Fields 28 – 37)

- Compliance Flags (Fields 38 – 47) indicating that there were fields that were not reported according to Section 111 requirements or the record was not submitted timely.

You must develop processing to react to the response file. Disposition, error and compliance flag codes are shown in Appendix E.

12.1 Disposition Codes

The Applied Disposition Code is Field 27 on the Claim Response File Detail Record. Disposition code values are listed in Appendix E of this guide along with the actions the RRE must take upon receipt of each disposition code, if any.

Every Claim Input File record will receive a disposition code on the corresponding Claim Response File record. Records rejected due to errors receive an ‘SP’ disposition code and must be resubmitted. Records accepted for Section 111 reporting because the injured party was identified as a Medicare beneficiary based upon the information submitted receive an ‘01’, ’02, or ‘03’ disposition code and only need to be resubmitted under certain circumstances as specified below. Records with an injured party who was not identified as a Medicare beneficiary based upon the information submitted receive a ‘51’ disposition code. In rare cases, records that have not finished processing by the time the response file is generated will be returned with a disposition code of ’50’ and these must be resubmitted on the next quarterly file submission.

RREs must take the following actions:

- ‘**SP’ Disposition Code – Record in Error**
  Records returned with an ‘SP’ disposition code failed the COBC edits with errors and **must be corrected and resent on your next quarterly submission**. No interim Claim Input File submissions will be accepted. Associated error codes will be placed in Fields 28 - 37. Edits performed and associated error codes are documented in Appendix E.

- **'51' Disposition Code – Injured Party Not Identified as a Medicare Beneficiary**
  Records returned with a '51' disposition code were not matched to a Medicare beneficiary.
    - As long as the injured party information you submitted was completely correct and the claim does NOT represent ongoing responsibility for medicals, you do not have to submit this claim again for Section 111 reporting unless subsequent TPOC payments are made.
    - ***If the claim represents ongoing responsibility for medicals, you must continue to monitor the status of the injured party*** as long as the claim remains open in order to determine if/when the injured party becomes covered by Medicare. (Your monitoring process might include communication with the injured party and/or use of the Section 111 Query process described in Section 13.) When the RRE determines the injured party becomes covered by Medicare, then the record must be resubmitted on the next submission of the Claim Input File. However, monitoring of such individuals may cease before they become a Medicare beneficiary if the ORM is not subject to reopening or otherwise subject to further request for payment **or** if the standard for ORM termination set forth in "Special Exception" of Section 11.6 regarding reporting termination of ORM is met. One final query or claim report should be submitted after an ORM Termination Date has been established.

- **'01' Disposition Code – Record Accepted for Individual Identified as a Medicare Beneficiary and ORM**
  Records accepted with an '01' disposition code were accepted by the COBC as claims where the **RRE has indicated ongoing responsibility for medicals**. The claim record does not need to be reported again until the ongoing responsibility for medicals ends or updates are needed for material fields as described in previous sections (see the Event Table) or a resubmission is needed to correct the TIN due to a compliance flag (see Section 12.4) The response record will be returned with:
    - Applied MSP Effective and Termination Dates and MSP Type Indicator
    - Applied Injured Party HICN, Name, DOB, Gender
    - No error codes
    - Applicable compliance flags.

- **'02' Disposition Code – Record Accepted for Individual Identified as a Medicare Beneficiary and No ORM**
  Records accepted with an '02' disposition code were accepted by the COBC as claims where the injured party is a Medicare beneficiary during the time between the CMS Date of Incident and TPOC Date and the **RRE has indicated NO ongoing responsibility for medicals**. The claim record does not need to be reported again unless updates are needed for material fields as described in previous sections (see the Event Table) or a resubmission is needed to correct the TIN due to a compliance flag (see Section 12.4). The response record will be returned with:
    - Applied Injured Party HICN, Name, DOB, Gender
    - No error codes
    - Applicable compliance flags.

- **'03' Disposition Code – Record Accepted for Individual Identified as a Medicare Beneficiary but Outside Medicare Coverage Period**
  Records accepted with an '03' disposition code were accepted by the COBC as claims where the injured party is a Medicare beneficiary, but the beneficiary's Medicare coverage dates are outside the time period between the date of incident and TPOC Date or the date ORM ended, as applicable. For example, the individual may have been covered by Medicare but that coverage ended prior to the CMS Date of Incident (DOI) or the individual's Medicare coverage was not effective until after the TPOC Date or after the ORM Termination Date. In other words, the beneficiary's Medicare coverage does not currently overlap the applicable period of time reflected on the submitted claim.

  The response record will be returned with:
  - Applied Injured Party HICN, Name, DOB, Gender
  - No error codes
  - No compliance flags.

  As long as the injured party information you submitted was completely correct and the claim does NOT represent ongoing responsibility for medicals (no ORM), you do not have to submit a claim record again after receiving an '03' disposition code.

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

  Monitoring of such individuals or resubmission of the affected claims may cease once the RRE's ORM has ended and the claim is closed (ORM is not subject to reopening or otherwise subject to a further request for payment **or** if the standard for ORM termination set forth in "Special Exception" of Section 11.8 regarding reporting termination of ORM is met). One final claim report should be submitted after an ORM Termination Date has been established and that date has passed.

- **All Other Disposition Codes**
  Records that are rejected with any other disposition code **must be resubmitted on your next quarterly update file**. As a rule, you should check these records for accuracy, update the information previously sent, as applicable, and resubmit. At this time, the only disposition code that can occur is a '50' which indicates that the COBC did not finish processing the record in time to produce a response

record within the required 45-day turnaround. This will occur only in very rare circumstances. Only the records on the file that did not complete will be returned with a '50'. Records that completed processing by the time the response file was created will be returned with one of the other values described above. When a record originally returned with a '50' is resubmitted, it will be reprocessed by the COBC and returned on the corresponding response file with one of the disposition codes described above.

12.2 Error Codes

In Appendix E, all possible error codes and the edits performed on Claim Input Files are listed for reference.

Some error codes received on your Claim Response File may be due to errors on your TIN Reference File. If there is an error in a TIN or an insurer name or address submitted on a TIN Reference File, you will see the associated error codes posted on your corresponding Claim Response File records. In order to correct these errors, you will need to resubmit an updated TIN Reference File with your next quarterly Claim Input File submission.

12.3 File Level and Threshold Errors

12.3.1 Severe Errors

Files with any of the following severe errors will be suspended from processing. The Account Manager for the RRE ID will receive an e-mail notification of severe errors. You must contact your EDI Rep (see Section 18.1) to resolve the situation. Files with severe errors will be deleted by your EDI Rep and you must resend a corrected file as instructed by your EDI Rep.

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

12.3.2 Threshold Errors

After completion of data quality edits, the COBC 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 prevent erroneous information from being accepted and processed by the COBC. In some cases there could be a reasonable explanation. The file threshold checks include:

- More than 4% of the total records are delete transactions
- 20% or more of the total records failed with a disposition code of 'SP' due to errors
- More than one Claim Input File was submitted during your defined quarter.

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

12.4 Compliance Flags

The Claim Response File contains ten 2-byte Compliance Flags in Fields 38 - 47 which are indicators that provide information on issues related to reporting requirements compliance. The possible values that could be posted in these flags are documented in the Compliance Flag Code table in Appendix E. If no compliance issue is found with the record, all the Compliance Flags on the response file record will be blank. If only one issue is found, then the corresponding code will be placed in the first flag. If additional issues are found with the same record, then the corresponding compliance flag code will be placed in the second and subsequent flags (the first available flag field). Compliance flags will only be set for records receiving an '01' or '02' Applied Disposition Code.

These flags are different from error codes. Unlike an error code, a record will **not** be rejected if one of the conditions to set the flags is found on the record. Instead, the record is processed. However the COBC will set the flags, track this information, and include it on compliance reports. The flags provide the RRE notice that the submitted record was not in compliance with Section 111 reporting requirements. You must review these flags, apply corrections to your internal system or data used for Section 111 reporting, and resubmit records with corrections as update records on your next quarterly Claim Input File submission, when applicable.

The first such flag has a value of '01' which indicates that the submitted **add** record containing one or more TPOC Dates was not sent timely. It is put in the first available Compliance Flag field when **the most recent TPOC Date** on the claim is more than 45 calendar days older than the start of the RRE's prior quarter submission timeframe. If the most recent TPOC Date is within 45 days prior to the start of your 7-day file submission timeframe, then you may submit that information on your next quarterly file. This grace period allows you time to process the new claim information internally prior to submission for Section 111. Another way to look at it is that any add record received on a quarterly file submission will be marked as late if the most

recent TPOC Date is more than 135 days older than the start date of that same file submission period. This compliance flag does not apply to update or delete records.

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

The second compliance flag value is an '02' which reflects the submission of a TIN that cannot be validated by the COBC. For example, if a Claim Input File record is submitted with an RRE/Plan TIN in Field 72 that matches a TIN submitted on the TIN Reference File but it is not found to be a valid, IRS-assigned TIN, then the record will be processed, but the corresponding Claim Response File record will contain a value of '02' in the first available Compliance Flag. When a value of '02' is received back in a Compliance Flag on a response record, you must obtain the valid TIN and resubmit the record as an update transaction on your next quarterly file submission. At the same time, the valid TIN and any associated Office Code must also be submitted on an updated TIN Reference File record. If you believe that the TIN is indeed valid, then please contact your EDI Rep for resolution.

The third possible flag has a value of '03' which indicates that the submitted record containing an ORM Termination Date was not sent timely. It is put in the first available Compliance Flag field when the ORM Termination Date on the claim record is more than 45 calendar days older than the start of the RRE's prior quarter submission timeframe. If the ORM Termination Date is within 45 days prior to the start of your 7-day file submission timeframe, then you may submit that information on your next quarterly file. This grace period allows you time to process the new claim information internally prior to submission for Section 111. Another way to look at it is that any record received on a quarterly file submission will be marked as late if the ORM Termination Date is more than 135 days older than the start date of that same file submission period.

Establishment/assumption of ongoing responsibility for medicals can take place at various times during a claim review. RREs will not receive a compliance flag regarding possible late submission of a 'Y' value for the ORM Indicator (Field 98 on the Claim Input File Detail Record). However, CMS reserves the right to audit an RRE and/or their agent(s) with respect to this issue (or any other Section 111 reporting issue). The RRE must have a record of when ongoing responsibility for medicals was assumed/terminated on a reported claim and when such ongoing responsibility for medicals was reported to the COBC under Section 111 in order to establish timely reporting.

13 Query Files

13.1 Query Process

RREs must implement a procedure in their claims resolution process to determine whether an injured party is a Medicare beneficiary. RREs must submit either the Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) 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 identified as a Medicare beneficiary based upon the submitted information, the COBC will reject the record for that individual.

The Query Input File is a dataset transmitted from a Section 111 RRE to request information regarding whether a particular injured party is a Medicare beneficiary (is or was covered by Medicare) prior to submitting the claim. Use of the Query Input and Response Files is optional under Section 111 reporting. You may use the query process to help you determine whether a particular claim must be reported under Section 111 due to the injured party being a Medicare beneficiary. Query Input File records must be submitted with the SSN or HICN, name, date of birth and gender of the injured party. The query process is to be used only for Section 111 reporting purposes. Please review the data use agreement in a later section of this guide for restrictions on the use of data exchanged for Section 111.

To determine whether an injured party is a Medicare beneficiary, the COBC must match your data to Medicare's. For matching an individual to determine if they are a Medicare beneficiary the COBC uses:

- HICN or SSN
- First initial of the first name
- First 6 characters of the last name
- Date of birth (DOB)
- Gender

First the COBC must find an exact match on the SSN or HICN. Then at least three out of the four remaining criteria must be matched exactly. If a match is found, you will always be returned the correct HICN. You should store this HICN on your internal files and use it on future transactions. This is CMS' official identifier for the beneficiary and will be used by the COBC when matching claim records to Medicare beneficiaries when submitted. The COBC will also supply updated values for the first initial, first 6 characters of the last name, date of birth and gender in the applicable fields of the Query Response File records based on the information stored for that beneficiary on Medicare's files. The SSN returned on the response record will always be the SSN submitted on the query input record by the RRE for matching the response to the original query input record. Other than the HICN, the updated fields returned on the response record are simply for informational purposes.

After the COBC has processed the Query Input File it will return the Query Response File with a determination as to whether the queried injured party can be identified as a Medicare beneficiary based upon the information submitted. Note that due to privacy concerns, this file does not provide the actual dates of Medicare entitlement and enrollment or the reason for entitlement. The Query Response File records contain a Disposition Code in Field 8. A value of '01' indicates that the injured party submitted on the input record is/was a Medicare beneficiary and the record will contain the updated HICN, name fields, DOB and gender according to Medicare's information. A value of '51' indicates that the information supplied on the query record could not be matched to a Medicare beneficiary.

The Query Input and Response Files are transmitted using the ANSI X12 270/271 Entitlement Query transaction set (version 4010A1). However, the COBC will supply software (the HIPAA Eligibility Wrapper or "HEW software") to translate flat files to and from the X12 270/271 formats. The file layouts that serve as input and output for the HEW software are documented in Appendix D of this guide.

If you choose to use your own ANSI X12 translator to create the ANSI X12 270 files for the Section 111 Query File and process the X12 271 response, you may download the Section 111 X12 270/271 companion guide with the necessary mapping information at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPInterfaceSpecVersion2.1.pdf or contact your EDI Representative for a copy.

Note: Where you have information that the injured individual is/was a Medicare beneficiary early in your claim review process, you know that you will be reporting for that person if there is a settlement, judgment, award or other payment (TPOC and/or ORM). However, for an individual who is not Medicare beneficiary at the time he/she files a claim or whom you are initially unable to identify as a beneficiary, you **must** also determine beneficiary status as of the date of the settlement, judgment, award, or other payment (TPOC and/or ORM) if there is a TPOC and/or ORM. The HICN and Medicare coverage start dates are usually established and on the COBC database well in advance of the actual Medicare coverage effective dates. ***So it is recommended that an RRE send a query record associated with an initial claim report after the TPOC Date or after ORM has been assumed.***

13.2 HEW Software

The Query Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set. You may use your own translator software, or the HIPAA Eligibility Wrapper (HEW) software (provided free of charge by the COBC) to submit a Query Input File and process the Query Response File.

During registration for Section 111 reporting, you will be asked to indicate whether you wish to use the HEW software. If you choose that option, you must request a copy of the HEW software from your EDI Representative. It is available in mainframe and Windows PC/server versions. The Windows version is available for download on the Section 111 COBSW.

To use the HEW software, you first will create an input file according to the specifications in Appendix D. This flat file is then used as input to the HEW software. You will install

and run the HEW software in your data center. The HEW software produces the X12 270 eligibility query file format which you then transmit to the COBC. The COBC will send back your response file in the X12 271. You will feed that into the HEW software to produce the Query Response File according to the specifications in Appendix D. This flat file containing Medicare information for the individuals identified as Medicare beneficiaries based upon the information submitted can then be used in your internal systems to assist with Claim Input File creation. Note that the Query Response File that is output from the HEW software does not contain any header or trailer records.

Query Only Input and Response File specifications for the flat files that are the input and output of the HEW software can be found in Appendix D.

The HEW software is available in mainframe and Windows PC/Server versions. It will not run on a Linux or UNIX platform. The mainframe version will not execute in an AS400 environment. It cannot be invoked using a command line interface. APIs are not made available for the Windows version. Network communication ports are not part of the HEW application. The HEW only converts incoming/outgoing files. Telecommunications must be done separately. The Windows PC/Server version will execute on any Microsoft operating system of NT or better (2000, 2003, XP, etc.) and requires at least a Pentium II with 64 MB of memory.

13.3 Query File Requirements

- Query Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set.
- Query Input Files may be submitted up to once per calendar month per RRE ID at any time of the month. These files do not have to be submitted during a specific submission timeframe.
- Query Response Files will be returned to you within 14 calendar days.
- An RRE ID must be in a testing status in order for test or production Query Input Files to be accepted. Once in a production status (dependent on completion of Claim Input File testing), both test and production files will continue to be accepted.
- The following edits will be applied to the Query Input File. Any failure of these edits will result in the file being placed in a severe error status. The Account Manager for the RRE ID will receive an e-mail notification and the RRE or its agent must contact the assigned EDI Rep to address the identified errors. Files failing for these errors must be corrected and resubmitted before they can be processed.
    - File does not contain a header record
    - Header record does not contain a valid Section 111 RRE ID
    - File does not contain a trailer record.
- E-mail notifications will be sent to the Account Manager for the RRE ID after the file has been received and when a response file has been transmitted or is available for download. File processing status may be viewed on the Section 111 COBSW by any user associated with the RRE ID.
- Query Response Files will be returned with NO header and trailer records.
- Each Query Response File record will contain a disposition code that indicates the results of matching the input record information to Medicare's file of

beneficiary information. An exact match must be found on either the SSN or HICN supplied. Then three out of four of the remaining fields (first initial, first 6 characters of the last name, date of birth, and/or gender) must match in order for the record to be considered a match to a Medicare beneficiary. A value of '01' in the disposition code on the response record indicates that the injured party submitted on the input record is/was a Medicare beneficiary. A value of '51' indicates that the individual could not be identified as a Medicare beneficiary based upon the information submitted.

- If a match is found, the response record will also contain the HICN for the Medicare beneficiary as well as updates to the name fields, date of birth and gender as they are stored on Medicare's files.
- If a match is not found, the record will be returned with a '51' disposition code and all other fields as they were submitted on the input record. No information is supplied regarding "partial matches".
- The SSN returned on the response record will **always** be the SSN submitted on the query input record by the RRE for matching the response to the original query input record.

14 Testing the Section 111 Reporting Process

14.1 Testing Overview

RREs must pass a testing process for the Claim Input and Response Files prior to sending production Claim Input Files for Section 111. Testing of the Query Files is optional but recommended. The testing process will ensure that the RRE has developed an adequate system internally to capture and report data to the COBC as well as process the corresponding response files. A series of test files will be submitted to the COBC in order to verify that the RRE can transmit files successfully in the correct format, accept and process response files, and properly submit add, update, and delete records. If the RRE is using an agent to test, the agent must submit and pass the testing process on behalf of the RRE. Testing must be completed for each RRE ID registered.

RREs will submit test files in the same manner as the method they choose for submitting production files (HTTPS, SFTP or Connect:Direct). All RREs will be able to monitor the status of the testing process on the COBSW no matter what method is chosen.

