CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R Coordination of Benefits and Recovery

Group Health Plan (GHP) Section 111 Reporting Webinar

March 29, 2023

Presentation Overview

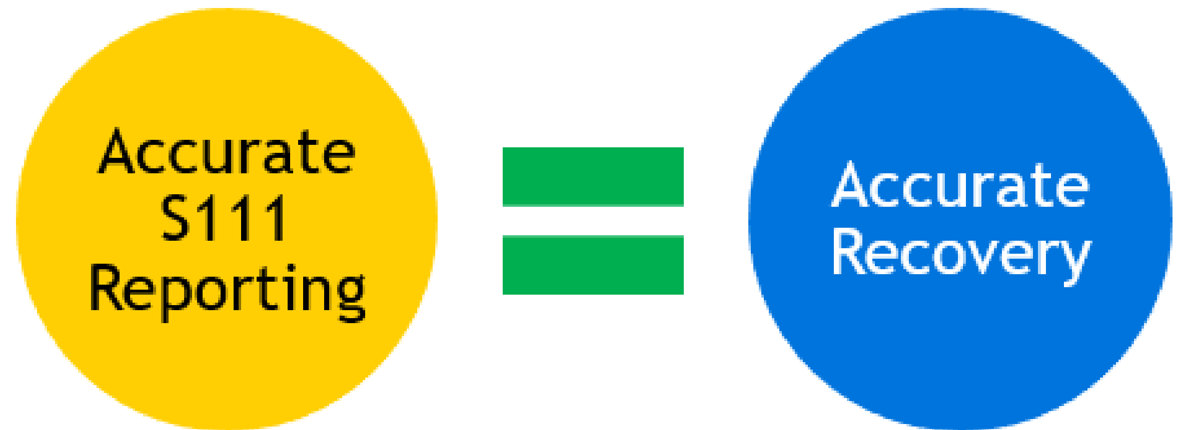
S111 Reminders and Best Practices

Coming Soon

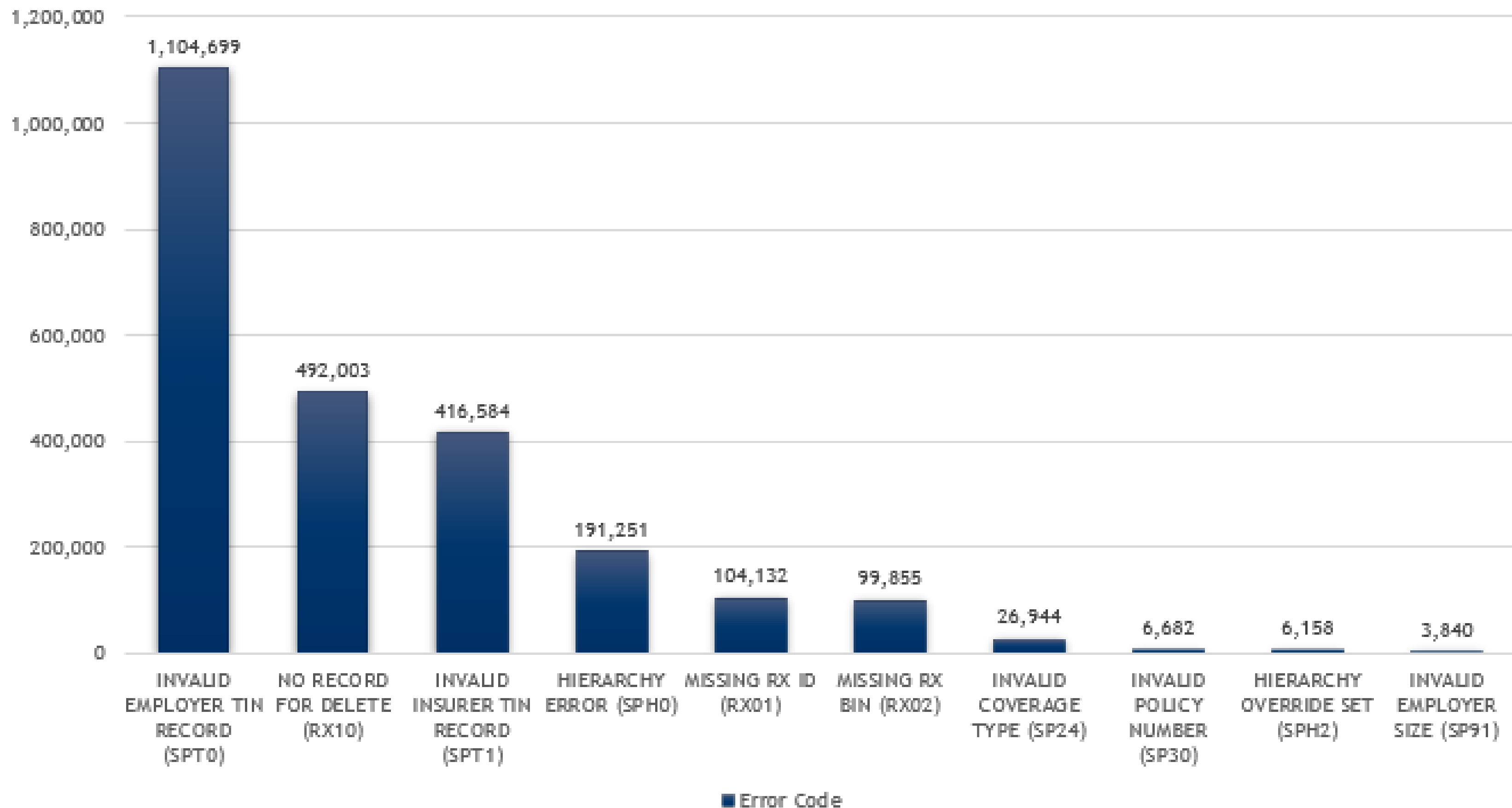
Additional Resources

Questions & Answers

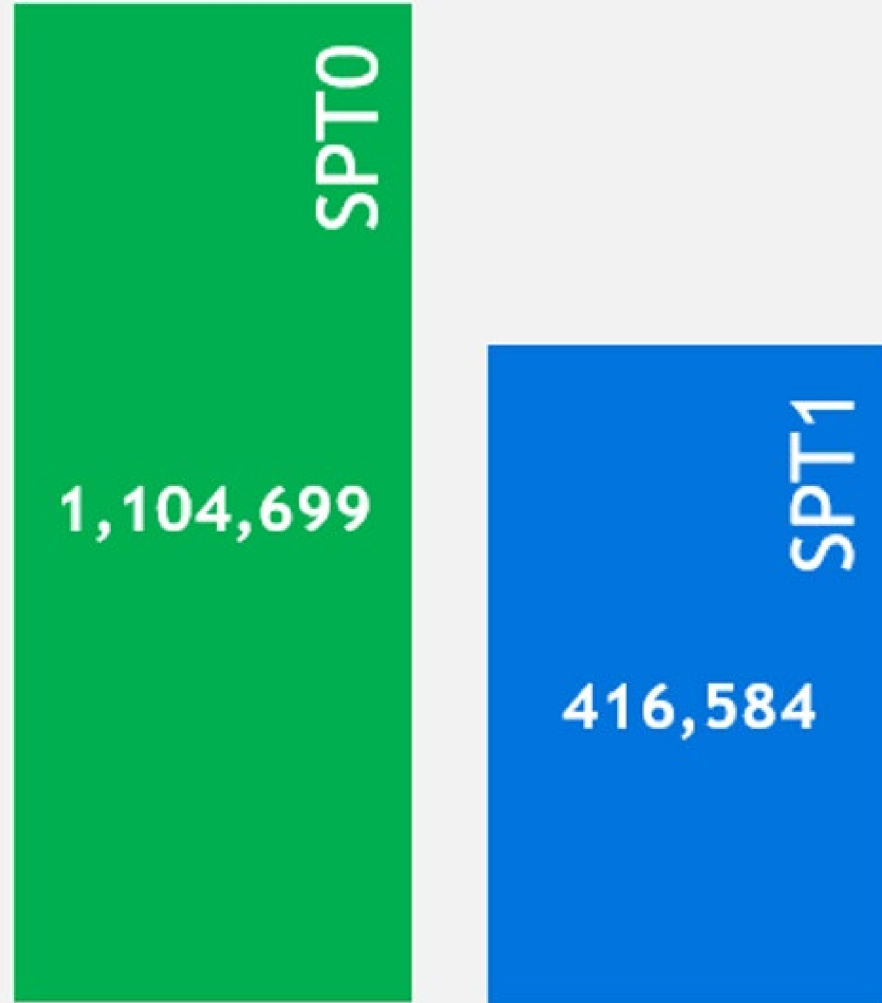
Why Accurate Reporting Matters