The results of the Claim Input File testing will trigger the transition of an RRE from a test status to a production status. However, testing of the Query Files is highly recommended.

Your COBC EDI Representative will be your main point of contact to assist you throughout the testing process.

An RRE ID must be in a test **or** production status in order for production Query Input Files to be accepted. An RRE ID must be in a production status in order for production Claim Input Files to be accepted. Test files may be sent at any time after the RRE ID is in a testing status – there is no file submission timeframe assigned to the RRE ID for test files. Test files will always be accepted and processed by the COBC after the RRE ID has attained a production status and production Claim Input File submission has commenced in order to allow the RRE to test changes it may make in the future to its internal data processing system for Section 111.

14.2 Claim File Testing

Claim Input File testing requirements:

- Claim Input File testing will commence on January 1, 2010.
- RREs must complete the registration and account setup process on the COBSW and return the signed profile report to the COBC before testing may begin. Once the COBC has recorded receipt of the signed profile report, the RRE ID will be updated to a test status and test files will be accepted.
- The period of time allowed for testing is essentially from the later of the date the RRE ID is set to a testing status or January 1, 2010 until the first day of the first production Claim Input File submission timeframe assigned to the RRE ID. If you run the risk of not completing testing on time, please notify your EDI Rep

immediately. Even after the RRE ID has been put in a production status, you may continue to send test files for any file type as you deem necessary.

- Testing must be completed for each RRE ID.
- The RRE must transmit test files to the COBC in the same transmission method as that chosen for production files.
- The COBC will maintain a test environment that contains a mirror image of the COB Beneficiary Master Database containing all beneficiary information the COBC has in production and programs that will mimic the way the files would be processed in production, with the exception of actually updating other Medicare systems and databases. However, this environment will be refreshed on a limited basis and information returned on test response files should not be used in production applications.
- Test Medicare beneficiaries will be provided for RRE use in a downloadable file, as these submitters may not yet know of real Medicare beneficiaries. This test data will only contain SSN, HICN, name, date of birth and gender for test beneficiaries. It will not include claim information.
- RREs may use actual production claim information or their own fabricated test data. RREs may submit test records using the test Medicare beneficiary identifiers for the injured party on some test records in order to test getting a match to a Medicare beneficiary. On other test records, injured party information that does not match the test Medicare beneficiary identifiers should be sent to test conditions where the injured party is not a Medicare beneficiary.
- Test files **must** be limited to no more than 100 records. Test files with more than 100 detail records will be rejected and not processed.
- The system will apply the same file error threshold checks to test files as those applied to production files.
- RREs must submit at least the following test files:
    - One initial Claim Input File with at least 25 add records.
    - A second Claim Input File with at least 5 updates and 5 deletes for previously submitted records.
    - A TIN Reference File with information for at least one TIN/Office Code combination. The Office Code may be left blank if not used.
- RREs must process at least the following test response files sent back by the COBC:
    - Two (2) corresponding Claim Response Files.
- The COBC will return test Claim Response Files within one week of submission of the test Claim Input File.
- RREs must successfully perform the following to pass the testing process:
    - Post at least 25 new claims with add records in *one* file submission. These records must receive either an ‘01’, ‘02’, or ’03 disposition code on corresponding response file records.
    - Complete at least 5 updates to previously posted records in *one* file submission.
    - Complete at least 5 deletes to previously posted records in *one* file submission.

  Additional test files must be submitted until these requirements are met.
- RREs choosing to transmit files via SFTP will receive a test submission mailbox/directory separate from their production submission mailbox/directory on the Section 111 SFTP server. RREs choosing to transmit files via HTTPS will do so using the “Upload File” action on the RRE Listing page after logging on to the

Section 111 COBSW application which requires you to indicate whether you are submitting a test or production file. RREs choosing Connect:Direct will send test files to a different destination dataset name than production files.

The COBC will track the progress made with test files, display results on the COBSW and put the RRE ID in a production status after the testing requirements have been successfully completed. In the Section 111 application on the COBSW, users will be able to see what test files were submitted and processed, the number of records accepted and rejected and whether the testing requirements have been fulfilled. The RRE may continue to test with additional test file submissions after being placed in a production status. Subsequent test files received will be processed by the COBC, response files produced and results displayed on the COBSW.

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

Once Claim Input File testing has been completed and the RRE has moved to a production status, an e-mail will be sent to the RRE's Account Manager as notification of the change in status and that production files may now be submitted.

14.3 Query File Testing

Since the use of the query process is optional, the RRE testing status is only driven off testing results from the Claim Input File. The Query Input and Response File testing requirements are less stringent. As described previously, you may use the HEW software to produce your test Query Input Files and process your test Query Response Files or use your own X12 translator software.

Test Query Input Files **must** be limited to 100 records. RREs will submit test files in the same manner as the method they choose for submitting production files (HTTPS, SFTP or Connect:Direct). You may use the information for test Medicare beneficiaries provided for Claim Input File testing to test for positive responses. You may provide a test Query Input File to the COBC after the COBC has received your signed profile report and the RRE ID has been updated to a testing status.

After processing the test Query Input File, the COBC will provide you a test Query Response File identifying those individuals identified as Medicare beneficiaries and those individuals who could not be identified as Medicare beneficiaries based upon the information submitted as prescribed by the file record layouts in Appendix D. The COBC will return a Query Response File to you within a week of receipt of test file submission. The COBC will request that you submit another test Query Input File if errors are found with the initial test submission. After you are satisfied with the results of the testing, you may begin submitting regular production Query Input Files on a monthly basis.

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

Query File testing requirements:

- Query File testing will commence on July 1, 2009.
- RREs must complete the registration and account setup process and return the signed profile report to the COBC before testing may begin. Once the COBC has recorded receipt of the signed profile report, the RRE ID will be updated to a test status and test and production Query files will be accepted.
- The RRE must transmit test files to the COBC in the same transmission method as that chosen for production files.
- The COBC will maintain a test environment that contains a mirror image of the COB Beneficiary Master Database containing all beneficiary information the COBC has in production and programs that will mimic the way the files would be processed in production. However, this environment will be refreshed on a limited basis and information returned on test response files should not be used in production applications.
- RREs should send actual injured party information (or derived test data) on records in the test files in order to test realistic situations. Include records for individuals age 65 and over in order to improve the likelihood of a positive match.
- Test files **must** be limited to no more than 100 records. Test files with more than 100 records will be rejected and not processed.
- RREs should submit at least the following test files:
    - One Query Input File with at least one detail record.
    - Additional Query Input Files as needed until the input and response files are processed successfully.
- RREs should process at least the following test response files sent back by the COBC:
    - One (1) corresponding Query Response File.
    - Additional response files as needed.
- The COBC will return test Query Response Files within one week of submission of the test Query Input File.
- RREs choosing to transmit files via SFTP will receive a test submission mailbox/directory separate from their production submission mailbox/directory on the Section 111 SFTP server. RREs choosing to transmit files via HTTPS will do so using the “Upload File” action on the RRE Listing page after logging on to the Section 111 COBSW application which requires you to indicate whether you are submitting a test or production file. RREs choosing Connect:Direct will send test files to a different destination dataset name than production files.

15 Electronic Data Exchange

15.1 Overview

There are three separate methods of data transmission that Section 111 RREs may utilize. As part of your registration for Section 111 on the COBSW, you will indicate the method you will use and submit the applicable transmission information. Each file type (Claim Input or Query Input) can be set up with the same file transmission method or you may select a different file transmission method for each. However, whatever method is selected for the file type will be used to transmit the corresponding response file back to the RRE or its agent.

Generally speaking, if you expect to be transmitting files with more than 24,000 records in one file submission on a regular basis, it is suggested that you use either the Connect:Direct or SFTP methods described below. HTTPS is more suitable for use with smaller files due to the time it may take to upload and download files during an active user session using that method.

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

15.2 Connect:Direct (NDM via the AT&T Global Network System (AGNS))

For responsible reporting entities with very large transmission volume the preferred method of electronic transmission is Connect:Direct (formerly known as Network Data Mover [NDM]) via the AT&T Global Network System (AGNS). AGNS is capable of transporting multiple protocol data streams to its clients world-wide, and uses triple DES as its encryption default. Use of either SNA or TCP/IP is available to submitters connected to the AGNS network.

Using this method, responsible reporting entities must first establish an AGNS account in order to send files directly to the COBC over AGNS. Section 111 responsible reporting entities that currently do not have an existing AGNS account and plan to send and receive information using this telecommunications link should contact AT&T or one of the well-established resellers of AT&T services to obtain a dedicated or a dial-up access line to the AGNS VAN. ***You are encouraged to do this as soon as possible since this setup can take a significant amount of time.***

During COBSW account setup, you will provide the AGNS account and connectivity information needed for this file transfer method as well as the dataset names you want the COBC to use when sending back response files. After your registration has

been processed, the COBC will e-mail a profile report with the COBC VTAM information and your Section 111 destination dataset names to which you will send your input files. The dataset naming convention you will use to transmit files to the COBC under this method is:

Production Files

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

Test Files

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

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

Files transmitted directly to the COBC via AGNS using Connect:Direct will be automatically converted to EBCDIC.

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

- AGNS Account ID
- Node ID, Net ID and Appl ID for SNA connections or IP Address and Port Address for IP connections
- Test and production destination dataset names to which you want the COBC to send your response files
- Optional special instructions such as file triggers you want the COBC to use.

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

15.3 Secure File Transfer Protocol (SFTP)

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

A Login ID and Password are required for the SFTP file transmission method. Any Login ID/Password assigned to a user of the Section 111 application on the COBSW associated with the RRE ID account may be used. During initial Account Setup on the Section 111 COBSW, the RRE's Account Manager will create a Login ID and

Password (or use his previously defined Login ID when performing setup for multiple RRE IDs). The Account Manager may then log in to the site and invite other users to be become Account Designees associated with the RRE ID. Each Account Designee will obtain his own Login ID and Password. These same Login IDs and Passwords are to be used for SFTP transmission. Each user of the COBSW will have one Login ID and Password. That same Login ID and Password can be used for multiple RRE ID SFTP transmissions. For example, an agent may be an Account Manager or Account Designee for many RRE IDs. That agent may use his one COBSW Login ID and Password to transmit files for all his RRE clients via SFTP as long as his Login ID is associated to all the applicable RRE IDs. The agent may also use this Login ID to log in to the Section 111 COBSW application and monitor file processing.

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

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

The following table contains the information you will need to configure your SFTP software to transmit Section 111 files:

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

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

Input Files (upload):

RREID/submission/test

RREID/submission/prod

Response Files (download):

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

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

In summary, the SFTP file directory is structured as:

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

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

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

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

Upload

- After going to the submission directory as described above, navigate (change directories) to either the test or prod directory as applicable to the file you are uploading.

- Once you have navigated to the correct directory, proceed to upload your file. There is no specific file naming convention needed. The COBC will determine the file type from the file contents and test/prod directory to which it's uploaded.

Download

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

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

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

Claim Response: PCOB.BA.MR.NGHPCLM.RESP.Dccyymmdd.Thhmmssmm.TXT
Query Response: PCOB.BA.MR.NGHPQRY.RESP.Dccyymmdd.Thhmmssmm.TXT

Where 'Dccyymmdd' is 'D' followed by date century/year/month/day and 'Thhmmssmm' is 'T' followed by hours/minutes/seconds/milliseconds.

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

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

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

15.4 Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)

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

During account setup on the COBSW, your Account Manager can select this method for file transfer. The account setup process is described in a previous section of the guide. The RRE's Account Manager obtains a COBSW Login ID and Password during the account setup process. After that, the Account Manager can sign onto the COBSW and invite other users to obtain Login IDs and be associated with the RRE's account as Account Designees. All users associated with the RRE's account will have the ability to upload input files and download response files.

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

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

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

There is no specific naming convention needed for uploaded input files.

The COBC will name response files according to the following convention. A list of files available for download will be presented to users of the COBSW when selecting the download option in the Section 111 COBSW application.

Claim Response: PCOB.BA.MR.NGHPCLM.RESP.Dccyymmdd.Thhmmssmm.TXT
Query Response: PCOB.BA.MR.NGHPQRY.RESP.Dccyymmdd.Thhmmssmm.TXT

> Where 'Dccyymmdd' is 'D' followed by date century/year/month/day and 'Thhmmssmm' is 'T' followed by hours/minutes/seconds/milliseconds.

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

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

16 Data Use Agreement

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

SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

I, the undersigned Authorized Representative of the Responsible Reporting Entity (RRE) defined above, certify that the information contained in this Registration is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS to verify this information. I agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged for the purposes of complying with the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The Responsible Reporting Entity and its duly authorized agent for this Section 111 reporting, if any, shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. I agree that the only entities authorized to have access to the data are CMS, the RRE or its authorized agent for Mandatory Reporting. RREs must ensure that agents reporting on behalf of multiple RREs will segregate data reported on behalf of each unique RRE to limit access to only the RRE and CMS and the agent. Further, RREs must ensure that access by the agent is limited to instances where it is acting solely on behalf of the unique RRE on whose behalf the data was obtained. I agree that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the RRE and its duly authorized agent, if any, is in compliance with the security requirements specified above. Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and RRE employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized under Section 111 of the MMSEA of 2007. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

17 COB Secure Web Site

The COBC will maintain a new 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 will register and set up accounts on the COBSW starting May 1, 2009. The COBSW URL is www.Section111.cms.hhs.gov.

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

- Complete the registration process. All information will be collected through an interactive Web application.
- Obtain Login IDs and assign users for Section 111 RRE ID COBSW accounts.
- Exchange files via HTTPS or SFTP directly with the COBC.
- 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.

The registration and account setup process were described in a previous section of this guide. Additional information can be found on the homepage under the "How To…" menu option. Once users are logged into the site, they will have access to a detailed user guide and Help pages associated with each function. In addition, Computer-Based Training (CBT) modules for the Section 111 application on the COBSW are available to RREs and their agents.

The following e-mails are generated by the system to the Authorized Representative, Account Manager, and/or Account Designees for the RRE ID. E-mails will be sent from cob@section111.cms.hhs.gov. Please do not reply to this e-mail address as replies are not monitored by the COBC. If additional information or action is needed, please contact your EDI Rep directly.

E-Mail Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	Sent after Account Setup step is complete on the COBSW. Included attachment with Profile Report.

E-Mail Notification	Recipient	Purpose
Non-Receipt of Signed Profile Report	Authorized Representative, Account Manager	Generated 30 days after the Profile Report e-mail if a signed copy of the profile report has not been received at the COBC. The Authorized Representative for the RRE ID must sign and return the profile report. If another copy is needed, contact your EDI Rep.
Successful File Receipt	Account Manager	Sent after an input file has been successfully received at the COBC. Informational only. No action required.
Late File Submission	Authorized Representative, Account Manager	Sent 7 days after the end of the file submission period if no Claim Input File received for the RRE ID. Send the file immediately and contact your EDI Rep.
Threshold Error	Account Manager	Sent when an input file has been suspended for a threshold error. Contact your EDI Rep to resolve.
Severe Error	Account Manager	Sent when an input file has been suspended for a severe error. Contact your EDI Rep to resolve.
Ready for Testing	Account Manager	Account setup is complete and the signed profile report has been received at the COBC. 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 COBC has completed processing on an input file and the response file is available.

E-Mail Notification	Recipient	Purpose
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.

18 Customer Service and Reporting Assistance for Section 111

Please be sure to visit the Section 111 page on the CMS Web site www.cms.hhs.gov/MandatoryInsRep 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 page, click on the "For e-mail updates and notifications" link and add your e-mail address to the distribution list for these updates.

18.1 EDI Representative

After you register for Section 111 reporting, you will be assigned a COBC EDI Rep to be your main contact for Section 111 file transmission and reporting issues. Contact information for your EDI Rep will be provided on your profile report.

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

18.2 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 COBC.** Your EDI Rep 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 COBC EDI Department number at 646-458-6740 for assistance.

Escalation Process

The COBC 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:

- If your Section 111 COBC EDI Representative does not respond to your inquiry or issue within **two business days**, you may contact the COBC EDI Department Supervisor, Jeremy Farquhar, at 646-458-6614. Mr. Farquhar's e-mail address is JFarquhar@ehmedicare.com.
- If the EDI Supervisor or the supervisor's designee does not respond to your inquiry or issue within **one business day**, you may contact the COBC EDI Department Manager, William Ford, at 646-458-6613. Mr. Ford's e-mail address is WFord@ehmedicare.com.
- If the EDI Manager does not respond to your inquiry or issue within **one business day**, you may contact the COBC Project Director, Jim Brady, who has overall responsibility for the COBC 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.

19 Training and Education

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

- The Section 111 CMS Web page at www.cms.hhs.gov/MandatoryInsRep will contain 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 page, click on the "For e-mail updates and notifications" link and add your e-mail address to the distribution list for these updates.
- During implementation of the Section 111 reporting, CMS is conducting a series of teleconferences to provide information 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 at www.cms.hhs.gov/MandatoryInsRep and downloaded from www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPRevTeleconfDoc2009.pdf .
- CMS has made available a curriculum of computer-based training (CBT) courses to Section 111 RREs. These courses provide in-depth training on Section 111 registration, reporting requirements, the COBSW, file transmission, file formats, and file processing. The curriculum and instructions on how to sign up for these courses is posted on www.cms.hhs.gov/MandatoryInsRep under the MMSEA 111 Computer Based Training (CBT) tab on the left side of the page or directly at www.cms.hhs.gov/MandatoryInsRep/05_Computer_Based_Training.asp. Those who sign up will be notified as new or updated courses are made available.

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: www.cms.hhs.gov/COBGeneralInformation, www.msprc.info, www.cms.hhs.gov/WorkersCompAgencyServices and www.cms.hhs.gov/manuals/IOM.

20 Checklist - Summary of Steps to Register, Test and Submit Production Files

In summary, the following are the high-level steps you need to follow to set up your reporting process for Section 111:

- Determine individuals who will be the RRE's Authorized Representative, Account Manager and Account Designees.
- Determine whether reporting agents will be used.
- Determine 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.
- Determine which file transmission method you will use. 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 (AGNS) you must establish a connection to AGNS, if you don't have one yet, and create transmission jobs and datasets.
- 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 indicating your registration and account setup were accepted by the COBC.
- Verify, sign and return your profile report to the COBC.
- 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 COBC.
- Submit your initial Claim Input File by your assigned production live date.
- Submit your Query File as needed but no more than once per calendar month ongoing.
- Submit your quarterly Claim Input File ongoing during your assigned submission periods.

Appendix A – Claim Input File Layout

MMSEA Section 111 Mandatory Reporting - Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation

Claim Input File Layout

Claim Input File Header Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Header Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGCH'. **Required.**
2	Section 111 RRE ID	9	5	13	Numeric	COBC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Pad with leading zeroes. **Required.**
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Must be 'NGHPCLM'. **Required.**
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the COBC. Format: CCYYMMDD **Required.**
5	Reserved for Future Use	2192	29	2220	Alpha-numeric	Fill with spaces.

Claim Input File Detail Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
Injured Party/Medicare Beneficiary Information (The injured party is/was a Medicare beneficiary.)						
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGCD'. **Required.**
2	DCN	15	5	19	Alpha-numeric	Document Control Number; assigned by the Section 111 RRE. Each record shall have a unique DCN within the file submitted. The DCN only needs to be unique within the current file being submitted. DCN will be supplied back by COBC on corresponding response file records for tracking purposes. **Required.**
3	Action Type	1	20	20	Numeric	Action to be performed. Valid values: 0 = Add 1 = Delete 2 = Update/Change Note: For changes/corrections to the initial reports of TPOC amounts or to add additional TPOCs, report use '2'. **Required.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
4	Injured Party HICN	12	21	32	Alpha-numeric	Medicare Health Insurance Claim Number Fill with spaces if unknown and SSN provided. Do not include dashes. **Required if SSN not provided.**
5	Injured Party SSN	9	33	41	Alpha-numeric	Social Security Number Fill with spaces if unknown and HICN provided. Do not include dashes. **Required if HICN not provided.**
6	Injured Party Last Name	40	42	81	Alpha-betic	Surname of Injured Party Name should be submitted as it appears on the individual's Social Security or Medicare Insurance card. **Required.**
7	Injured Party First Name	30	82	111	Alpha-betic	Given or first name of Injured Party. Name should be submitted as it appears on the individual's Social Security or Medicare Insurance card. **Required.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
8	Injured Party Middle Init	1	112	112	Alpha-betic	First letter of Injured Party middle name. Name should be submitted as it appears on the individual's Social Security or Medicare Insurance card. Fill with space if unknown.
9	Injured Party Gender	1	113	113	Numeric	Code to reflect the sex of the injured party. Valid values: 1 = Male 2 = Female 0 = Unknown Default to 0, if unknown. **Required.**
10	Injured Party DOB	8	114	121	Numeric Date	Date of Birth of Injured Party Format: CCYYMMDD **Required.**
11	Reserved for Future Use	20	122	141	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
***Injury/Incident/Illness* Information**						
12	**CMS** Date of Incident (DOI*)*: *DOI as defined by CMS*	8	142	149	Numeric Date	Date of Incident (DOI*) **as defined by CMS*****:** For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the ***date of first exposure*****.** For claims involving ingestion (for example, a recalled drug), it is the ***date of first ingestion*****.** For claims involving implants, it is the ***date of the implant (or date of the first implant if there are multiple implants)***. Note: CMS' definition of DOI generally differs from the definition routinely used by the insurance/workers' compensation industry (Field 13) only for claims involving exposure, ingestion, or implants. Format: CCYYMMDD **Required.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
13	**Industry** Date of Incident (DOI): *DOI routinely used by the insurance/workers' compensation industry*	8	150	157	Numeric Date	Date of Incident (DOI) *used by the insurance/workers' compensation industry*: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure, ingestion, or implantation, the date of incident is the date of ***last*** exposure, ingestion, or implantation. Note: The definition of DOI routinely used by the insurance/workers' compensation industry DOI generally differs from the definition which CMS must use (Field 12) only for claims involving exposure, ingestion, or implants. Format: CCYYMMDD **Optional.**
14	Reserved for Future Use	1	158	158	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Codes.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
15	Alleged Cause of Injury, Incident, or Illness	5	159	163	Alpha-numeric	ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) External Cause of Injury Code "E Code" describing the alleged cause of injury/illness (E800.0 - E999.1). Left justify. Do not include decimal point. A one position decimal will be assumed for E-codes. Must be on the most current list of valid codes accepted by CMS for Section 111 reporting found at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Use the current version download published once per year (e.g. V26 I-9 Diagnosis.txt effective 10/1/2008). ***Must NOT be on the list of Insufficient ICD-9 Diagnosis Codes found in Appendix H.*** Examples: 'E812.0' should be submitted as 'E8120'; 'E919.2' should be submitted as 'E9192'; 'E956' should be submitted as 'E956 '. For more information on ICD-9-CM refer to http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf and http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm. **Required for add and update records (Action Type = 0 or 2) submitted on or after January 1, 2011. See Field 57 for interim requirement.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
16	Reserved for Future use	2	164	165	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Codes.
17	State of Venue	2	166	167	Alpha-betic	US postal abbreviation corresponding to the US State whose state law controls resolution of the claim. See www.usps.com/ncsc/lookups/abbreviations.html. Insert 'US' where the claim is a Federal Tort Claims Act liability insurance matter or a Federal workers' compensation claim. Insert 'FC' in the case where the state of venue is outside the United States. If the state of venue is in dispute at the time an RRE reports acceptance of ongoing responsibility for medicals, the RRE should use its best judgment regarding the state of venue and submit updated information, if applicable, when the ongoing responsibility is terminated or further reporting is required because of a settlement, judgment, award or payment other than payment made under the ongoing responsibility for medicals. **Required.**
18	Reserved for Future Use	1	168	168	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
19	ICD-9	5	169	173	Alpha-	ICD-9-CM (International

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
	Diagnosis Code 1				numeric	Classification of Diseases, Ninth Revision, Clinical Modification) Diagnosis Code describing the alleged injury/illness. Left justify. Include any leading zeros. Do not include decimal point. A one position decimal will be assumed for a four position numeric diagnosis code and E-codes. A two position decimal will be assumed for a five position numeric diagnosis code and V-codes. Must be on the most current list of valid codes accepted by CMS for Section 111 reporting found at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Use the current version download published once per year (e.g. V26 I-9 Diagnosis.txt effective 10/1/2008). ***At least one valid diagnosis code submitted on the record must NOT be on the list of Insufficient ICD-9 Diagnosis Codes found in Appendix H AND NOT an E code AND NOT a V code. "Insufficient" codes will be accepted as long as one numeric diagnosis code NOT on this list is provided.*** Examples: '037' should be submitted as '037 '; '038.3' should be submitted as '0383 '; '038.42' should be submitted as '03842'; 'V01.5' should be submitted as 'V015 '; 'V15.86' should be submitted as 'V1586'. For more information on ICD-9-

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
						CM refer to http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf and http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm. **Required for add and update records (Action Type = 0 or 2) submitted on or after January 1, 2011. See Field 57 for interim requirement.**
20	Reserved for Future Use	2	174	175	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
21	ICD-9 Diagnosis Code 2	5	176	180	Alpha-numeric	See explanation for Field 19. May include additional ICD-9 Diagnosis Code or ICD-9 External Cause of Injury Codes "E Code" (E800-E999) if applicable. **Required when multiple body parts are affected.** Provide if available/applicable.
22	Reserved for Future Use	2	181	182	Alpha-numeric	Fill with spaces.
23	ICD-9 Diagnosis Code 3	5	183	187	Alpha-numeric	See explanation for Field 19 and 21. **Required when 3 or more body parts are affected.** Provide if available/applicable.
24	Reserved for Future Use	2	188	189	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
25	ICD-9 Diagnosis Code 4	5	190	194	Alpha-numeric	See explanation for Field 19 and 21. **Required when 4 or more body parts are affected.** Provide if available/applicable.
26	Reserved for Future Use	2	195	196	Alpha-numeric	Fill with spaces.
27	ICD-9 Diagnosis Code 5	5	197	201	Alpha-numeric	See explanation for Field 19 and 21. **Required when 5 or more body parts are affected.** Provide if available/applicable.
28	Reserved for Future Use	2	202	203	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
29	ICD-9 Diagnosis Code 6	5	204	208	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
30	Reserved for Future Use	2	209	210	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
31	ICD-9 Diagnosis Code 7	5	211	215	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
32	Reserved for Future Use	2	216	217	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
33	ICD-9 Diagnosis Code 8	5	218	222	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
34	Reserved for Future Use	2	223	224	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
35	ICD-9 Diagnosis Code 9	5	225	229	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
36	Reserved for Future Use	2	230	231	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
37	ICD-9 Diagnosis Code 10	5	232	236	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
38	Reserved for Future Use	2	237	238	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
39	ICD-9 Diagnosis Code 11	5	239	243	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
40	Reserved for Future Use	2	244	245	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
41	ICD-9 Diagnosis Code 12	5	246	250	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
42	Reserved for Future Use	2	251	252	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
43	ICD-9 Diagnosis Code 13	5	253	257	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
44	Reserved for Future Use	2	258	259	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
45	ICD-9 Diagnosis Code 14	5	260	264	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
46	Reserved for Future Use	2	265	266	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
47	ICD-9 Diagnosis Code 15	5	267	271	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
48	Reserved for Future Use	2	272	273	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
49	ICD-9 Diagnosis Code 16	5	274	278	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
50	Reserved for Future Use	2	279	280	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
51	ICD-9 Diagnosis Code 17	5	281	285	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
52	Reserved for Future Use	2	286	287	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
53	ICD-9 Diagnosis Code 18	5	288	292	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
54	Reserved for Future Use	2	293	294	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Diagnosis Codes.
55	ICD-9 Diagnosis Code 19	5	295	299	Alpha-numeric	See explanation for Field 19 and 21. Provide if available/applicable.
56	Reserved for Future Use	59	300	358	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
57	Description of Illness/Injury	50	359	408	Alpha-numeric	Free-form text description of illness or injury. Include description of major body part injured (e.g. head, arm, leg, etc.) and cause of illness/injury. **Required through December 31, 2010, if no Alleged Cause of Illness/Injury Code (Field 15) or no ICD-9 Diagnosis Code 1 (Field 19) provided.** **Prior to January 1, 2011, RREs must provide either:** **1) both a valid Alleged Cause of Injury, Incident, or Illness (Field 15) and at least one valid diagnosis code in the ICD-9 Diagnosis Code 1 (Field 19);** **or** **2) the Description of Illness/Injury (Field 57).** **Add and update (Action Type = 0 or 2) claim records submitted on or after January 1, 2011 must contain both the Alleged Cause of Injury, Incident, or Illness (Field 15) and the ICD-9 Diagnosis Code 1 (Field 19).** **NOTE: This field will be changed to "Reserved for Future Use" and must be filled with spaces for add and update records submitted on or after January 1, 2011.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
58	Product Liability Indicator	1	409	409	Alpha-numeric	Indicates whether injury, illness or incident was allegedly caused by/contributed to by a particular product. Some product liability situations involve a product which allegedly results in situations involving falls or other accidents. Others may involve exposure to, implantation of, or ingestion of a particular product. Valid values: 1 = No 2 = Yes, but not a mass tort situation. 3 = Yes, and is a mass tort situation. ***Required.***
59	Product Generic Name	40	410	449	Alpha-numeric	Generic name of product alleged to be cause of injury, illness or incident. If no generic name applicable, supply brand name. **Required if Product Liability Indicator (Field 58) is 3 (mass tort).** **Required for add and update records (Action Type = 0 or 2) submitted on or after January 1, 2011, if Product Liability Indicator (Field 58) is either 2 or 3.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
60	Product Brand Name	40	450	489	Alpha-numeric	Brand name of product alleged to be cause of injury, illness or incident. **Required if Product Liability Indicator (Field 58) is 3.** **Required for add and update records (Action Type = 0 or 2) submitted on or after January 1, 2011, if Product Liability Indicator (Field 58) is either 2 or 3.**
61	Product Manufacturer	40	490	529	Alpha-numeric	Maker of product named in Fields 59 and/or 60 above. **Required if Product Liability Indicator (Field 58) is 3.** **Required for add and update records (Action Type = 0 or 2) submitted on or after January 1, 2011, if Product Liability Indicator (Field 58) is either 2 or 3.**
62	Product Alleged Harm	200	530	729	Alpha-numeric	Free-form description of harm allegedly caused by product named in Fields 59 and/or 60 above. **Required if Product Liability Indicator (Field 58) is 3.** **Required for add and update records (Action Type = 0 or 2) submitted on or after January 1, 2011, if Product Liability Indicator (Field 58) is either 2 or 3.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
63	Reserved for Future Use	20	730	749	Alpha-numeric	Fill with spaces.
Self-Insurance Information – Information required to: 1) indicate if the reportable event involves "self-insurance" as defined by CMS; and 2) if yes, specific information regarding the self-insured individual or entity.						
64	Self Insured Indicator	1	750	750	Alpha-numeric	Indication of whether the reportable event involves self-insurance as defined by CMS. Valid values: Y = Yes N = No Self-insurance is defined in "Attachment A – Definitions and Reporting Responsibilities" to the Supporting Statement for the FR PRA Notice (CMS-10265) for this mandatory reporting and is available in Appendix G of this User Guide. You **must** use this definition of self-insurance for purposes of this reporting. ***Required if Plan Insurance Type (Field 71) is E or L (Workers' Compensation or Liability).***
65	Self-Insured Type	1	751	751	Alpha-numeric	Identifies whether the self-insured is an organization or individual. Valid values: I = Individual O = Other than Individual (e.g. business, corporation, organization, company, etc.) ***Required if Self Insured Indicator (Field 64) is Y.***

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
66	Policyholder Last Name	40	752	791	Alpha-betic	Surname of policyholder. **Required if Self-Insured Type (Field 65) = I.**
67	Policyholder First Name	30	792	821	Alpha-betic	Given/First name of policyholder. **Required if Self-Insured Type (Field 65) = I.**
68	DBA Name	70	822	891	Alpha-numeric	"Doing Business As" Name of self-insured organization/business. DBA Name or Legal Name is required for Self-Insured Type = O. **Required if Self-Insured Type (Field 65) = O and Legal Name (Field 69) not provided.**
69	Legal Name	70	892	961	Alpha-numeric	Legal Name of self-insured organization/business. DBA Name or Legal Name is required for Self-Insured Type = O. **Required if Self-Insured Type (Field 65) = O and DBA Name (Field 68) not provided.**
70	Reserved for Future Use	20	962	981	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
Plan Information						
71	Plan Insurance Type	1	982	982	Alpha-numeric	Type of insurance coverage or line of business provided by the plan policy or self-insurance. Valid values: D = No-Fault E = Workers' Compensation L = Liability ***Required.*** *Note: When selecting "no-fault" as the type of insurance, you* ***must*** *use the CMS definition of no-fault insurance found at 42 CFR 411.50. This definition is different from the industry definition which is generally limited to certain automobile insurance.* "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', or 'medical expense coverage.' See 42 CFR 411.50."

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
72	TIN	9	983	991	Numeric	Federal Tax Identification Number of the "applicable plan" used by the RRE, whether liability insurance (including self-insurance), no-fault insurance or a workers' compensation law or plan. Must have a corresponding entry with associated Office Code/Site ID on the TIN Reference File. ***Required.***
73	Office Code/Site ID	9	992	1000	Alpha-Numeric	RRE-defined code to uniquely identify variations in insurer addresses/claim offices/Plan Contact Addresses under the same TIN. Defined by RRE. Used to uniquely specify different addresses associated with one TIN. If only one address will be used per reported TIN, leave blank. Must have a corresponding entry with associated TIN on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Office Code combination. ***Optional.***

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
74	Policy Number	30	1001	1030	Alpha-numeric	The unique identifier for the policy under which the underlying claim was filed. RRE defined. If liability self-insurance or workers' compensation self-insurance, fill with 0's if you do not have or maintain a specific number reference. ***Required.***
75	Claim Number	30	1031	1060	Alpha-numeric	The unique claim identifier by which the primary plan identifies the claim. If liability self-insurance or workers' compensation self-insurance, fill with 0's if you do not have or maintain a claim number reference. ***Required.***
76	Plan Contact Department Name	70	1061	1130	Alpha-numeric	Name of department for the Plan Contact to which claim-related communication and correspondence should be sent. ***Optional.***
77	Plan Contact Last Name	40	1131	1170	Alpha-numeric	Surname of individual that should be contacted at the Plan for claim-related communication and correspondence. ***Optional.***
78	Plan Contact First Name	30	1171	1200	Alpha-numeric	Given or first name of individual that should be contacted at the Plan for claim-related communication and correspondence. ***Optional.***

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
79	Plan Contact Phone	10	1201	1210	Numeric	Telephone number of individual that should be contacted at the Plan for claim-related communication. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). Fill with zeroes if not available. ***Optional.***
80	Plan Contact Phone Extension	5	1211	1215	Alpha-numeric	Telephone extension number of individual that should be contacted at the Plan for claim-related communication. Fill with all spaces if unknown or not applicable. ***Optional***

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
81	No-Fault Insurance Limit	11	1216	1226	Numeric	Dollar amount of limit on no-fault insurance. Specify dollars and cents with implied decimal. No formatting (no $ or , or .) For example, a limit of $10,500.00 should be coded as 00001050000. Fill with all 9's if there is no dollar limit. Fill with all 0's if Plan Insurance Type (Field 71) is E (Workers' Compensation) or L (Liability Insurance (including Self-Insurance)). **Required if Plan Insurance Type (Field 71) is D (No-Fault).**
82	Exhaust Date for Dollar Limit for No-Fault Insurance	8	1227	1234	Numeric Date	Date on which limit was reached or benefits exhausted for No-Fault Insurance Limit (Field 81). Format: CCYYMMDD Fill with zeros if No-Fault limit has not been reached/exhausted or Plan Insurance Type (Field 71) is E (Workers' Compensation) or L (Liability Insurance (including Self-Insurance)). **Required if Plan Insurance Type (Field 71) is D (No-Fault) and benefit limit reached/exhausted.**
83	Reserved for Future Use	20	1235	1254	Alpha-numeric	Fill with spaces

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
Injured Party's Attorney or Other Representative Information						
Attorney/Representative information required only if injured party has a representative*. If injured party does not have a representative, default each field in this section to its appropriate default value per the field type (zeroes or spaces).*						
84	Injured Party Representative Indicator	1	1255	1255	Alpha-numeric	Code indicating the type of Attorney/Other Representative information provided. Valid values: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Space = None If the injured party has more than one representative, provide the injured party's attorney information if available. **Required if Injured Party has a representative.**
85	Representative Last Name	40	1256	1295	Alpha-betic	Surname of representative. **Required if Injured Party has a representative (Representative Indicator not equal to a space).**
86	Representative First Name	30	1296	1325	Alpha-betic	Given or first name of representative. **Required if Injured Party has a representative (Representative Indicator not equal to a space).**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
87	Representative Firm Name	70	1326	1395	Alpha-numeric	Representative's firm name. **Required on reports submitted on or after January 1, 2011, if Representative is associated with or a member of a firm.**
88	Representative TIN	9	1396	1404	Numeric	Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN). **Required if Injured Party has a representative.**
89	Representative Mailing Address Line 1	50	1405	1454	Alpha-numeric	First line of the mailing address for the representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Injured Party has a representative.**
90	Representative Mailing Address Line 2	50	1455	1504	Alpha-numeric	Second line of the mailing address of the representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
91	Representative City	30	1505	1534	Alpha-numeric	Mailing address city for the representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Injured Party has a representative.**
92	Representative State	2	1535	1536	Alpha-numeric	US Postal abbreviation State Code for the representative named above. See www.usps.com/ncsc/lookups/abbreviations.html. If no US address is available, supply 'FC'. **Required if Injured Party has a representative.**
93	Representative Mail Zip Code	5	1537	1541	Numeric	5-digit Zip Code for the representative named above. If no US address is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required if Injured Party has a representative.**
94	Representative Mail Zip+4	4	1542	1545	Numeric	4-digit Zip+4 Code for the representative named above. If not applicable or unknown, fill with zeroes (0000).