Top 10 Error Codes July 1 to December 31, 2022



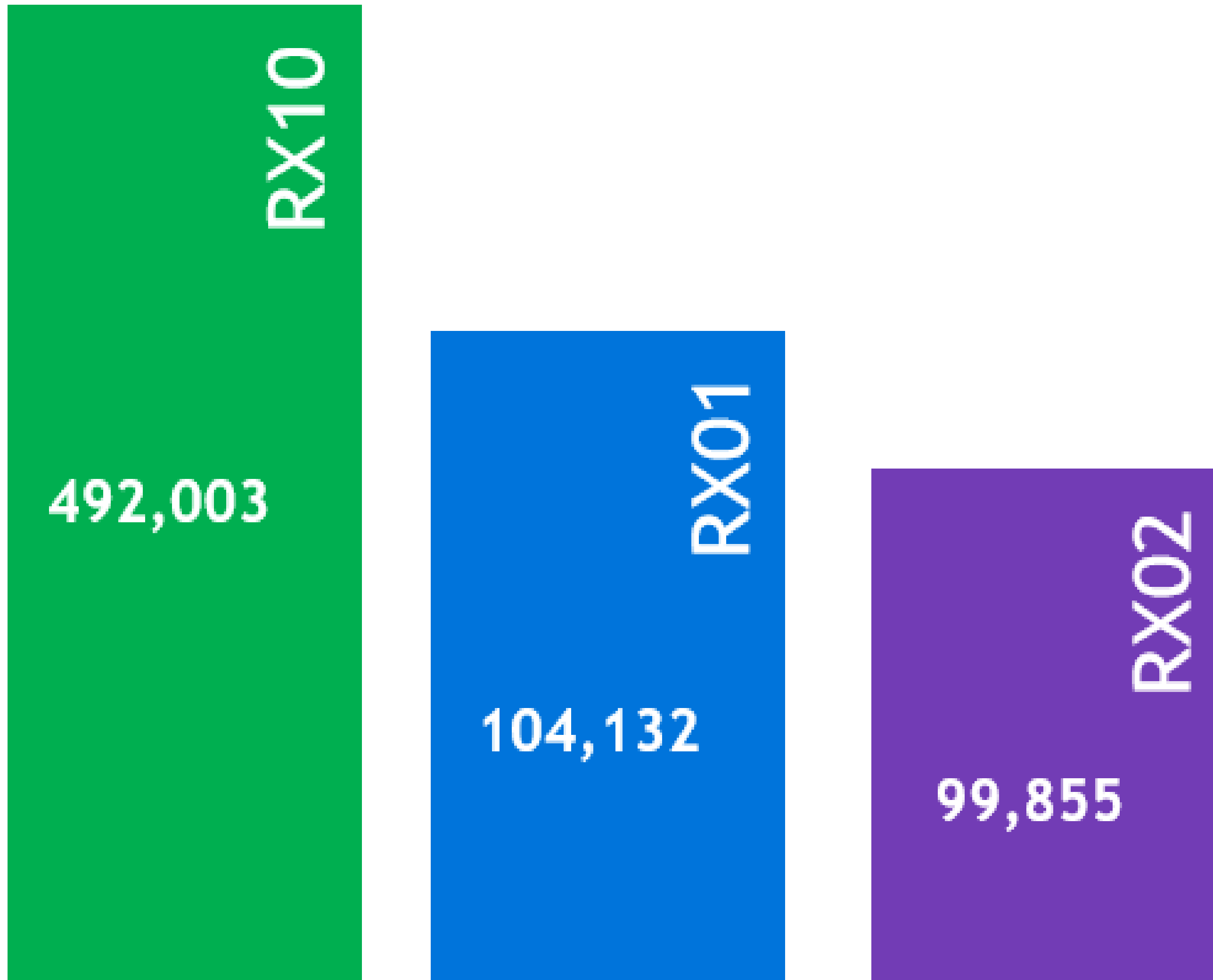
TIN-Related Errors



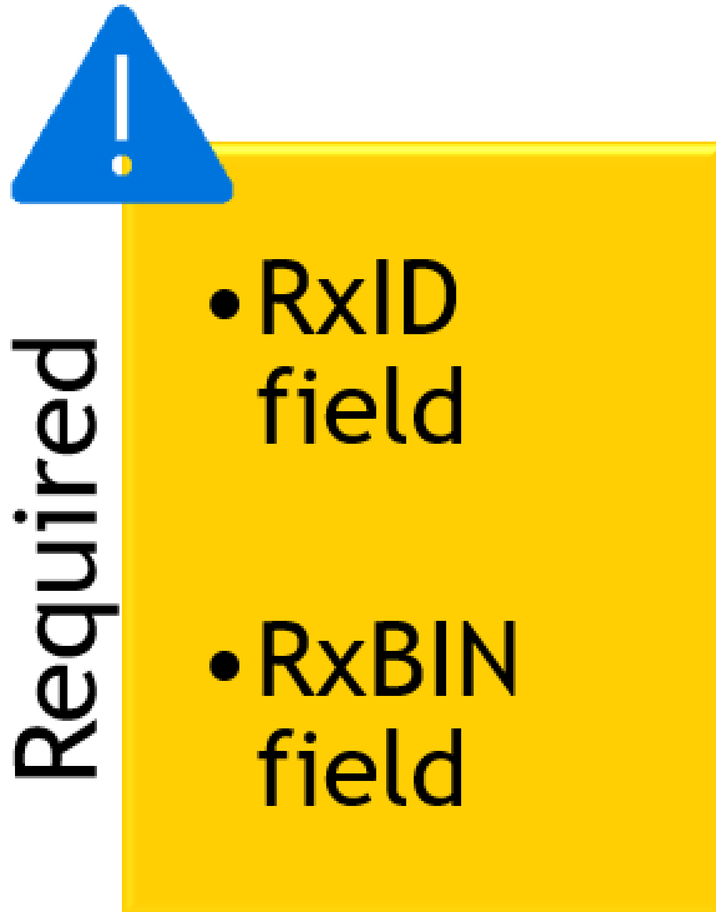
Acme Insurance Company
123 Smith Rd
Anytown, NY 12345-1234