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
95	Representative Phone	10	1546	1555	Numeric	Telephone number of the representative named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). If no US phone number is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required if Injured Party has a representative.**
96	Representative Phone Extension	5	1556	1560	Alpha-numeric	Telephone extension number of representative named above. Fill with all spaces if unknown or not applicable.
97	Reserved for Future Use	20	1561	1580	Alpha-numeric	Fill with spaces.
Settlement, Judgment, Award or Other Payment Information						
98	ORM Indicator	1	1581	1581	Alpha-numeric	Indication of whether there is on-going responsibility for medicals (ORM). Fill with Y if there is ongoing responsibility for medicals. Valid values: Y - Yes N – No **The Y value remains in this field even when an ORM Termination Date (Field 99) is submitted in this same record or a subsequent record.** **Required.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
99	ORM Termination Date	8	1582	1589	Numeric Date	Date ongoing responsibility for medicals ended, where applicable. Only applies to records previously submitted (or submitted in this record where ongoing responsibility for medicals and termination of such responsibility are reported in this same submission) with ORM Indicator = Y. ORM Termination Date is not applicable if claimant retains the ability to submit/apply for payment for additional medicals related to the claim. See Sections 11.8 and 11.9 of the User Guide for information concerning extensions/exceptions regarding reporting ORM. Future dates are accepted. When an ORM termination date is submitted, the ORM indicator in Field 98 **must remain as 'Y'.** Format: CCYYMMDD Fill with zeroes if ORM Indicator = 'N' or if a date for the termination of ORM has not been established.
100	TPOC Date 1	8	1590	1597	Numeric Date	Date of associated Total Payment Obligation to the Claimant (TPOC) without regard to **ongoing** responsibility for medicals (ORM).

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
						Date payment obligation was established. This is the date the obligation is signed if there is a written agreement unless court approval is required. If court approval is required it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement it is the date the payment (or first payment if there will be multiple payments) is issued. Format: CCYYMMDD **Not required for the initial report of a claim reflecting ongoing responsibility for medicals. If there is a TPOC amount/date reportable at the same time ORM termination is being reported, report the TPOC fields on the second (final) report for the ongoing responsibility for medicals. Fill with all zeroes if there is no TPOC to report.** **Required for all other claim reports.** **Use the TPOC fields on the Auxiliary Record to report additional, separate TPOCs as required.**
101	TPOC Amount 1	11	1598	1608	Numeric	Total Payment Obligation to the Claimant (TPOC) amount: Dollar amount of the total payment obligation to the claimant. If there is a structured settlement, the amount is the total payout

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
						amount. If a settlement provides for the purchase of an annuity, it is the total payout from the annuity. For annuities, base the total amount upon the time period used in calculating the purchase price of the annuity or the minimum payout amount (if there is a minimum payout), whichever calculation results in the larger amount. When this record includes information reflecting ongoing responsibility for medicals (either current or terminated), fill with zeroes unless there is a TPOC date/amount for a settlement, judgment, award, or other payment in addition to/apart from the information which must be reported with respect to responsibility for ongoing medicals. Specify dollars and cents with implied decimal. No formatting (no $, .) For example, an amount of $20,500.55 should be coded as 00002050055. **Not required for the initial report of a claim reflecting ongoing responsibility for medicals. If there is a TPOC amount/date reportable at the same time ORM termination is being reported, report the TPOC fields on the second (final) report for the ongoing responsibility for medicals. Fill with all zeroes if there is no TPOC to report.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
						Required for all other claim reports. **Use the TPOC fields on the Auxiliary Record to report additional, separate TPOCs as required.**
102	Funding Delayed Beyond TPOC Start Date 1	8	1609	1616	Numeric Date	If funding for the Total Payment Obligation to Claimant Amount 1 is delayed, provide actual or estimated date of funding. Format: CCYYMMDD Fill with zeroes if not applicable.
103	Reserved for Future Use	20	1617	1636	Alpha-numeric	Fill with spaces
Claimant Information 1						
This section is only required if the Claimant is not the Injured Party/Medicare Beneficiary. The claimant may be the beneficiary's estate, or other claimant in the case of wrongful death or survivor action. Additional claimants must be listed on the Auxiliary Record. *If not supplying Claimant 1 information, default each field in this section* (Fields 104-118) *to its appropriate default value per the field type (zeroes or spaces)*. This section is **not** used when the injured party/Medicare beneficiary is alive and an individual is pursuing a claim on behalf of the beneficiary. See the section for Injured Party's Attorney or Other Representative Information.						
104	Claimant 1 Relationship	1	1637	1637	Alpha-numeric	Relationship of the claimant to the injured party/Medicare beneficiary. This field also indicates whether the claimant name refers to an individual or an entity/organization (e.g. "The Trust of John Doe" or "The Estate of John Doe"). Valid values: E = Estate, Individual Name

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
						Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Space = Not applicable (rest of the section will be ignored) Optional January 1, 2010 – March 31, 2010. **Required April 1, 2010 and subsequent if claimant is not the injured party.**
105	Claimant 1 TIN	9	1638	1646	Numeric	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 1. Must not match injured party named above or other claimant(s) listed on the Auxiliary Record. **Required April 1, 2010 and subsequent if claimant is not the injured party.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
106	Claimant 1 Last Name	40	1647	1686	Alpha-betic	Surname of Claimant 1. **Required April 1, 2010 and subsequent if claimant is not the injured party and Claimant 1 Relationship is 'E', 'F' or 'O'.**
107	Claimant 1 First Name	30	1687	1716	Alpha-betic	Given/First name of Claimant 1. **Required April 1, 2010 and subsequent if claimant is not the injured party and Claimant 1 Relationship is 'E', 'F' or 'O'.**
108	Claimant 1 Middle Initial	1	1717	1717	Alpha-betic	First letter of Claimant 1's middle name. Use only if **Claimant 1 Relationship is 'E', 'F' or 'O'.**
109	Claimant 1 Entity/Organization Name	71	1647	1717	Alpha-numeric	Name of Claimant 1 Entity/Organization. Redefines Fields 106-108. **Required April 1, 2010 and subsequent if claimant is not the injured party and Claimant 1 Relationship is 'X', 'Y' or 'Z'.**
110	Claimant 1 Mailing Address Line 1	50	1718	1767	Alpha-numeric	First line of the mailing address for the claimant named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required April 1, 2010 and subsequent if claimant is not the injured party (Claimant 1 Relationship is not blank).**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
111	Claimant 1 Mailing Address Line 2	50	1768	1817	Alpha-numeric	Second line of the mailing address of the claimant named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code.
112	Claimant 1 City	30	1818	1847	Alpha-betic	Mailing address city for the claimant named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required April 1, 2010 and subsequent if claimant is not the injured party (Claimant 1 Relationship is not blank).**
113	Claimant 1 State	2	1848	1849	Alpha-betic	US Postal abbreviation State Code for the claimant named above. See www.usps.com/ncsc/lookups/abbreviations.html. If no US address is available, supply 'FC'. **Required April 1, 2010 and subsequent if claimant is not the injured party (Claimant 1 Relationship is not blank).**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
114	Claimant 1 Zip	5	1850	1854	Numeric	5-digit Zip Code for the claimant named above. If no US address is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required April 1, 2010 and subsequent if claimant is not the injured party (Claimant 1 Relationship is not blank).**
115	Claimant 1 Zip+4	4	1855	1858	Numeric	4-digit Zip+4 Code for the claimant named above. If not applicable or unknown, fill with zeroes (0000).
116	Claimant 1 Phone	10	1859	1868	Numeric	Telephone number of the claimant named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). If no US phone number is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required April 1, 2010 and subsequent if claimant is not the injured party (Claimant 1 Relationship is not blank).**
117	Claimant 1 Phone Extension	5	1869	1873	Alpha-numeric	Telephone extension number of the claimant named above. Fill with all spaces if unknown or not applicable.
118	Reserved for Future Use	20	1874	1893	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
Claimant 1 Attorney/Other Representative Information						
This section is only required if Claimant 1 has a representative. *If not supplying Claimant 1 Representative information, default each field in this section* (Fields 119-131) *to its appropriate default value per the field type (zeroes or spaces)*.						
119	Claimant 1 (C1) Representative Indicator	1	1894	1894	Alpha-numeric	Code indicating the type of Attorney/Other Representative information provided for Claimant 1. Valid values: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Space = Not applicable (rest of the section will be ignored) **Required if Claimant 1 has a representative.**
120	C1 Representative Last Name	40	1895	1934	Alpha-betic	Surname of C1 representative. **Required if Injured Party has a representative (Representative Indicator not equal to a space).**
121	C1 Representative First Name	30	1935	1964	Alpha-betic	Given/First name of C1 representative. **Required if Injured Party has a representative (Representative Indicator not equal to a space).**
122	C1 Representative Firm Name	70	1965	2034	Alpha-numeric	Representative's firm name. **Required on reports submitted on or after January 1, 2011, if Representative is associated with or a member of a firm.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
123	C1 Representative TIN	9	2035	2043	Numeric	C1 representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN). **Required.**
124	C1 Representative Mailing Address 1	50	2044	2093	Alpha-numeric	First line of the mailing address for the C1 representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 1 has a representative.**
125	C1 Representative Mailing Address 2	50	2094	2143	Alpha-numeric	Second line of the mailing address of the C1 representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code.
126	C1 Representative Mailing City	30	2144	2173	Alpha-betic	Mailing address city for the C1 representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 1 has a representative.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
127	C1 Representative State	2	2174	2175	Alpha-betic	US Postal abbreviation State Code for the C1 representative named above. See www.usps.com/ncsc/lookups/abbreviations.html. If no US address is available, supply 'FC'. **Required if Claimant 1 has a representative.**
128	C1 Representative Zip	5	2176	2180	Numeric	5-digit Zip Code for the C1 representative named above. If no US address is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required if Claimant 1 has a representative.**
129	C1 Representative Zip+4	4	2181	2184	Numeric	4-digit Zip+4 Code for the C1 representative named above. If not applicable or unknown, fill with zeroes (0000).

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
130	C1 Representative Phone	10	2185	2194	Numeric	Telephone number of the C1 representative named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). If no US phone number is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required if Claimant 1 has a representative.**
131	C1 Representative Phone Extension	5	2195	2199	Alpha-numeric	Telephone extension number of the C1 representative named above. Fill with all spaces if unknown or not applicable.
132	Reserved for Future Use	21	2200	2220	Alpha-numeric	Fill with spaces.

Claim Input File Auxiliary Record

This record is only required if there are additional claimants to report for the associated Detail Claim Record and/or if there is more than one TPOC Amount to report. Do not include this record for the claim unless one or both of these situations exist(s). Fields 1-6 must always be completed and match the associated detail record in order submit this Auxiliary Record. Claimant 1 on the Detail Claim Record must be completed in order for information concerning additional claimants to be accepted. Only ***one*** Auxiliary Record may be submitted per claim report.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGCE'. **Required.**
2	DCN	15	5	19	Alpha-numeric	Document Control Number (DCN) assigned by the Section 111 RRE. Must match the DCN on the corresponding Claim Input File Detail Record (Record Identifier NGCD). **Required.**
3	Injured Party HICN	12	20	31	Alpha-numeric	Must match the value in this field on the Claim Input File Detail Record. **Required.**
4	Injured Party SSN	9	32	40	Numeric	Must match the value in this field on the Claim Input File Detail Record. **Required.**
5	Injured Party Last Name	40	41	80	Alpha-betic	Must match the value in this field on the Claim Input File Detail Record. **Required.**
6	Injured Party First Name	30	81	110	Alpha-betic	Must match the value in this field on the Claim Input File Detail Record. **Required.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
Claimant 2 Information *If not supplying Claimant 2 information, default each field in this section* (Fields 7 - 20) *to its appropriate default value per the field type (zeroes or spaces)*.						
7	Claimant 2 Relationship	1	111	111	Alpha-numeric	Relationship of the claimant to the injured party/Medicare beneficiary. This field also indicates whether the claimant name refers to an individual or an entity/organization (e.g. "The Trust of John Doe" or "The Estate of John Doe") Valid values: E = Estate, Individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Space = Not applicable (rest of the section will be ignored) Optional January 1, 2010 – March 31, 2010. **Required April 1, 2010 and subsequent if claimant is not the injured party and there is more than one claimant to report.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
8	Claimant 2 TIN	9	112	120	Numeric	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 2. Must not match injured party named above or other claimant(s) listed on the Auxiliary Record. **Required.**
9	Claimant 2 Last Name	40	121	160	Alpha-betic	Surname of Claimant 2. **Required if Claimant 2 Relationship is 'E', 'F' or 'O'.**
10	Claimant 2 First Name	30	161	190	Alpha-betic	Given/First name of Claimant 2. **Required if Claimant 2 Relationship is 'E', 'F' or 'O'.**
11	Claimant 2 Middle Initial	1	191	191	Alpha-betic	First letter of Claimant 2's middle name. Provide if available and Claimant 2 Relationship is 'E', 'F' or 'O'.
12	Claimant 2 Entity/Organization Name	71	121	191	Alpha-numeric	Name of Claimant 2 Entity/Organization. Redefines Fields 9-11. **Required if Claimant 2 Relationship is 'X', 'Y' or 'Z'.**
13	Claimant 2 Mailing Address Line 1	50	192	241	Alpha-numeric	First line of the mailing address for Claimant 2 named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 2 Relationship is not blank.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
14	Claimant 2 Mailing Address Line 2	50	242	291	Alpha-betic	Second line of the mailing address for Claimant 2 named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code.
15	Claimant 2 City	30	292	321	Alpha-betic	Mailing address city for Claimant 2 named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 2 Relationship is not blank.**
16	Claimant 2 State	2	322	323	Alpha-betic	US Postal abbreviation State Code for Claimant 2 named above. See www.usps.com/ncsc/lookups/abbreviations.html. If no US address is available, supply 'FC'. **Required if Claimant 2 Relationship is not blank.**
17	Claimant 2 Zip	5	324	328	Numeric	5-digit Zip Code for Claimant 2 named above. If no US address is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required if Claimant 2 Relationship is not blank.**
18	Claimant 2 Zip+4	4	329	332	Numeric	4-digit Zip+4 Code for Claimant 2 named above. If not applicable or unknown, fill with zeroes (0000).

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
19	Claimant 2 Phone	10	333	342	Numeric	Telephone number of Claimant 2 named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). If no US phone number is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required if Claimant 2 Relationship is not blank.**
20	Claimant 2 Phone Extension	5	343	347	Alpha-numeric	Telephone extension number of Claimant 2 named above. Fill with all spaces if unknown or not applicable.
21	Reserved for Future Use	20	348	367	Alpha-numeric	Fill with spaces.
Claimant 2 Attorney/Other Representative Information						
This section is only required if Claimant 2 has a representative. *If not supplying Claimant 2 Representative information, default each field in this section* (Fields 22-35) *to its appropriate default value per the field type (zeroes or spaces)*.						
22	Claimant 2 (C2) Representative Indicator	1	368	368	Alpha-numeric	Code indicating the type of Attorney/Other Representative information provided for Claimant 2 (C2). Valid values: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Space = Not applicable (rest of the section will be ignored) **Required if Claimant 2 has a representative.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
23	C2 Representative Last Name	40	369	408	Alpha-betic	Surname of C2 attorney or representative. **Required if Injured Party has a representative (Representative Indicator not equal to a space).**
24	C2 Representative First Name	30	409	438	Alpha-betic	Given/First name of C2 attorney or representative. **Required if Injured Party has a representative (Representative Indicator not equal to a space).**
25	C2 Representative Firm Name	70	439	508	Alpha-numeric	Representative's firm name. **Required on reports submitted on or after January 1, 2011, if Representative is associated with or a member of a firm.**
26	C2 Representative TIN	9	509	517	Numeric	C2 representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN). **Required.**
27	C2 Representative Mailing Address Line 1	50	518	567	Alpha-numeric	First line of the mailing address for the C2 representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 2 has a representative.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
28	C2 Representative Mailing Address Line 2	50	568	617	Alpha-numeric	Second line of the mailing address of the C2 representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code.
29	C2 Representative City	30	618	647	Alpha-betic	Mailing address city for the C2 representative named above. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 2 has a representative.**
30	C2 Representative State	2	648	649	Alpha-betic	US Postal abbreviation State Code for the C2 representative named above. See www.usps.com/ncsc/lookups/abbreviations.html. If no US address is available supply 'FC'. **Required if Claimant 2 has a representative.**
31	C2 Representative Zip	5	650	654	Numeric	5-digit Zip Code for the C2 representative named above. If no US address is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required if Claimant 2 has a representative.**
32	C2 Representative Zip+4	4	655	658	Numeric	4-digit Zip+4 Code for the C2 representative named above. If not applicable or unknown, fill with zeroes (0000).

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
33	C2 Representative Phone	10	659	668	Numeric	Telephone number of the C2 representative named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). If no US phone number is available, fill with zeroes and supply 'FC' in the corresponding State Code. **Required if Claimant 2 has a representative.**
34	C2 Representative Phone Extension	5	669	673	Alpha-numeric	Telephone extension number of the C2 representative named above. Fill with all spaces if unknown or not applicable.
35	Reserved for Future Use	20	674	693	Alpha-numeric	Fill with spaces.
Claimant 3 Information						
If not supplying Claimant 3 information, default each field in this section (Fields 36-49) *to its appropriate default value per the field type (zeroes or spaces)*. ***See Claimant 2 Information section above for individual field specifications***.						
36	Claimant 3 Relationship	1	694	694	Alpha-numeric	
37	Claimant 3 TIN	9	695	703	Numeric	
38	Claimant 3 Last Name	40	704	743	Alpha-betic	
39	Claimant 3 First Name	30	744	773	Alpha-betic	
40	Claimant 3 Middle Initial	1	774	774	Alpha-betic	
41	Claimant 3 Entity/Organization Name	71	704	774	Alpha-numeric	
42	Claimant 3 Mailing Address Line 1	50	775	824	Alpha-numeric	

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
43	Claimant 3 Mailing Address Line 2	50	825	874	Alpha-numeric	
44	Claimant 3 City	30	875	904	Alpha-betic	
45	Claimant 3 State	2	905	906	Alpha-betic	
46	Claimant 3 Zip	5	907	911	Numeric	
47	Claimant 3 Zip+4	4	912	915	Numeric	
48	Claimant 3 Phone	10	916	925	Numeric	
49	Claimant 3 Phone Extension	5	926	930	Alpha-numeric	
50	Reserved for Future Use	20	931	950	Alpha-numeric	Fill with spaces.
Claimant 3 Attorney/Representative Information						
This section is only required if Claimant 3 has a representative. *If not supplying Claimant 3 Representative information, default each field in this section* (Fields 51-63) *to its appropriate default value per the field type (zeroes or spaces)*. ***See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.***						
51	Claimant 3 (C3) Representative Indicator	1	951	951	Alpha-numeric	
52	C3 Representative Last Name	40	952	991	Alpha-betic	
53	C3 Representative First Name	30	992	1021	Alpha-betic	
54	C3 Representative Firm Name	70	1022	1091	Alpha-numeric	
55	C3 Representative TIN	9	1092	1100	Numeric	
56	C3 Representative Mailing Address Line 1	50	1101	1150	Alpha-numeric	

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
57	C3 Representative Mailing Address Line 2	50	1151	1200	Alpha-numeric	
58	C3 Representative City	30	1201	1230	Alpha-betic	
59	C3 Representative State	2	1231	1232	Alpha-betic	
60	C3 Representative Zip	5	1233	1237	Numeric	
61	C3 Representative Zip+4	4	1238	1241	Numeric	
62	C3 Representative Phone	10	1242	1251	Numeric	
63	C3 Representative Phone Extension	5	1252	1256	Alpha-numeric	
64	Reserved for Future Use	20	1257	1276	Alpha-numeric	Fill with spaces.
Claimant 4 Information						
If not supplying Claimant 4 information, default each field in this section (Fields 65-78) *to its appropriate default value per the field type (zeroes or spaces)*. ***See Claimant 2 Information section above for individual field specifications***.						
65	Claimant 4 Relationship	1	1277	1277	Alpha-numeric	
66	Claimant 4 TIN	9	1278	1286	Numeric	
67	Claimant 4 Last Name	40	1287	1326	Alpha-betic	
68	Claimant 4 First Name	30	1327	1356	Alpha-betic	
69	Claimant 4 Middle Initial	1	1357	1357	Alpha-betic	
70	Claimant 4 Entity/Organization Name	71	1287	1357	Alpha-numeric	

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
71	Claimant 4 Mailing Address Line 1	50	1358	1407	Alpha-numeric	
72	Claimant 4 Mailing Address Line 2	50	1408	1457	Alpha-numeric	
73	Claimant 4 City	30	1458	1487	Alpha-betic	
74	Claimant 4 State	2	1488	1489	Alpha-betic	
75	Claimant 4 Zip	5	1490	1494	Numeric	
76	Claimant 4 Zip+4	4	1495	1498	Numeric	
77	Claimant 4 Phone	10	1499	1508	Numeric	
78	Claimant 4 Phone Extension	5	1509	1513	Alpha-numeric	
79	Reserved for Future Use	20	1514	1533	Alpha-numeric	Fill with spaces.
Claimant 4 Attorney/Representative Information						
This section is only required if Claimant 4 has a representative. *If not supplying Claimant 4 Representative information, default each field in this section* (Fields 80-92) *to its appropriate default value per the field type (zeroes or spaces)*. ***See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.***						
80	Claimant 4 (C4) Representative Indicator	1	1534	1534	Alpha-betic	
81	C4 Representative Last Name	40	1535	1574	Alpha-betic	
82	C4 Representative First Name	30	1575	1604	Alpha-betic	
83	C4 Representative Firm Name	70	1605	1674	Alpha-numeric	
84	C4 Representative TIN	9	1675	1683	Numeric	
85	C4 Representative Mailing Address Line 1	50	1684	1733	Alpha-numeric	

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
86	C4 Representative Mailing Address Line 2	50	1734	1783	Alpha-numeric	
87	C4 Representative City	30	1784	1813	Alpha-betic	
88	C4 Representative State	2	1814	1815	Alpha-betic	
89	C4 Representative Zip	5	1816	1820	Numeric	
90	C4 Representative Zip+4	4	1821	1824	Numeric	
91	C4 Representative Phone	10	1825	1834	Numeric	
92	C4 Representative Phone Extension	5	1835	1839	Alpha-numeric	
Additional TPOC Fields						
93	TPOC Date 2	8	1840	1847	Numeric Date	Date of second (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). See Field 100 on the Claim Input Detail Record for format requirements. Use this field only to report on an ***additional*** **TPOC** settlement, judgment, award or other payment.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
94	TPOC Amount 2	11	1848	1858	Numeric	Second (additional) Total Payment Obligation to the Claimant (TPOC) amount: Dollar amount of the total payment obligation to the claimant for a settlement, judgment, award, or other payment in addition to/apart from the information which must be reported with respect to responsibility for ORM. See Field 101 on the Claim Input Detail Record for format requirements. Use this field only to report on an ***additional*** TPOC settlement, judgment, award or other payment.
95	Funding Delayed Beyond TPOC Start Date 2	8	1859	1866	Numeric Date	If funding for the Total Payment Obligation to Claimant 2 is delayed, provide actual or estimated date of funding. Format: CCYYMMDD Fill with zeroes if not applicable.
96	TPOC Date 3	8	1867	1874	Numeric Date	Date of third (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). See Field 100 on the Claim Input Detail Record. Use this field only to report on an ***additional*** TPOC settlement, judgment, award or other payment.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
97	TPOC Amount 3	11	1875	1885	Numeric	Third (additional) Total Payment Obligation to the Claimant (TPOC) amount See Field 101 on the Claim Input Detail Record for format requirements. Use this field only to report on an ***additional*** TPOC settlement, judgment, award or other payment.
98	Funding Delayed Beyond TPOC Start Date 3	8	1886	1893	Numeric Date	If funding for the Total Payment Obligation to Claimant 3 is delayed, provide actual or estimated date of funding. Format: CCYYMMDD Fill with zeroes if not applicable.
99	TPOC Date 4	8	1894	1901	Numeric Date	Date of fourth (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). See Field 100 on the Claim Input Detail Record. Use this field only to report on an ***additional*** TPOC settlement, judgment, award or other payment.
100	TPOC Amount 4	11	1902	1912	Numeric	Fourth (additional) Total Payment Obligation to the Claimant (TPOC) amount See Field 101 on the Claim Input Detail Record for format requirements. Use this field only to report on an ***additional*** TPOC settlement, judgment, award or other payment.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
101	Funding Delayed Beyond TPOC Start Date 4	8	1913	1920	Numeric Date	If funding for the Total Payment Obligation to Claimant 4 is delayed, provide actual or estimated date of funding. Format: CCYYMMDD Fill with zeroes if not applicable.
102	TPOC Date 5	8	1921	1928	Numeric Date	Date of fifth (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). See Field 100 on the Claim Input Detail Record. Use this field only to report on an ***additional*** TPOC settlement, judgment, award or other payment.
103	TPOC Amount 5	11	1929	1939	Numeric	Fifth (additional) Total Payment Obligation to the Claimant (TPOC) amount See Field 101 on the Claim Input Detail Record for format requirements. Use this field only to report on an ***additional*** TPOC settlement, judgment, award or other payment.
104	Funding Delayed Beyond TPOC Start Date 5	8	1940	1947	Numeric Date	If funding for the Total Payment Obligation to Claimant 5 is delayed, provide actual or estimated date of funding. Format: CCYYMMDD Fill with zeroes if not applicable.
105	Reserved for Future Use	273	1948	2220	Alpha-numeric	Fill with spaces.

Claim Input File Trailer Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Trailer Record – 2220 bytes						
Field No.	**Name**	**Len**	**Start Pos.**	**End Pos.**	**Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGCT' **Required.**
2	Section 111 RRE ID	9	5	13	Numeric	COBC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Pad with leading zeroes. Must match RRE ID supplied on corresponding file header record. **Required.**
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Must be 'NGHPCLM' **Required.**
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the COBC. Format: CCYYMMDD **Required.**
5	File Record Count	7	29	35	Numeric	Number of Detail and Auxiliary records contained within file (do not include header or trailer records in the count.) **Required.**
6	Reserved for Future Use	2185	36	2220	Alpha-numeric	Fill with spaces.

Appendix B - TIN Reference File Layout

MMSEA Section 111 Mandatory Reporting - Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation

TIN Reference File Layout – to be submitted with the Claim Input File

TIN Reference Header Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference File Header Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGTH' **Required.**
2	Section 111 RRE ID	9	5	13	Alpha-numeric	COBC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Pad with leading zeroes. **Required.**
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Must be 'NGHPTIN' **Required.**
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the COBC. Format: CCYYMMDD **Required.**
5	Reserved for Future Use	2192	29	2220	Alpha-numeric	Fill with spaces.

TIN Reference Detail Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation TIN Reference File Detail TIN/Office Code Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGTD' **Required.**
2	Section 111 RRE ID	9	5	13	Numeric	COBC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Pad with leading zeroes. **Required.**
3	TIN	9	14	22	Numeric	Federal Tax Identification Number of the insurer, applicable plan (s), workers' compensation law/plan (s), or self-insured entities reported in Field 72 of each Detail Claim Record. Used in conjunction with the Office Code/Site ID reported in Field 73 of the Detail Claim Record. Also known as the Employer Identification Number (EIN). Each TIN/Office Code combination reported in Fields 72 and 73 of the Detail Claim Records must have a corresponding record reported on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Office Code combination. **Required.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation TIN Reference File Detail TIN/Office Code Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
4	Office Code/Site ID	9	23	31	Alpha-Numeric	RRE-defined code to uniquely identify variations in insurer addresses/claim offices/Plan Contact Addresses as reported in Field 73 of each Detail Claim Record. Used in conjunction with the TIN reported in Field 72 of the Detail Claim record to uniquely specify different addresses associated with one TIN. ***If only one address will be used per reported TIN, leave blank.*** Each TIN/Office Code combination reported in Fields 72 and 73 of the Detail Claim Records must have a corresponding record reported on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Office Code combination. ***Required.***
5	TIN/Office Code Mailing Name	70	32	101	Alpha-numeric	Name associated with the RRE reflected by the unique TIN/Office Code combination. This name should reflect what should be used to address correspondence to the RRE related to the associated claim reports if necessary. **Required.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation TIN Reference File Detail TIN/Office Code Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
6	TIN/Office Code Mailing Address Line 1	50	102	151	Alpha-numeric	First line of the address associated with the unique TIN/Office Code combination reflected on this record. This mailing address should reflect where the RRE wishes to have all correspondence (including correspondence associated with recoveries, if applicable) directed for the TIN/Office Code combination. Must be a US address. **Required.**
7	TIN/Office Code Mailing Address Line 2	50	152	201	Alpha-numeric	Second line of the address associated with the unique TIN/Office Code combination reflected on this record. This mailing address should reflect where the RRE wishes to have the recoveries and other associated correspondence directed for the TIN/Office Code combination. Must be a US address.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation TIN Reference File Detail TIN/Office Code Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
8	TIN/Office Code City	30	202	231	Alpha-numeric	City of the address associated with the unique TIN/Office Code combination reflected on this record. This mailing address should reflect where the RRE wishes to have the recoveries and other associated correspondence directed for the TIN/Office Code combination. Must be a US city. **Required.**
9	TIN/Office Code State	2	232	233	Alpha-numeric	US Postal state abbreviation of the address associated with the unique TIN/Office Code combination reflected on this record. See www.usps.com/ncsc/lookups/abbreviations.html. Must be a US State Code. 'FC' will not be accepted. This mailing address should reflect where the RRE wishes to have the recoveries and other associated correspondence directed for the TIN/Office Code combination. **Required.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation TIN Reference File Detail TIN/Office Code Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
10	TIN/Office Code Zip	5	234	238	Numeric	5-digit Zip Code of the address associated with the unique TIN/Office Code combination reflected on this record. Must be a US Zip Code. **Required.**
11	TIN/Office Code Zip+4	4	239	242	Numeric	4-digit Zip+4 code of the address associated with the unique TIN/Office Code combination reflected on this record. If not applicable fill with zeroes (0000).
12	Reserved for Future Use	1978	243	2220	Alpha-numeric	Fill with spaces.

TIN Reference Trailer Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference File Trailer Record – 2220 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Date Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGTT' **Required.**
2	Section 111 RRE ID	9	5	13	Numeric	COBC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Pad with leading zeroes. Must match the RRE ID supplied on the corresponding header record. **Required.**
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Must be 'NGHPTIN' **Required.**
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the COBC. Format: CCYYMMDD **Required.**
5	File Record Count	7	29	35	Numeric	Number of records contained within this TIN Reference File (do not include header or trailer records in count.) **Required.**
6	Reserved for Future Use	2185	36	2220	Alpha-numeric	Fill with spaces.

Appendix C - Claim Response File Layout

Claim Response Header Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Header Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value of 'NGRH' COBC supplied.
2	Section 111 RRE ID	9	5	13	Numeric	COBC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Padded with leading zeroes. As supplied by RRE input record.
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Contains value of 'NGHPRSP' COBC supplied.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the RRE. Format: CCYYMMDD COBC supplied.
5	Reserved for Future Use	432	29	460	Alpha-numeric	Contains all spaces.

Claim Response Detail Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value of 'NGRD' COBC supplied.
2	Submitted DCN	15	5	19	Alpha-numeric	Document Control Number (DCN) submitted by RRE on input record. Used for matching input records with response records. As supplied by RRE on input record.
3	Submitted Action Type	1	20	20	Numeric	Action to be performed. As supplied by RRE on input record.
4	Injured Party HICN	12	21	32	Alpha-numeric	Health Insurance Claim Number (HICN) of Injured Party. As supplied by RRE on input record.
5	Submitted Injured Party SSN	9	33	41	Numeric	Social Security Number of Injured Party. As supplied by RRE on input record.
6	Submitted Injured Party Last Name	40	42	81	Alpha-betic	As supplied by RRE on input record.
7	Submitted Injured Party First Name	30	82	111	Alpha-betic	As supplied by RRE on input record.
8	Submitted Injured Party Middle Init	1	112	112	Alpha-betic	As supplied by RRE on input record.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
9	Submitted Injured Party Gender	1	113	113	Numeric	As supplied by RRE on input record.
10	Submitted Injured Party DOB	8	114	121	Numeric Date	As supplied by RRE on input record.
11	Submitted Plan TIN	9	122	130	Numeric	As supplied by RRE on input record.
12	Submitted Plan Office Code/Site ID	9	131	139	Alpha-numeric	As supplied by RRE on input record.
13	Submitted Policy Number	30	140	169	Alpha-numeric	As supplied by RRE on input record.
14	Submitted Claim Number	30	170	199	Alpha-numeric	As supplied by RRE on input record.
15	Reserved for Future Use	20	200	219	Alpha-numeric	Filled with spaces.
16	Applied Injured Party HICN	12	220	231	Alpha-numeric	Current Medicare Health Insurance Claim Number (HICN) of Injured Party if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
17	Reserved for Future Use	9	232	240	Alpha-numeric	Filled with spaces.
18	Applied Injured Party Last Name	40	241	280	Alpha-betic	Injured Party Last Name, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
19	Applied Injured Party First Name	30	281	310	Alpha-betic	Injured Party First Name, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
20	Applied Injured Party Middle Initial	1	311	311	Alpha-betic	Injured Party Middle Initial, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
21	Applied Injured Party Gender	1	312	312	Numeric	Sex of Injured Party, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. COBC supplied. 1 - Male 2 - Female
22	Applied Injured Party DOB	8	313	320	Numeric Date	Date of birth (DOB) of Injured Party, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. Format: CCYYMMDD COBC supplied.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
23	Applied MSP Effective Date	8	321	328	Numeric Date	Applied Medicare Secondary Payer (MSP) effective date. If injured party is identified as a Medicare beneficiary based upon the information submitted, and the submitted claim information reflects ORM, the start date of Medicare's secondary payment status for the incident, illness or injury. Will be the later of the beneficiary's Medicare coverage start date or the CMS Date of Incident (DOI). This is the effective date of the MSP occurrence posted to the internal Medicare systems which are used in Medicare claim payment determinations. Will contain all zeroes if not applicable. Format: CCYYMMDD COBC supplied.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
24	Applied MSP Termination Date	8	329	336	Numeric Date	Applied Medicare Secondary Payment (MSP) Termination Date. If injured party is a Medicare beneficiary based upon the information submitted, the date posted to internal Medicare systems for the termination of responsibility for ongoing medicals as reported by the RRE. Format: CCYYMMDD Will contain all zeroes if open-ended or not applicable. COBC supplied.
25	Applied MSP Type Indicator	1	337	337	Alpha-numeric	Applied Medicare Secondary Payer (MSP) Type. D = No-Fault E = Workers' Compensation L = Liability COBC supplied.
26	Reserved for Future Use	20	338	357	Alpha-numeric	Filled with spaces.
27	Applied Disposition Code	2	358	359	Alpha-numeric	2-digit code indicating how the record was processed. See Disposition Code Table for values. COBC supplied.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
The following Error Code fields indicate an error was found on the submitted claim record. The submitted claim record was **rejected and not processed**. The RRE must correct these errors and resubmit the record on the next quarterly file submission.						
28	Applied Error Code 1	5	360	364	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error. See Error Code Table for values. COBC supplied.
29	Applied Error Code 2	5	365	369	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 2 errors were found. See Error Code Table for values. COBC supplied.
30	Applied Error Code 3	5	370	374	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 3 errors were found. See Error Code Table for values. COBC supplied.
31	Applied Error Code 4	5	375	379	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 4 errors were found. See Error Code Table for values. COBC supplied.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
32	Applied Error Code 5	5	380	384	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 5 errors were found. See Error Code Table for values. COBC supplied.
33	Applied Error Code 6	5	385	389	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 6 errors were found. See Error Code Table for values. COBC supplied.
34	Applied Error Code 7	5	390	394	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 7 errors were found. See Error Code Table for values. COBC supplied.
35	Applied Error Code 8	5	395	399	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 8 errors were found. See Error Code Table for values. COBC supplied.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
36	Applied Error Code 9	5	400	404	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 9 errors were found. See Error Code Table for values. COBC supplied.
37	Applied Error Code 10	5	405	409	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 10 errors were found. See Error Code Table for values. COBC supplied.
The following Compliance Flag fields provide information on issues related to reporting requirement compliance. **Records will *not* be rejected for these issues.** The disposition code in Field 27 will indicate how the record was processed by the COBC. The RRE must review and correct compliance issues as applicable and resubmit the record as an update transaction on the next quarterly file submission.						
38	Applied Compliance Flag 1	2	410	411	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. See Compliance Flag Code Table for values. COBC supplied.
39	Applied Compliance Flag 2	2	412	413	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if at least 2 issues were found. See Compliance Flag Code Table for values. COBC supplied.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
40	Applied Compliance Flag 3	2	414	415	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if at least 3 issues were found. See Compliance Flag Code Table for values. COBC supplied.
41	Applied Compliance Flag 4	2	416	417	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if at least 4 issues were found. See Compliance Flag Code Table for values. COBC supplied.
42	Applied Compliance Flag 5	2	418	419	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if at least 5 issues were found. See Compliance Flag Code Table for values. COBC supplied.
43	Applied Compliance Flag 6	2	420	421	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if at least 6 issues were found. See Compliance Flag Code Table for values. COBC supplied.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
44	Applied Compliance Flag 7	2	422	423	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if at least 7 issues were found. See Compliance Flag Code Table for values. COBC supplied.
45	Applied Compliance Flag 8	2	424	425	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if at least 8 issues were found. See Compliance Flag Code Table for values. COBC supplied.
46	Applied Compliance Flag 9	2	426	427	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if at least 9 issues were found. See Compliance Flag Code Table for values. COBC supplied.
47	Applied Compliance Flag 10	2	428	429	Alpha-numeric	Alphanumeric code indicating compliance issue found with record. Populated if 10 issues were found. See Compliance Flag Code Table for values. COBC supplied.
48	Reserved for Future Use	31	430	460	Alpha-numeric	Filled with spaces.