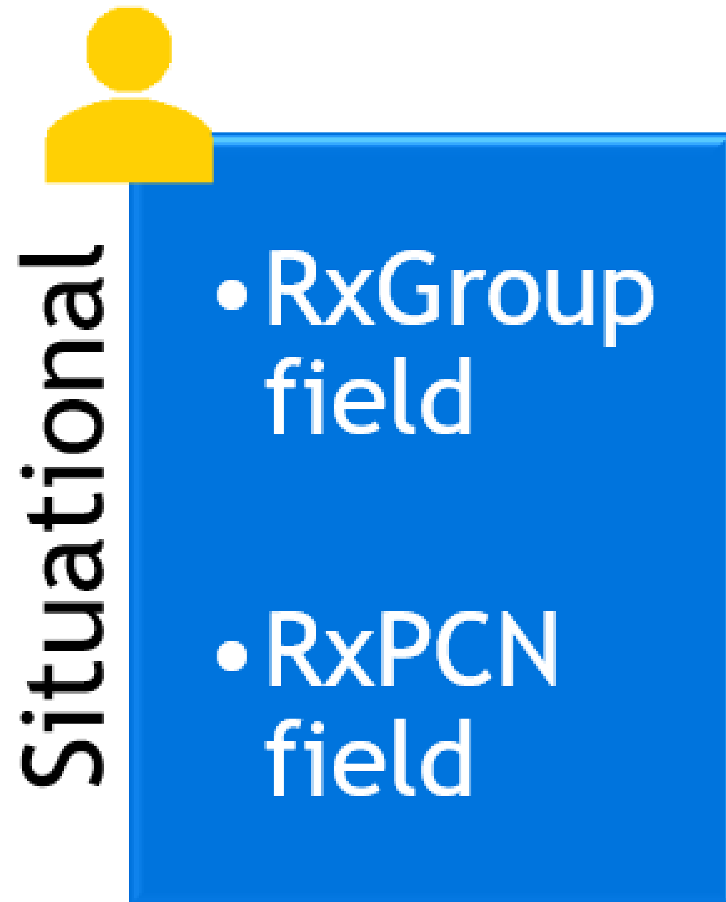
USPS Address Validation

RX Errors



RX Reporting Reminder

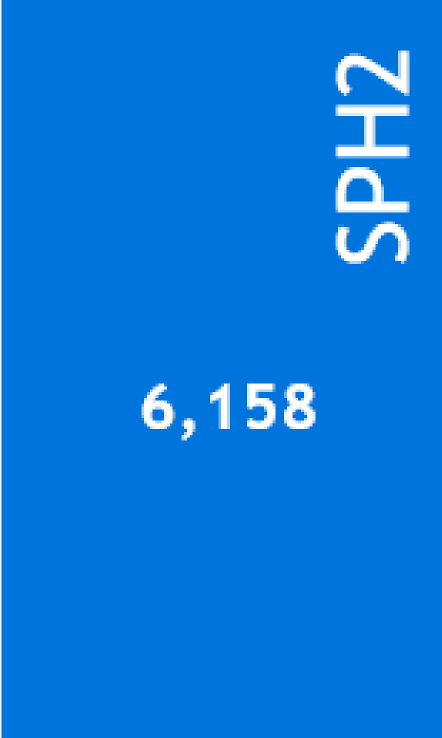


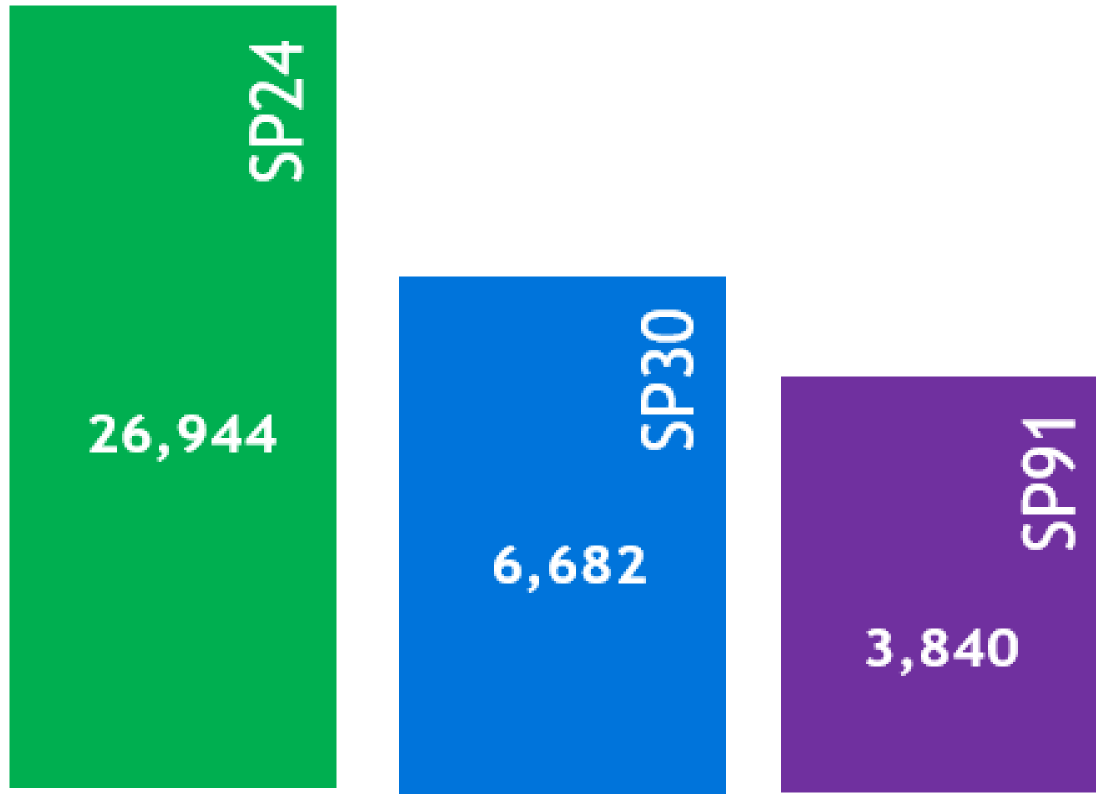


Hierarchy Overview

Hierarchy Ranking	Source of Update/Delete Request
First	• BCRC Analyst (Note: BCRC Analysts may manually lock an MSP occurrence from any subsequent changes except those made by the BCRC)
Second	• BCRC Call Center • Commercial Repayment Center (CRC) • Beneficiary Call Center (1-800-Medicare)
Third	• Section 111 RRE • Medicare Advantage (MA)/(Part C Plan)
Fourth	• Employer Voluntary Data Sharing Agreements (VDSAs)
Fifth	• Other Medicare Contractors • All others