Claim Response Trailer Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Trailer Record – 460 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value of 'NGRT' COBC supplied.
2	Section 111 RRE ID	9	5	13	Numeric	COBC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Padded with leading zeroes. As supplied by RRE input record.
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Contains value of 'NGHPRSP' COBC supplied.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the RRE. Format: CCYYMMDD COBC supplied.
5	File Record Count	7	29	35	Numeric	Number of detail response records contained within file (does not include header or trailer records). COBC supplied.
6	Reserved for Future Use	425	36	460	Alpha-numeric	Filled with spaces.

Appendix D – Query File Input and Response File Layouts

Section 111 Query Input File (ANSI X12 270/271 Entitlement Query HEW Flat File Input/Output Format)

Note: These file layouts are for use with the HIPAA Eligibility Wrapper (HEW) software supplied by the COBC to process the X12 270/271. They reflect the flat file input and output for the HEW software. If you choose to use your own ANSI X12 translator to create the ANSI X12 270 files for the Section 111 Query File and process the X12 271 response, you may download the Section 111 X12 270/271 companion guide with the necessary mapping information at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPInterfaceSpecVersion2.1.pdf or contact your EDI Representative for a copy.

Query Input Header Record

Section 111 Query Input File Header Record – 38 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Header Indicator	2	1-2	Must be: 'H0' Alphanumeric. **Required.**
2.	RRE ID	9	3-11	'000010001', '000010002', etc. RRE ID number assigned by COBC. Pad with leading zeroes. Numeric. **Required.**
3.	File Type	4	12-15	'NGHQ' – NGHP Query. Alphanumeric. **Required.**
4.	Cycle Date	8	16-23	File date (CCYYMMDD). Numeric Date. **Required.**
5.	Filler	15	24-38	Unused Field. Fill with spaces.

Query Input Detail Record

Section 111 Query Input File Detail Record – 38 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number. Alphanumeric. Optional.
2.	Last Name	6	13-18	First 6 characters of the surname of Individual/Injured Party. Alphabetic. Should be submitted as the first 6 characters of the last name appear on the individual's Social Security or Medicare Insurance card. **Required.**
3.	First Initial	1	19-19	First Initial of Individual/Injured Party. Alphabetic. Should be submitted as the first character of the first name appears on the individual's Social Security or Medicare Insurance card. **Required.**
4.	DOB	8	20-27	Individual's Date of Birth (CCYYMMDD). Numeric Date. **Required.**
5.	Sex Code	1	28-28	Individual's Gender: 0 = Unknown 1 = Male 2 = Female Numeric. **Required.**
6.	SSN	9	29-37	Social Security Number of the Individual/Injured Party. Numeric. **Required if HICN not provided.**
7.	Filler	1	38	Unused. Fill with spaces.

Query Input Trailer Record

Section 111 Query Input File Trailer Record – 38 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Trailer Indicator	2	1-2	Must be: 'T0' Alphanumeric. **Required.**
2.	RRE ID	9	3-11	'000010001', '000010002', etc. RRE ID number assigned by COBC. Numeric. Pad with leading zeroes. Must match RRE ID supplied on header record. **Required.**
3.	File Type	4	12-15	Must be 'NGHQ' – NGHP Query. Required.
4.	Cycle Date	8	16-23	File date (CCYYMMDD). Numeric Date. **Required.**
5.	Record Count	9	24-32	Number of individual query records in this file. Do not include the Header and Trailer Records in the Record Count. Numeric. **Required.**
6.	Filler	6	33-38	Unused Field. Fill with spaces.

Query Response Record

Note: The Query Only Response File does not have a header or trailer record.

Section 111 Query Response File Record – 116 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	HIC Number (HICN)	12	1-12	Medicare Health Insurance Claim Number. Medicare's unique identifier associated with the individual. Filled with spaces if the individual is not identified as a Medicare beneficiary based upon the information submitted. **COBC supplied.**
2.	Last Name	6	13-18	Surname of Individual/Injured Party. **Updated with Medicare information** if the individual is identified as a Medicare beneficiary based upon the information submitted.
3.	First Initial	1	19-19	First Initial of Individual/Injured Party. **Updated with Medicare information** if the individual is identified as a Medicare beneficiary based upon the information submitted.
4.	DOB	8	20-27	Individual's Date of Birth (CCYYMMDD). **Updated with Medicare information** if the individual is identified as a Medicare beneficiary based upon the information submitted.
5.	Sex Code	1	28-28	Covered Individual's Gender: 0 = Unknown 1 = Male 2 = Female **Updated with Medicare information** if the individual is identified as a Medicare beneficiary based upon the information submitted.

Section 111 Query Response File Record – 116 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
6.	SSN	9	29-37	Social Security Number of the individual **as submitted by the RRE** on the input record. Note: If both a HICN and an SSN were submitted on the input file and CMS matched on the HICN, CMS takes no action to validate the SSN.
7.	Filler	62	38-99	Future Use
8.	Disposition Code	2	100-101	01 = Individual was identified as a Medicare beneficiary based upon the information submitted. 51 = Individual was not identified as a Medicare beneficiary based upon the information submitted. COBC supplied.
9.	CMS Document Control Number	15	102-116	Unique ID assigned to response record for tracking by the COBC. COBC supplied.

Appendix E – Disposition, Error and Compliance Flag Codes

Response File Disposition Codes

Disposition Codes	Description
01	Record accepted by the COBC as an “Add”, “Delete” or “Update” record. For Claim Input records, RRE has indicated ongoing responsibility for medicals. For queries, the individual was identified as a Medicare beneficiary based upon the information submitted.
02	Record accepted by the COBC as an “Add”, “Delete” or “Update” record. For Claim records, RRE has indicated **no** ongoing responsibility for medicals.
03	Record accepted by the COBC. The injured party was identified as a Medicare beneficiary based upon the information submitted, but the beneficiary did not have Medicare coverage during the reported time period. For claims **with no** ongoing responsibility for medicals (no ORM), record does not need to be resubmitted unless subsequent TPOC payments must be reported. For claims **with** ongoing responsibility for medicals (ORM), RRE must continue to check the injured party’s Medicare status and report when he/she becomes a Medicare beneficiary until the ongoing responsibility ends. Monitoring of such individuals may cease before they become a Medicare beneficiary if the standard for ORM termination set forth in “Special Exception” of Section 11.8 regarding reporting termination of ORM is met.

Disposition Codes	Description
SP	Record not accepted by the COBC due to errors in the data reported. Record returned with at least one error code (specific edits and associated error codes are described below). ***Record must be corrected and resubmitted on the next quarterly file submission.*** Note: RREs will receive this disposition code if neither the HICN nor SSN is submitted on the input record. In this case the RRE must obtain a valid HICN or SSN and resubmit the record on the next file submission.
50	Record still being processed by CMS. Internal CMS use only. ***Record must be resubmitted on the next quarterly file submission.*** This disposition code will only be returned under rare circumstances. Records in the file that completed processing will be returned with an applicable disposition code.
51	Individual was not identified as a Medicare Beneficiary. For claims **with no** ongoing responsibility for medicals (no ORM), record does not need to be resubmitted if all information submitted was correct. For claims **with** ongoing responsibility for medicals (ORM), RRE must continue to check the injured party's Medicare status and report when he/she becomes a Medicare beneficiary until the ongoing responsibility ends. Monitoring of such individuals may cease before they become a Medicare beneficiary if the ORM is not subject to reopening or otherwise subject to an additional request for payment **or** if the standard for ORM termination set forth in "Special Exception" of Section 11.8 regarding reporting termination of ORM is met. For queries, the individual was **not** identified as a Medicare beneficiary based upon the information submitted.

Response File Compliance Flag Codes

Compliance Code	Description
01	Late Submission of TPOC. Record was not reported timely. Most recent TPOC Date submitted on an add record is more than 135 days older than the start date of the current file submission period.
02	An invalid RRE TIN [Federal Tax Identification Number of the "applicable plan," whether liability insurance (including self-insurance), no-fault insurance or a workers' compensation law or plan] was supplied in the Claim Input Detail Record. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. Refer to the disposition code for results. ***Claim and TIN Reference File records must be resubmitted with the correct RRE TIN in the next quarterly Claim Input File submission.***
03	Late Submission of ORM Termination Date. Record was not reported timely. ORM Termination Date on an add record is more than 135 days older than the start date of the current file submission period.

Response File Error Codes

Error Code	Field	DESCRIPTION
CB01	Detail or Auxiliary Record Identifier	Required. Must be equal to 'NGCD' (Claim Input File Detail Record) or 'NGCE' (Claim Input File Auxiliary Record). 'NGCE' must always follow an 'NGCD' record. If 'NGCE' record submitted, DCN/HICN/SSN/Injured Party First Name/Injured Party Last Name must match values on the 'NGCD' record.
CB02	DCN	Required. Field must contain value greater than spaces. Value on each detail record must be unique within the file submission.
CB03	Action Type	Required. Field must contain a numeric character. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record
CB04	Injured Party HICN	Field must contain spaces or alphanumeric characters. No dashes or hyphens allowed.
CB05	Injured Party SSN	Field must contain spaces or numeric values. No dashes or hyphens allowed.
CB06	Injured Party HICN/SSN	A valid Injured Party HICN or Injured Party SSN must be provided.
CB07	Injured Party Last Name	Required. First position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space. Submit as shown on Social Security or Medicare Card.
CB08	Injured Party First Name	Required. Must contain letters or spaces. Submit as shown on Social Security or Medicare Card.
CB09	Injured Party Middle Init	Optional. Field must contain an alphabetic character or space. No other characters allowed.
CB10	Injured Party Gender	Required. Field must contain a numeric character. Field cannot be spaces or alpha characters. Acceptable numeric characters include the following: 0 = Unknown 1 = Male 2 = Female
CB11	Injured Party DOB	Required. Field must be numeric and contain a valid date prior to the current date. Formatted as CCYYMMDD. Field cannot contain spaces, alpha characters or all zeroes.
CI01	CMS Date of Incident	Required. Field must be numeric and a valid date prior to or equal to the current date. Formatted as CCYYMMDD. Field cannot contain spaces, alpha characters or all zeroes.

Error Code	Field	DESCRIPTION
CI02	Industry Date of Incident	Optional. Edit bypassed if field equal to all zeroes. Field must be numeric and contain a valid date prior to or equal to the current date or equal to zeroes. Formatted as CCYYMMDD.
CI03	Alleged Cause of Injury	Required for Add and Update records (Action Type = 0 or 2) as of 01/01/2011. If field is equal to spaces prior to 01/01/2011 edit bypassed. First position must be 'E'. Field must contain a valid ICD-9-CM 'E' Code after 1/1/2011. May equal to spaces prior to 1/1/2011. Must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must **not** be on the list of "Insufficient Codes" in Appendix H. Must not include decimal point.
CI04	State of Venue	Required. Must be a valid US Postal state abbreviation (www.usps.com/ncsc/lookups/abbreviations.html), a value of 'US', or a value of 'FC'.
CI05	ICD-9 Diagnosis Code 1	Required for Add and Update records (Action Type = 0 or 2) as of 01/01/2011. May equal spaces prior to 1/1/2011. If field is equal to spaces prior to 01/01/2011 edit bypassed. Must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI06	ICD-9 Diagnosis Code 2	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI07	ICD-9 Diagnosis Code 3	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI08	ICD-9 Diagnosis Code 4	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI09	ICD-9 Diagnosis Code 5	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.

Error Code	Field	DESCRIPTION
CI10	ICD-9 Diagnosis Code 6	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI11	ICD-9 Diagnosis Code 7	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI12	ICD-9 Diagnosis Code 8	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI13	ICD-9 Diagnosis Code 9	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI14	ICD-9 Diagnosis Code 10	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI15	ICD-9 Diagnosis Code 11	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI16	ICD-9 Diagnosis Code 12	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI17	ICD-9 Diagnosis Code 13	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI18	ICD-9 Diagnosis Code 14	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.

Error Code	Field	DESCRIPTION
CI19	ICD-9 Diagnosis Code 15	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI20	ICD-9 Diagnosis Code 16	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI21	ICD-9 Diagnosis Code 17	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI22	ICD-9 Diagnosis Code 18	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI23	ICD-9 Diagnosis Code 19	Optional. Must contain spaces or must match a value in the first 5 bytes of a record on the current list of valid ICD-9 diagnosis codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. Must not include decimal point.
CI24	Description of Illness/Injury	Required on Add and Update records (Action Type = 0 or 2) if ICD-9-CM Diagnosis Code 1 and Alleged Cause of Injury not both provided and prior to 01/01/2011. If required must contain alphanumeric characters and not equal to spaces.
CI25	ICD-9 Diagnosis and Alleged Cause of Injury	Prior to 01/01/2011, at least a valid ICD-9 Diagnosis Code 1 and a valid Alleged Cause of Injury must be provided or Description of Illness/Injury must be provided. After 12/31/2010, both a valid ICD-9 Diagnosis Code 1 and a valid Alleged Cause of Injury must be provided.
CI26	Product Liability Indicator	Required. Field must contain numeric character. Field cannot be spaces or alpha characters. Acceptable numeric characters include the following: 1 = No 2 = Yes, not a mass tort situation 3 = Yes, mass tort situation
CI27	Product Generic Name	Required on Add and Update records (Action Type = 0 or 2) if Product Liability Indicator equal to 3 and prior to 01/01/2011. Required if Product Liability Indicator equal to 2 or 3 and after 12/31/2010. If required must contain alphanumeric characters and not equal to all spaces.

Error Code	Field	DESCRIPTION
CI28	Product Brand Name	Required on Add and Update records (Action Type = 0 or 2) if Product Liability Indicator equal to 3 and prior to 01/01/2011. Required if Product Liability Indicator equal to 2 or 3 and after 12/31/2010. If required must contain alphanumeric characters and not equal to all spaces.
CI29	Product Manufacturer	Required on Add and Update records (Action Type = 0 or 2) if Product Liability Indicator equal to 3 and prior to 01/01/2011. Required if Product Liability Indicator equal to 2 or 3 and after 12/31/2010. If required must contain alphanumeric characters and not equal to all spaces.
CI30	Product Alleged Harm	Required on Add and Update records (Action Type = 0 or 2) if Product Liability Indicator equal to 3 and prior to 01/01/2011. Required if Product Liability Indicator equal to 2 or 3 and after 12/31/2010. If required must contain alphanumeric characters and not equal to all spaces.
C131	Sufficient ICD-9 Diagnosis Required	If both a valid Alleged Cause of Injury and valid ICD-9 Diagnosis Code 1 provided and the record is an Add or Update (Action Type 0 or 2), at least one valid diagnosis code (ICD-9 Diagnosis Code 1-19) submitted on the record must NOT be on the list of “Insufficient ICD-9 Diagnosis Codes” found in Appendix H AND NOT an ‘E’ code AND NOT a ‘V’ code. “Insufficient” codes will be accepted as long as one numeric diagnosis code NOT on this list is provided.
CS01	Self Insured Indicator	Required if Plan Insurance Type equal to ‘E’ or ‘L’. If required, value must be equal to ‘Y’ or ‘N’. If not required must equal space.
CS02	Self Insured Type	Required if Self Insured Indicator equal to ‘Y’. If required, value must equal to ‘’I or ‘O’. If not required must equal space.
CS03	Policyholder Last Name	Required when Self Insured Type equal to ‘I’. If required, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space. Field must be equal to spaces if Self Insured type not equal to ‘I’
CS04	Policyholder First Name	Required when Self Insured Type equal to ‘I’. If required must contain letters or spaces. Field must be equal to spaces if Self Insured Type is not equal to ‘I’.
CS05	DBA Name	Field must be equal to spaces if Self Insured Type is equal to ‘I’. If greater than spaces, field must contain at least 2 alphanumeric characters.

Error Code	Field	DESCRIPTION
CS06	Legal Name	Field must be equal to spaces if Self Insured Type is equal to 'I'. If greater than spaces, field must contain at least 2 alphanumeric characters.
CS07	DBA/Legal Name	DBA or Legal name must be provided if Self Insured Type is equal to 'O'.
CP01	Plan Insurance Type	Required. Must contain one of the following alpha characters: 'D' = No-Fault 'E' = Workers' Compensation 'L' = Liability
CP02	TIN	Required. Must contain a valid 9-digit IRS-assigned Federal Tax Identification Number. A corresponding TIN record must have been submitted on the TIN Reference File. Must be numeric. Include leading zeroes. Do not include hyphens.
CP03	Office Code/Site ID	Optional. Must be equal to spaces or must contain a 9-digit numeric code. Must have a corresponding entry with associated TIN on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Office Code combination.
CP04	Policy Number	Required. Must be at least 3 characters in length. Acceptable characters (alpha, numeric, space, comma, & - ' . @ # / ; or :). Cannot be equal to all spaces.
CP05	Claim Number	Required. Must contain alphanumeric values and cannot be equal to spaces.
CP06	Plan Contact Department Name	Optional. Field may contain alphanumeric characters. If field is not used, field must contain spaces.
CP07	Plan Contact Last Name	Optional. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CP08	Plan Contact First Name	Optional. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
CP09	Plan Contact Phone	Optional. Must contain 10-digit numeric value or zeroes if not provided.
CP10	Plan Contact Phone Extension	Optional. Must contain numeric value or all spaces if not provided.
CP11	No-Fault Insurance Limit	Must contain a numeric value or all zeroes. If Plan Insurance Type is equal to 'D', a value greater than zeroes must be provided. Fill with all 9's if there is no dollar limit. Fill with zeroes if Plan Insurance Type is 'E' or 'L'.
CP12	Exhaust Date for No-Fault Insurance Limit	Must contain zeroes or a valid date. If Plan Insurance Type is equal to an 'E' or 'L', must contain zeroes.

Error Code	Field	DESCRIPTION
CP13	TIN/Office Code Mailing Name	Required. Field must contain at least 2 alphanumeric characters. If the Insurer's plan name is equal to SUPPLEMENT, SUPPLEMENTAL, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, MISC, NO, BC, BX, BS, BCBX, BLUE CROSS, BLUE SHIELD, or MEDICARE the CP13 error will be applied. Extracted from TIN Reference file.
CP14	TIN/Office Code Mailing Address Line 1	Required. Field must contain alphanumeric characters. Field cannot be blank or equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . Extracted from TIN Reference file.
CP15	TIN/Office Code Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . Extracted from TIN Reference file.
CP16	TIN/Office Code City	Required. Embedded spaces are allowed for multi-word city name. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . Extracted from TIN Reference file.
CP17	TIN/Office Code State	Required. Field must contain US Postal Abbreviation Code. See www.usps.com/ncsc/lookups/abbreviations.html. Extracted from TIN Reference file.
CP18	TIN/Office Code Zip	Required. Field must contain a valid 5-digit numeric US Zip Code. Extracted from TIN Reference file.
CP19	TIN/Office Code Zip+4	Field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. Extracted from TIN Reference file.
CR01	Injured Party Representative Indicator	Must be an alpha value of: 'A' – Attorney 'G' – Guardian 'P' – Power of Attorney 'O' – Other Space – None
CR02	Representative Last Name	If Representative Indicator equal to space, field must be equal to spaces. Required if Representative Indicator is not a space. First position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR03	Representative First Name	If Representative Indicator equal to space, field must be equal to spaces. Required if Representative Indicator is not a space. First position must be an alphabetic character. Other positions must contain letters or spaces.
CR04	Representative Firm Name	If Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . Field must contain at least 2 alphanumeric characters.

Error Code	Field	DESCRIPTION
CR05	Representative TIN	If Representative Indicator is not equal to space, field must contain numeric characters. If Representative Indicator equal to spaces, field must be equal to zeroes.
CR06	Representative Mailing Address Line 1	Required if Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Representative Indicator is equal to spaces, field must be equal to spaces. If Representative State = 'FC', field must be equal to all spaces.
CR07	Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR08	Representative City	Required if Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Representative State = 'FC', field must be equal to all spaces
CR09	Representative State	If Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Representative Indicator equal to spaces, field must be equal to spaces.
CR10	Representative Mail Zip Code	If Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR11	Representative Mail Zip+4	If Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR12	Representative Phone	If Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Representative Indicator equal to spaces, field must be equal to zeroes. If Representative State = 'FC', field must be equal to all zeroes.
CR13	Representative Phone Extension	If Representative Indicator is not equal to spaces, field must contain 4-digit numeric value or spaces. If Representative Indicator equal to spaces, field must be equal to spaces.
CJ01	ORM Indicator	Required. Must contain a value of 'Y' or 'N'.
CJ02	ORM Termination Date	Must contain a valid date or zeroes. Must be all zeroes if ORM Indicator = 'N'. Future dates are allowed.

Error Code	Field	DESCRIPTION
CJ03	TPOC Date 1	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date).
CJ04	TPOC Amount 1	Must contain a numeric value or zeroes.
CJ05	Funding Delayed Beyond TPOC Start Date 1	Must contain a valid date or zeroes.
CJ06	DOI/ORM Termination Date	ORM Termination Date must be at least 30 days after the CMS Date of Incident.
CJ07	TPOC Threshold	Total of TPOC Amounts reported on Add record (Action Type = 0) with ORM Indicator = 'N' does not exceed interim reporting threshold.
CC01	Claimant 1 Relationship	Must be an alpha value of: E – Estate, Individual Name F – Family, Individual Name O – Other, Individual Name X – Estate, Entity Name Y – Family, Entity Name Z – Other, Entity Name Space – Not Applicable.
CC02	Claimant 1 TIN	If Claimant 1 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. Must not match Injured Party SSN or other Claimant SSNs.
CC03	Claimant 1 Last Name	If Claimant 1 Relationship equal to space, field must be equal to spaces. If Claimant 1 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC04	Claimant 1 First Name	If Claimant 1 Relationship equal to space, field must be equal to spaces. . If Claimant 1 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC05	Claimant 1 Middle Initial	Field must be equal to space or an alpha character. If Claimant 1 Relationship equal to space, field must be equal to space.
CC06	Claimant 1 Mailing Address Line 1	Required if Claimant 1 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 1 Relationship is equal to spaces, field must be equal to spaces. If Claimant 1 State = 'FC', field must be equal to all spaces
CC07	Claimant 1 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.

Error Code	Field	DESCRIPTION
CC08	Claimant 1 City	Required if Claimant 1 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 1 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 1 State = 'FC', field must be equal to all spaces
CC09	Claimant 1 State	If Claimant 1 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 1 Relationship equal to spaces, field must be equal to spaces.
CC10	Claimant 1 Zip	If Claimant 1 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC11	Claimant 1 Zip+4	If Claimant 1 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC12	Claimant 1 Phone	If Claimant 1 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 1 Relationship equal to spaces, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC13	Claimant 1 Phone Extension	If Claimant 1 Relationship is not equal to spaces, field must contain 4-digit numeric value or zeroes. If Claimant 1 Relationship equal to spaces, field must be equal to spaces.
CC14	Claimant 1 Entity/Organization Name	If Claimant 1 Relationship equal to space, field must contain spaces. If Claimant 1 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CC21	Claimant 2 Relationship	Must be an alpha value of: E – Estate, Individual Name F – Family, Individual Name O – Other, Individual Name X – Estate, Entity Name Y – Family, Entity Name Z – Other, Entity Name Space – Not Applicable.
CC22	Claimant 2 TIN	If Claimant 2 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. Must not match Injured Party SSN or other Claimant SSNs.

Error Code	Field	DESCRIPTION
CC23	Claimant 2 Last Name	If Claimant 2 Relationship equal to space, field must be equal to spaces. If Claimant 2 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC24	Claimant 2 First Name	If Claimant 2 Relationship equal to space, field must be equal to spaces. . If Claimant 2 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC25	Claimant 2 Middle Initial	Field must be equal to space or an alpha character. If Claimant 2 Relationship equal to space, field must be equal to space.
CC26	Claimant 2 Mailing Address Line 1	Required if Claimant 2 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 2 Relationship is equal to spaces, field must be equal to spaces. If Claimant 2 State = 'FC', field must be equal to all spaces
CC27	Claimant 2 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC28	Claimant 2 City	Required if Claimant 2 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 2 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 2 State = 'FC', field must be equal to all spaces
CC29	Claimant 2 State	If Claimant 2 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 2 Relationship equal to spaces, field must be equal to spaces.
CC30	Claimant 2 Zip	If Claimant 2 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC31	Claimant 2 Zip+4	If Claimant 2 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC32	Claimant 2 Phone	If Claimant 2 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 2 Relationship equal to spaces, field must be equal to zeroes. If Claimant 2 State = 'FC', field must be equal to all zeroes.

Error Code	Field	DESCRIPTION
CC33	Claimant 2 Phone Extension	If Claimant 2 Relationship is not equal to spaces, field must contain 4-digit numeric value or zeroes. If Claimant 2 Relationship equal to spaces, field must be equal to spaces.
CC34	Claimant 2 Entity/Organization Name	If Claimant 2 Relationship equal to space, field must contain spaces. If Claimant 2 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CC41	Claimant 3 Relationship	Must be an alpha value of: E – Estate, Individual Name F – Family, Individual Name O – Other, Individual Name X – Estate, Entity Name Y – Family, Entity Name Z – Other, Entity Name Space – Not Applicable.
CC42	Claimant 3 TIN	If Claimant 3 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. Must not match Injured Party SSN or other Claimant SSNs.
CC43	Claimant 3 Last Name	If Claimant 3 Relationship equal to space, field must be equal to spaces. If Claimant 3 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC44	Claimant 3 First Name	If Claimant 3 Relationship equal to space, field must be equal to spaces. . If Claimant 3 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC45	Claimant 3 Middle Initial	Field must be equal to space or an alpha character. If Claimant 3 Relationship equal to space, field must be equal to space.
CC46	Claimant 3 Mailing Address Line 1	Required if Claimant 3 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 3 Relationship is equal to spaces, field must be equal to spaces. If Claimant 3 State = 'FC', field must be equal to all spaces
CC47	Claimant 3 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.

Error Code	Field	DESCRIPTION
CC48	Claimant 3 City	Required if Claimant 3 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 3 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 3 State = 'FC', field must be equal to all spaces
CC49	Claimant 3 State	If Claimant 3 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 3 Relationship equal to spaces, field must be equal to spaces.
CC50	Claimant 3 Zip	If Claimant 3 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC51	Claimant 3 Zip+4	If Claimant 3 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC52	Claimant 3 Phone	If Claimant 3 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 3 Relationship equal to spaces, field must be equal to zeroes. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC53	Claimant 3 Phone Extension	If Claimant 3 Relationship is not equal to spaces, field must contain 4-digit numeric value or zeroes. If Claimant 3 Relationship equal to spaces, field must be equal to spaces.
CC54	Claimant 3 Entity/Organization Name	If Claimant 3 Relationship equal to space, field must contain spaces. If Claimant 3 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CC61	Claimant 4 Relationship	Must be an alpha value of: E – Estate, Individual Name F – Family, Individual Name O – Other, Individual Name X – Estate, Entity Name Y – Family, Entity Name Z – Other, Entity Name Space – Not Applicable.
CC62	Claimant 4 TIN	If Claimant 4 Relationship is not equal to spaces, field must contain a non-zero 9-digit numeric value. Must not match Injured Party SSN or other Claimant SSNs.

Error Code	Field	DESCRIPTION
CC63	Claimant 4 Last Name	If Claimant 4 Relationship equal to space, field must be equal to spaces. If Claimant 4 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CC64	Claimant 4 First Name	If Claimant 4 Relationship equal to space, field must be equal to spaces. . If Claimant 4 Relationship = 'E', 'F' or 'O', first position must be an alphabetic character. Other positions must contain letters or spaces.
CC65	Claimant 4 Middle Initial	Field must be equal to space or an alpha character. If Claimant 4 Relationship equal to space, field must be equal to space.
CC66	Claimant 4 Mailing Address Line 1	Required if Claimant 4 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 4 Relationship is equal to spaces, field must be equal to spaces. If Claimant 4 State = 'FC', field must be equal to all spaces
CC67	Claimant 4 Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CC68	Claimant 4 City	Required if Claimant 4 Relationship is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 4 Relationship is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If Claimant 4 State = 'FC', field must be equal to all spaces
CC69	Claimant 4 State	If Claimant 4 Relationship is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 4 Relationship equal to spaces, field must be equal to spaces.
CC70	Claimant 4 Zip	If Claimant 4 Relationship is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC71	Claimant 4 Zip+4	If Claimant 4 Relationship is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC72	Claimant 4 Phone	If Claimant 4 Relationship is not equal to spaces, field must contain a non-zero 10-digit numeric value. If Claimant 4 Relationship equal to spaces, field must be equal to zeroes. If Claimant 4 State = 'FC', field must be equal to all zeroes.

Error Code	Field	DESCRIPTION
CC73	Claimant 4 Phone Extension	If Claimant 3 Relationship is not equal to spaces, field must contain 4-digit numeric value or zeroes. If Claimant 4 Relationship equal to spaces, field must be equal to spaces.
CC74	Claimant 4 Entity/Organization Name	If Claimant 4 Relationship equal to space, field must contain spaces. If Claimant 4 Relationship = 'X', 'Y', or 'Z', field must contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . and field must contain at least 2 non-space alphanumeric characters.
CR21	Claimant 1 Representative Indicator	Must be an alpha value of: 'A' – Attorney 'G' – Guardian 'P' – Power of Attorney 'O' – Other Space – None
CR22	Claimant 1 Representative Last Name	If C1 Representative Indicator equal to space, field must be equal to spaces. Required if C1 Representative Indicator is not a space. First position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR23	Claimant 1 Representative First Name	If C1 Representative Indicator equal to space, field must be equal to spaces. Required if C1 Representative Indicator is not a space. First position must be an alphabetic character. Other positions must contain letters or spaces.
CR24	Claimant 1 Representative Firm Name	If C1 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . Field must contain at least 2 alphanumeric characters.
CR25	Claimant 1 Representative TIN	If C1 Representative Indicator is not equal to space, field must contain numeric characters. If C1 Representative Indicator equal to spaces, field must be equal to zeroes.
CR26	Claimant 1 Representative Mailing Address 1	Required if C1 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C1 Representative Indicator is equal to spaces, field must be equal to spaces. If C1 Representative State = 'FC', field must be equal to all spaces.
CR27	Claimant 1 Representative Mailing Address 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.

Error Code	Field	DESCRIPTION
CR28	Claimant 1 Representative Mailing City	Required if C1 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C1 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C1 Representative State = 'FC', field must be equal to all spaces
CR29	Claimant 1 Representative State	If C1 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C1 Representative Indicator equal to spaces, field must be equal to spaces.
CR30	Claimant 1 Representative Zip	If C1 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR31	Claimant 1 Representative Zip+4	If C1 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR32	Claimant 1 Representative Phone	If C1 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C1 Representative Indicator equal to spaces, field must be equal to zeroes. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR33	Claimant 1 Representative Phone Extension	If C1 Representative Indicator is not equal to spaces, field must contain 4-digit numeric value or spaces. If C1 Representative Indicator equal to spaces, field must be equal to spaces.
CR41	Claimant 2 Representative Indicator	Must be an alpha value of: 'A' – Attorney 'G' – Guardian 'P' – Power of Attorney 'O' – Other Space – None
CR42	Claimant 2 Representative Last Name	If C2 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR43	Claimant 2 Representative First Name	If C2 Representative Indicator equal to space, field must be equal to spaces. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.

Error Code	Field	DESCRIPTION
CR44	Claimant 2 Representative Firm Name	If C2 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . Field must contain at least 2 alphanumeric characters.
CR45	Claimant 2 Representative TIN	If C2 Representative Indicator is not equal to space, field must contain numeric characters. If C2 Representative Indicator equal to spaces, field must be equal to zeroes.
CR46	Claimant 2 Representative Mailing Address Line 1	Required if C2 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C2 Representative Indicator is equal to spaces, field must be equal to spaces. If C2 Representative State = 'FC', field must be equal to all spaces.
CR47	Claimant 2 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR48	Claimant 2 Representative City	Required if C2 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C2 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C2 Representative State = 'FC', field must be equal to all spaces
CR49	Claimant 2 Representative State	If C2 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C2 Representative Indicator equal to spaces, field must be equal to spaces.
CR50	Claimant 2 Representative Zip	If C2 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.
CR51	Claimant 2 Representative Zip+4	If C2 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.
CR52	Claimant 2 Representative Phone	If C2 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C2 Representative Indicator equal to spaces, field must be equal to zeroes. If C2 Representative State = 'FC', field must be equal to all zeroes.

Error Code	Field	DESCRIPTION
CR53	Claimant 2 Representative Phone Extension	If C2 Representative Indicator is not equal to spaces, field must contain 4-digit numeric value or spaces. If C2 Representative Indicator equal to spaces, field must be equal to spaces.
CR54	Claimant 2 Representative Name/Firm Name	Either C2 Representative Last Name *and* C2 Representative First Name – or – C2 Representative Firm Name is required if C2 Representative Indicator is not equal to spaces.
CR61	Claimant 3 Representative Indicator	Must be an alpha value of: 'A' – Attorney 'G' – Guardian 'P' – Power of Attorney 'O' – Other Space – None
CR62	Claimant 3 Representative Last Name	If C3 Representative Indicator equal to space, field must be equal to spaces. Required if C3 Representative Indicator is not a space. First position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR63	Claimant 3 Representative First Name	If C3 Representative Indicator equal to space, field must be equal to spaces. Required if C3 Representative Indicator is not a space. First position must be an alphabetic character. Other positions must contain letters or spaces.
CR64	Claimant 3 Representative Firm Name	If C3 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . Field must contain at least 2 alphanumeric characters.
CR65	Claimant 3 Representative TIN	If C3 Representative Indicator is not equal to space, field must contain numeric characters. If C3 Representative Indicator equal to spaces, field must be equal to zeroes.
CR66	Claimant 3 Representative Mailing Address Line 1	Required if C3 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C3 Representative Indicator is equal to spaces, field must be equal to spaces. If C3 Representative State = 'FC', field must be equal to all spaces.
CR67	Claimant 3 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.