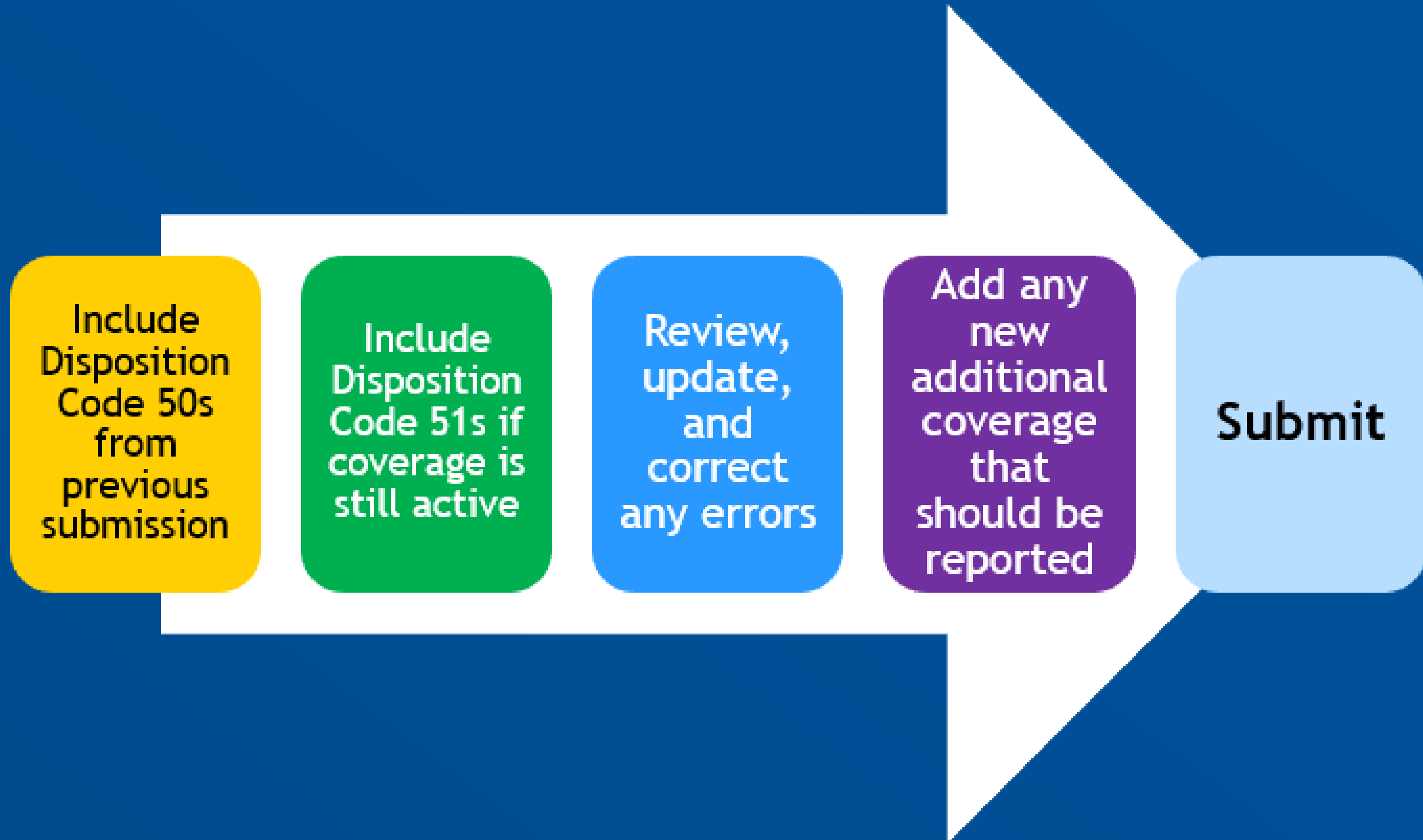
Hierarchy Errors





Other Common Errors

Submitting Subsequent MSP Files



File Submission Timeframes

Prior File Submission Completes Processing

↓

Response File Generated

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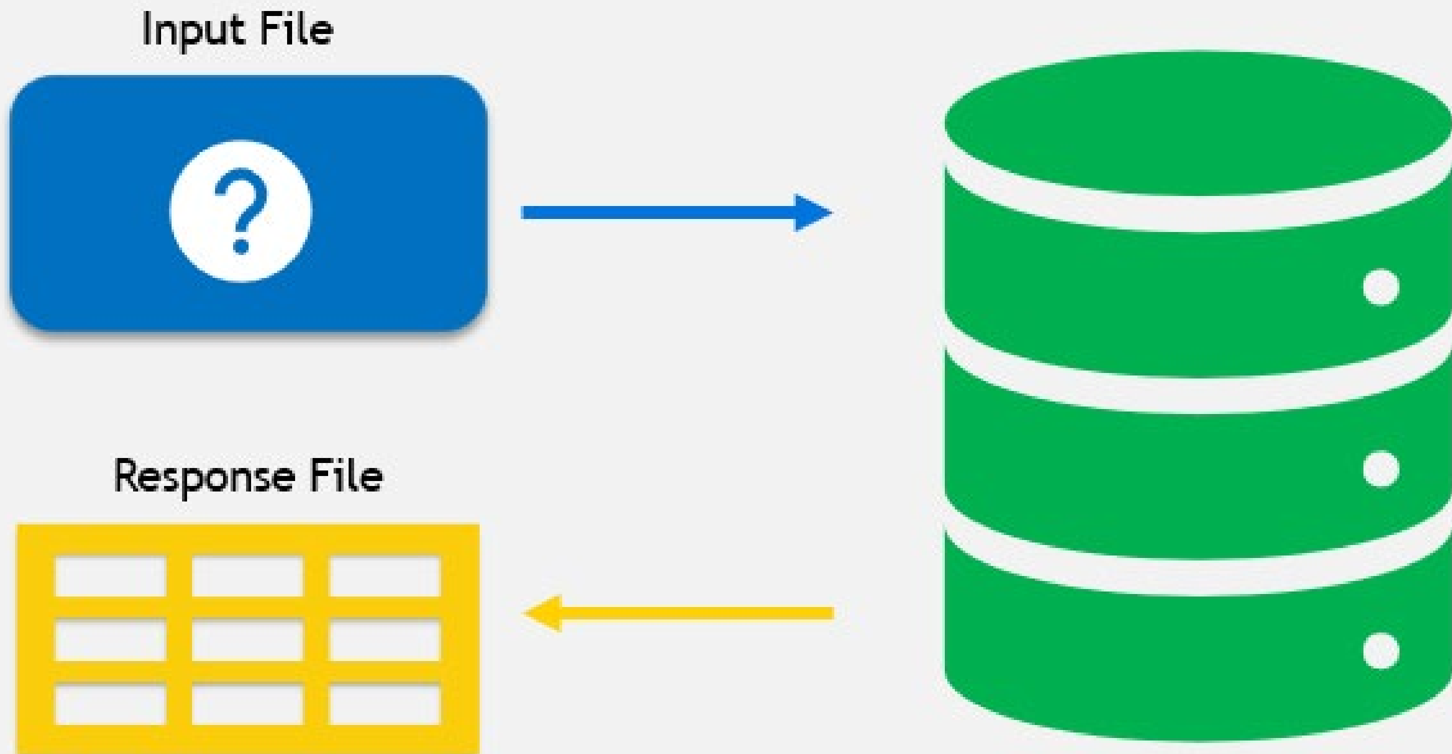
Subsequent File Submission Allowed

Query File Reminders



Health Reimbursement Arrangements (HRA) Reminders

To Delete or Not to Delete…That is the Question

- Submit delete transactions for MSP occurrences created in error
- Submit delete transactions for records that resulted in a "01" disposition code
- Only report employer-sponsored group health plans based on active employment
- Send an update transaction with a termination date (Field 11) when coverage ends for a previously sent and accepted individual