Error Code	Field	DESCRIPTION
CR68	Claimant 3 Representative City	Required if C3 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C3 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C3 Representative State = 'FC', field must be equal to all spaces
CR69	Claimant 3 Representative State	If C3 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C3 Representative Indicator equal to spaces, field must be equal to spaces.
CR70	Claimant 3 Representative Zip	If C3 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR71	Claimant 3 Representative Zip+4	If C3 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR72	Claimant 3 Representative Phone	If C3 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C3 Representative Indicator equal to spaces, field must be equal to zeroes. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR73	Claimant 3 Representative Phone Extension	If C3 Representative Indicator is not equal to spaces, field must contain 4-digit numeric value or spaces. If C3 Representative Indicator equal to spaces, field must be equal to spaces.
CR81	Claimant 4 Representative Indicator	Must be an alpha value of: 'A' – Attorney 'G' – Guardian 'P' – Power of Attorney 'O' – Other Space – None
CR82	Claimant 4 Representative Last Name	If C4 Representative Indicator equal to space, field must be equal to spaces. Required if C4 Representative Indicator is not a space. First position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.
CR83	Claimant 4 Representative First Name	If C4 Representative Indicator equal to space, field must be equal to spaces. Required if C4 Representative Indicator is not a space. First position must be an alphabetic character. Other positions must contain letters or spaces.

Error Code	Field	DESCRIPTION
CR84	Claimant 4 Representative Firm Name	If C4 Representative Indicator equal to space, field must contain spaces. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . Field must contain at least 2 alphanumeric characters.
CR85	Claimant 4 Representative TIN	If C4 Representative Indicator is not equal to space, field must contain numeric characters. If C4 Representative Indicator equal to spaces, field must be equal to zeroes.
CR86	Claimant 4 Representative Mailing Address Line 1	Required if C4 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C4 Representative Indicator is equal to spaces, field must be equal to spaces. If C4 Representative State = 'FC', field must be equal to all spaces.
CR87	Claimant 4 Representative Mailing Address Line 2	Optional. If field greater than spaces, field must contain at least 2 alphanumeric characters.
CR88	Claimant 4 Representative City	Required if C4 Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C4 Representative Indicator is equal to spaces, field must be equal to spaces. Embedded spaces are allowed for multi-word city name. If C4 Representative State = 'FC', field must be equal to all spaces
CR89	Claimant 4 Representative State	If C4 Representative Indicator is not equal to spaces, field must contain US Postal Abbreviation Code or 'FC'. If C4 Representative Indicator equal to spaces, field must be equal to spaces.
CR90	Claimant 4 Representative Zip	If C4 Representative Indicator is not equal to spaces, field must contain a valid 5-digit numeric US Zip Code. If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR91	Claimant 4 Representative Zip+4	If C4 Representative Indicator is not equal to spaces, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR92	Claimant 4 Representative Phone	If C4 Representative Indicator is not equal to spaces, field must contain a non-zero 10-digit numeric value. If C4 Representative Indicator equal to spaces, field must be equal to zeroes. If C4 Representative State = 'FC', field must be equal to all zeroes.

Error Code	Field	DESCRIPTION
CR93	Claimant 4 Representative Phone Extension	If C4 Representative Indicator is not equal to spaces, field must contain 4-digit numeric value or spaces. If C4 Representative Indicator equal to spaces, field must be equal to spaces.
CT01	TPOC Date 2	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date).
CT02	TPOC Amount 2	Must contain a numeric value or zeroes.
CT03	Funding Delayed Beyond TPOC Start Date 2	Must contain a valid date or zeroes.
CT11	TPOC Date 3	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date).
CT12	TPOC Amount 3	Must contain a numeric value or zeroes.
CT13	Funding Delayed Beyond TPOC Start Date 3	Must contain a valid date or zeroes.
CT21	TPOC Date 4	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date).
CT22	TPOC Amount 4	Must contain a numeric value or zeroes.
CT23	Funding Delayed Beyond TPOC Start Date 4	Must contain a valid date or zeroes.
CT31	TPOC Date 5	Must contain a valid date or zeroes. Date must be equal to or prior to current date (COBC processing date).
CT32	TPOC Amount 5	Must contain a numeric value or zeroes.
CT33	Funding Delayed Beyond TPOC Start Date 5	Must contain a valid date or zeroes.

Appendix F – MMSEA Section 111 Statutory Language

The Medicare Secondary Payor Mandatory Reporting Provisions
Of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007
(See 42 U.S.C. 1395y(b)(7)&(b)(8))

SECTION 111 – MEDICARE SECONDARY PAYOR

(a) In General - Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraphs:

(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS-

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall--

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) ENFORCEMENT-

(i) IN GENERAL- An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

(C) SHARING OF INFORMATION- Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS-

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall--

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) REQUIRED INFORMATION- The information described in this subparagraph is--

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) TIMING- Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) CLAIMANT- For purposes of subparagraph (A), the term 'claimant' includes--

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) ENFORCEMENT-

(i) IN GENERAL- An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section

1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) APPLICABLE PLAN- In this paragraph, 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.

(G) SHARING OF INFORMATION- The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(b) Rule of Construction- Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.

(c) Implementation- For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate, of $35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.

Appendix G – MMSEA Section 111 Definitions and Reporting Responsibilities

Attachment A – Definitions and Reporting Responsibilities

(Attachment A to the Supporting Statement for the MMSEA Section 111 Paperwork Reduction Act (PRA) Federal Register (FR) Notice published February 13, 2009.)

SUPPORTING DOCUMENT FOR PRA PACKAGE FOR MEDICARE SECONDARY PAYER REPORTING RESPONSIBILITIES FOR SECTION 111 OF THE MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

Note: The second paragraph under Liability Self-Insurance was revised subsequent to the initial publication of this Attachment on August 1, 2008.

DEFINITIONS AND REPORTING RESPONSIBILITIES

GROUP HEALTH PLAN (GHP) ARRANGEMENTS (42 U.S.C. 1395y(b)(7)) --

INSURER
For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), an insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. In instances where an insurer does not process GHP claims but has a third party administrator (TPA) that does, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

THIRD PARTY ADMINISTRATOR (TPA)
For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), a TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of GHPs (as defined at 42 U.S.C. 1395y(b)(1)(A)(v)), the plan sponsor(s) or the plan insurer. A TPA may perform these services for, amongst other entities, self-insured employers, unions, associations, and insurers/underwriters of such GHPs. If a GHP is self-funded and self-administered for certain purposes but also has a TPA as defined in this paragraph, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(7):
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7), agents may submit reports on behalf of :

- Insurers for GHPs
- TPAs for GHPs
- Employers with self-insured and self-administered GHPs

Accountability for submitting the reports in the manner and form stipulated by the Secretary and the accuracy of the submitted information continues to rest with each of the above-named entities.

The CMS will provide information on the format and method of identifying agents for reporting purposes.

LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION (42 U.S.C. 1395y(b)(8)) **--**

INSURER
For purposes of the reporting requirements for 42 U.S.C. 1395y**(**b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8) regardless of whether it uses another entity for claim processing.

CLAIMANT:
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), "claimant" includes: 1) an individual filing a claim directly against the applicable plan, 2) an individual filing a claim against an individual or entity insured or covered by the applicable plan, or 3) an individual whose illness, injury, incident, or accident is/was at issue in "1)" or "2)".

APPLICABLE PLAN:
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the "applicable plan" as defined in subsection (8)((F) has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). For workers' compensation information this would be the Federal agency, the State agency, or self-insured employer or the employer's insurer.

NO-FAULT INSURANCE:
Trade associations for liability insurance, no-fault insurance and workers' compensation have indicated that the industry's definition of no-fault insurance is narrower than CMS' definition. For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the definition of no-fault insurance found at 42 C.F.R. 411.50 is controlling.

LIABILITY SELF-INSURANCE:
42 U.S.C. 1395y(b)(2)(A) provides that an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no-fault insurance, or workers' compensation law or plan) for a business, trade or profession. See also 42 C.F.R. 411.50.

Special Considerations where liability self-insurance which is a deductible or co-payment for liability insurance, no-fault insurance, or workers' compensation is

paid to the insurer or workers' compensation entity for distribution (rather than directly to the claimant): As indicated in the definition of "liability self-insurance," such deductibles and co-payments constitute liability self-insurance, and require reporting by the self-insured entities. However, in order to avoid two entities reporting where the deductibles and/or co-payments are physically being paid by the insurance company or workers' compensation rather than the self-insured entity, CMS has determined that the liability insurance company, no-fault insurance company, or workers' compensation, as appropriate, must include the self-insurance deductible or co-pay in the amount it reports. Note that this rule only applies where the self-insurance deductible or co-pay is paid to the insurer for distribution rather than directly to the claimant

WORKERS' COMPENSATION LAW OR PLAN

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), 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. Where such a plan is directly funded by the employer, the employer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). Where such a plan is indirectly funded by the employer, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(8):

Agents may submit reports on behalf of:

- Insurers for no-fault or liability insurance
- Self-insured entities for liability insurance
- Workers' compensation laws or plans

Accountability for submitting the reports in the manner and form stipulated by the Secretary and the accuracy of the submitted information continues to rest with each of the above-named entities.

TPAs of any type (including TPAs as defined for purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7) for GHP arrangements) have no reporting responsibilities for purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8) for liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Where an entity reports on behalf of another entity required to report under 42 U.S.C. 1395y(b)(8), it is doing so as an agent of the second entity.

CMS will provide information on the format and method of identifying agents for reporting purposes.

Appendix H – Insufficient ICD-9 Diagnosis Codes

This list contains ICD-9 diagnosis codes that are considered inadequate or insufficient by CMS if submitted on a claim report for Section 111. Decimal points are not shown in these codes. Each code is 5 positions, left justified and padded at the end with spaces as necessary to fill 5 bytes.

None of these codes may be submitted in Field 15 Alleged Cause of Injury, Incident, or Illness on the Claim Input File Detail Record. Field 15 must be a code starting with the letter 'E' **not** on this list.

As of January 1, 2011, on add and update record submissions, at least one valid, numeric (not an E code and not a V code) ICD-9 diagnosis code that is ***not*** on this list must be submitted in one of the ICD-9 Diagnosis Codes in Fields 19-55 of the Claim Input File Detail Record. Insufficient codes on this list ***will be accepted*** in the Diagnosis Code Fields **as long as one, valid, numeric ICD-9 Diagnosis is provided that is NOT on this list.**

Insufficient ICD-9 Codes	Description
78099	Other general symptoms
7964	Other abnormal clinical findings
7969	Other nonspecific abnormal finding
7981	Instantaneous death
7982	Death occurring in less than 24 hours from onset of symptoms, not otherwise explained
7989	Unattended death
79989	Other ill-defined conditions
7999	Other ill-defined and unknown causes of morbidity and mortality.
V159	Unspecified personal history presenting hazards to health
V198	Family history of other conditions, Other condition
V4989	Other specified conditions influencing health status
V499	Other specified conditions influencing health status, Unspecified
V589	Encounter for other and unspecified procedures and aftercare, Unspecified aftercare
V600 V601 V602 V603 V604 V605 V606 V608 V609	Persons encountering health services in other circumstances - Housing, household and economic circumstances
V6101 V6102	Persons encountering health services in other circumstances - Other family circumstances

Insufficient ICD-9 Codes	Description
V6103 V6104 V6105 V6106 V6109 V6110 V6111 V6112 V6120 V6121 V6122 V6129 V613 V6141 V6149 V615 V616 V617 V618 V619	
V620 V621 V6221 V6222 V6229 V623 V624 V625 V626 V6281 V6282 V6283 V6284 V6289 V629	Persons encountering health services in other circumstances - Other psychosocial circumstances
V630 V631 V632 V638 V639	Unavailability of other medical facilities for care
V6400 V6401 V6402 V6403 V6404 V6405 V6406	Persons encountering health services for specific procedures, not carried out

Insufficient ICD-9 Codes	Description
V6407 V6408 V6409 V641 V642 V643 V6441 V6442 V6443	
V650 V6511 V6519 V652 V653 V6540 V6541 V6542 V6543 V6544 V6545 V6546 V6549 V655 V658 V659	Other persons seeking consultation
V669	Unspecified Convalescence
V6759	Follow-up examination, Following other treatment, Other
V676	Follow-up examination, Following combined treatment
V679	Follow-up examination, Unspecified follow-up examination
V6801 V6809 V681 V682 V6881 V6889 V689	Encounters for administrative purposes
V700	Routine general medical examination at a health care facility - health checkup
V703 V704 V705 V706 V707 V708 V709	General medical examination - Other medical examination for administrative purposes
V7189	Observation and evaluation for suspected conditions not found,

Insufficient ICD-9 Codes	Description
	Other specified suspected conditions
V719	Observation and evaluation for suspected conditions not found, Observation for unspecified suspected condition
V7285	Special investigations and examinations, Other specified examination
V729	Special investigations and examinations, Unspecified examination
V829	Special screening for other conditions, Unspecified condition
V850	Body mass index less than 19, adult
V851	Body mass index less than 19-24, adult
V8521	Body Mass Index 25.0-25.9, adult
V8522	Body Mass Index 26.0-26.9, adult
V8523	Body Mass Index 27.0-27.9, adult
V8524	Body Mass Index 28.0-28.9, adult
V8525	Body Mass Index 29.0-29.9, adult
V8530	Body Mass Index 30.0-30.9, adult
V8531	Body Mass Index 31.0-31.9, adult
V8532	Body Mass Index 32.0-32.9, adult
V8533	Body Mass Index 33.0-33.9, adult
V8534	Body Mass Index 34.0-34.9, adult
V8535	Body Mass Index 35.0-35.9, adult
V8536	Body Mass Index 36.0-36.9, adult
V8537	Body Mass Index 37.0-37.9, adult
V8538	Body Mass Index 38.0-38.9, adult
V8539	Body Mass Index 39.0-39.9, adult
V854	Body Mass Index 40 and over, adult
V8551	Body Mass Index, pediatric, less than 5th percentile for age
V8552	Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age
V8553	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age
V8554	Body Mass Index, pediatric, greater than or equal to 95th percentile for age
E8490	Place of Occurrence Home
E8491	Place of Occurrence Farm
E8492	Place of Occurrence Mine and Quarry
E8493	Place of Occurrence Industrial place and premises
E8494	Place of Occurrence for Recreation and Sport
E8495	Place of Occurrence Street and Highway
E8496	Place of Occurrence Public Building

Insufficient ICD-9 Codes	Description
E8497	Place of Occurrence Residential Institution
E8498	Place of Occurrence Other Specified Places
E8499	Place of Occurrence Unspecified Place
E9670	Perpetrator of child and adult abuse By father, stepfather, or boyfriend
E9671	Perpetrator of child and adult abuse by other specified person
E9672	Perpetrator of child and adult abuse by mother, stepmother or girlfriend
E9673	Perpetrator of child and adult abuse by spouse or partner
E9674	Perpetrator of child and adult abuse by child
E9675	Perpetrator of child and adult abuse by sibling
E9676	Perpetrator of child and adult abuse by grandparent
E9677	Perpetrator of child and adult abuse by other relative
E9678	Perpetrator of child and adult abuse by non-related caregiver
E9679	Perpetrator of child and adult abuse by unspecified person

Appendix I – Section 111 Acronym List

The following table contains a list of acronyms related to Section 111. It includes abbreviations related to both GHP and Non-GHP (Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation) reporting.

Acronym	Description
AGNS	AT&T Global Network System
ANSI	American National Standards Institute
ASCII	American Standard Code for Information Interchange
BASIS	Beneficiary Automated Status Inquiry System
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits Program
COBA	Coordination of Benefits Agreement
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COBSW	COB Secure Web site
CWF	Common Working File
DBA	Doing Business As…
DCN	Document Control Number
DES	Data Encryption Standard
DOB	Date of Birth
DOI	Date of Incident
E02	COBA Drug Coverage Eligibility
EBCDIC	Extended Binary Coded Decimal Interchange Code
EDI Rep	Electronic Data Interchange Representative
EGHP	Employer Group Health Plan
EIN (FEIN)	Employer Identification Number (Federal EIN)
ESRD	End Stage Renal Disease
FSA	Flexible Savings Account
GHP	Group Health Plan
HEW	HIPAA Eligibility Wrapper Software
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HICN	Health Insurance Claim Number
HRA	Health Reimbursement Account
HSA	Health Savings Account
HTTPS	Hypertext Transfer Protocol over Secure Socket Layer
ICD – 9 – CM	International Classification of Diseases, Ninth Revision, Clinical Modification
IACS UID	Individuals Authorized Access to CMS Computer Services User Identification Number
LGHPs	Large Group Health Plans
MBD	Medicare Beneficiary Database

Acronym	Description
MMSEA	Medicare, Medicaid and SCHIP Extension Act of 2007
MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
NAIC	National Association of Insurance Commissioners Code
NDM	Network Data Mover (now known as Connect:Direct)
NCPDP	National Council of Prescription Drug Programs
NGHP	Non Group Health Plan or Liability Insurance (including Self Insurance), No-Fault Insurance and Workers' Compensation
Non – MSP	Non Medicare Secondary Payer
ORM	Ongoing Responsibility for Medicals
PIN	Personal Identification Number
PRA	Paperwork Reduction Act
RDS	Retiree Drug Subsidy
RRE ID	Responsible Reporting Entity Identification Number or Section 111 Reporter ID
RREs	Responsible Reporting Entities
Rx BIN	Prescription Benefit Identification Number
Rx PCN	Prescription Processor Control Number
SCHIP	State Children's Health Insurance Program
SEE	Small Employer Exception
SFTP	Secure File Transfer Protocol
SNA	Systems Network Architecture
SSH	Secure Shell
SSN	Social Security Number
TCP/IP	Transmission Control Protocol/Internet Protocol (Internet Protocol Suite)
TIN	Tax Identification Number
TPA	Third Party Administrator
TPOC	Total Payment Obligation to Claimant
TrOOP	True Out of Pocket
TrOOP Rx BIN/Rx PCN	TrOOP specific drug payment code
URL	Uniform Resource Locator (Web site address)
VAN	Value Added Network
VDEA	Voluntary Data Exchange Agreement
VDSA	Voluntary Data Sharing Agreement
VTAM	Virtual Telecommunications Access Method