Coming Soon

July

- MSP coverage information is being added to the Beneficiary Lookup function on the COB Secure Website (COBSW)
- No longer limited to 500 queries per month

October

- Unsolicited alerts from the COBSW will include information for drug coverage types U,V, W, X, Y, Z, 4, 5, or 6 in the Unsolicited MSP Response File

Additional Resources

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

For additional information, please also see the following resources:

- Section 111 GHP User Guide
- Section 111 GHP Training Materials

Section 111 Mailbox
(PL110-173SEC111-comments@cms.hhs.gov)

Questions & Answers

Slide 0: Group Health Plan (GHP) Section 111 Reporting Webinar

Slide 1: Presentation Overview

During this presentation we want to review some Section 111 reminders and best practices, talk about an upcoming change, and remind you of additional resources that are available. Lastly, we will open the call up for questions and answers.

Slide 2: Why Accurate Reporting Matters

We want to start today by talking about why the accuracy of Section 111 reporting is so important.

The purpose of Section 111 reporting is to allow Centers for Medicare & Medicaid Services (CMS) to pay appropriately for Medicare-covered items and services furnished to Medicare beneficiaries. Section 111 GHP reporting of applicable coverage information helps CMS determine when other insurance coverage is primary to Medicare, meaning that it should pay for the items and services first, before Medicare considers its payment responsibilities.

This essentially means that the more accurate your S111 reporting is, the more accurate any needed recovery actions will be. This also means it is incredibly important for regular communication about this process to occur within your organization. Your reporting area needs to communicate with those responsible for recovery to avoid providing conflicting information.

With this in mind, let's walk through a few tips and reminders to help you have the most accurate reporting possible.

Slide 3: Top 10 Error Codes July 1 to December 31, 2022

We have seen some trends when it comes to error codes recently. We hope that by pointing these out the Benefits Coordination & Recovery Center (BCRC) will see fewer of them in the future and your files will process more smoothly. We should also note that we have begun posting the top 10 error code charts to CMS.gov for external stakeholders to reference. The chart is available in the Download section of the Mandatory Insurer Reporting for Group Health Plan "What's New" page and we will update them every 6 months. So, let's look in detail at the top 10 most common error codes from the last 6 months of 2022.

Let's break down these errors, and some of their associated issues, in a bit more detail by type. And remember, detailed information about all these codes is available in the GHP User Guide.

Slide 4: TIN-Related Errors

Tax Identification Number (TIN) related errors continue to trend as some of the most common error codes. Errors on TIN Reference File records will result in rejection of subsequently processed Medicare Secondary Payer (MSP) Input File Detail Records with matching insurer/Third-Party Agreement (TPA), or employer TINs. TIN records returned with errors must be corrected and resubmitted for the corresponding MSP records to process correctly.

The Insurer/TPA TIN (MSP Input Field 22) and Employer TIN (MSP Input Field 21) will be matched to the Coordination of Benefits (COB) database table of valid, accepted TIN Reference File records submitted by the Responsible Reporting Entity (RRE).

If a match is not found to a valid TIN record, the MSP Input File Detail Record will be rejected and returned on the MSP Response File with an "SP" disposition code and an error code indicating that a valid TIN record could not be found.

RREs will have to refer to the errors returned on their TIN Reference Response Files to determine what caused the matching TIN record to be rejected. It will be necessary for an RRE to resubmit corrected TIN Reference File records, along with resubmitting the corresponding MSP Input File Detail Records that were rejected, in its next file submission. The two codes in question are STP0 and STP1.

SPT0 – This is the most common error. It indicates no matching valid TIN Reference File Detail Record was found for the Employer TIN submitted. The main cause for this error is an incorrect Employer TIN submitted on the MSP Input File Detail Record. In this case, the RRE should correct and resubmit the MSP Input File Detail Record. This could also occur because a corresponding TIN Reference File Detail Record was not submitted for the Employer TIN or was submitted and rejected with errors. In that case, the RRE should refer to the errors returned on the TIN Reference Response File, submit an updated or corrected TIN Reference File, and resubmit the MSP Input File record.

SPT1 – This is another very common error. It indicates no matching valid TIN Reference File Detail Record was found for the Insurer/TPA TIN submitted. It can be caused by an incorrect Insurer/TPA TIN submitted on the MSP Input File Detail Record. In this case, the RRE should correct and resubmit the MSP Input File Detail Record. This could also occur because a corresponding TIN Reference File Detail Record was not submitted for the Insurer/TPA TIN or was submitted and rejected with errors. For this latter situation, an RRE should refer to the errors returned on the TIN Reference Response File, submit an updated or corrected TIN Reference File, and resubmit the MSP Input File record.

Also, remember that when you are reporting TIN information, this identifies who the debtor should be for recovery actions. If you are reporting records for a federal employer, make sure to report the correct federal Employer TIN and report it as an "F" TIN. This will identify that the Insurer/TPA for any related cases should be the debtor.

Slide 5: USPS Address Validation

A common reason for these TIN errors is invalid addresses. TIN Reference File records that pass the basic field validation edits are then processed by the BCRC using a postal software tool. This tool is used to validate and improve the deliverability of mailing addresses.

Non-foreign addresses will be reformatted into the standardized format as recommended by the U.S. Postal Service (USPS), so that they can be matched against a database of valid, deliverable addresses. To this end, RREs can only use addresses that are validated by the USPS website and, as much as possible, are in the format that is shown by the USPS website. For example, "RD" instead of "ROAD" or "STE" instead of "Suite."

RREs are encouraged to pre-validate employer and Insurer/TPA addresses using postal software or online tools available on the USPS website pages. RREs should use standard abbreviations and adhere to USPS standards. The address validation enhancements effective in the BCRC Section 111 system will "scrub" addresses submitted on the TIN Reference File using USPS standards, but it is recommended that RREs attempt to adhere to these standards as well to improve results.

While we are on the topic of addresses, we also want to offer an additional address reminder. It is important for RREs to remember that when updating an address, as well as making the update on the

TIN Reference File, you must also update the address on the MSP Input File submission in order to update the address on the corresponding MSP record.

Slide 6: RX Errors

The Rx error codes (Response Fields 71-74) are specific to the prescription drug coverage data elements on the MSP Input File including Rx Insured ID, Rx Group, Rx PCN, Rx BIN, Toll-Free Number, and Person Code. Drug records may also have errors for the nondrug-specific fields in the regular error codes found in Response Fields 40-43.

The current most common Rx error code is RX10. This error occurs when no drug record is found for a delete transaction. The matching criteria on the delete transaction may be incorrect, or the original add transaction may not have been accepted with a “01” disposition code, or the matching occurrence may have already been deleted prior to the processing of this transaction. The RRE should correct the matching criteria and resend as needed. However, if the submitted matching criteria was correct, and the RRE received the RX10 error because the drug record has already been deleted, the RRE should not submit the transaction again in subsequent file submissions.

We also see a fair number of the RX01 and RX02 errors codes.

RX01 is received when there is a missing RxID for a drug record. The RRE should update the RxID field and resubmit the record on the MSP Input File.

RX02 is received for a missing or invalid RxBIN for a drug record. The RRE should update or correct the RxBIN field and resubmit the record on the MSP Input File.

Slide 7: RX Reporting Reminder

When we look at prescription drug reporting and the related errors, there are often questions around what is required and what is not. The required data when reporting drug coverage are the RxID and the RxBIN fields. RREs must complete these fields. However, the RxGroup and RxPCN fields are situational. This means that RREs should complete these fields if they assign them to their members, but the fields can be left blank if they don’t. Remembering these key points will help cut down on RX01 and RX02 errors.

Slide 8: Hierarchy Overview

Another area that we see a lot of errors in is related to record hierarchy. So, before was talk specifically about the errors, let’s have a quick refresher on hierarchy rules. Listed here is the Hospital/Medical Hierarchy table.

As you know, the BCRC collects information to identify other health insurance that Medicare beneficiaries have that is primary to Medicare. The BCRC uses various methods to collect this information.

CMS has found that, historically, some sources are more reliable than others and collection from different entities can result in conflicting information. Because of this, CMS has ranked the possible sources of an update/delete request from the highest level (first) to the lowest level (fifth).

RRE attempts to update or delete an MSP occurrence that was last added or updated by a higher-ranking source, the record will be rejected. The error returned on the MSP Response File will depend

on whether the MSP occurrence is locked. The BCRC has the authority to manually lock an MSP occurrence from any subsequent changes except those made by the BCRC.

Slide 9: Hierarchy Errors

The most common hierarchy errors are SPH0 and SPH2.

SPH0 – This error occurs when a transaction attempted to update/delete an MSP occurrence last updated by a higher-ranking source where the MSP occurrence is not locked. After receipt of the SPH0 error, an RRE should review submitted information and determine if the update/delete must be applied. If it is determined that the update/delete must be applied, then the transaction should be submitted again in the next quarterly file submission with a value of HB (Hierarchy Bypass) in the Override Code (Field 33) of the MSP Input File Detail Record. If it is determined that the update/delete does not need to be applied, then the information should be updated in the RRE's internal system and the RRE should not submit this update/delete transaction again in subsequent file submissions.

SPH2 – This error is given when a transaction attempted to bypass hierarchy (using HB in the override code field) prior to receiving the SPH0 error. RREs will receive this error if they submit an Override Code on the first attempt of the update/delete, as well as an SP disposition code. RREs must first receive the SPH0 error and then submit the Override Code on the record in your next quarterly file submission after verifying that the override is appropriate and necessary. It should be noted that RREs who opt into and use the Unsolicited MSP Response File can submit an update transaction on their MSP Input File using the Hierarchy Override Code (HB) before receiving the SPH0 error.

We will touch on hierarchy again later when we talk about some upcoming changes.

Slide 10: Other Common Errors

To wrap up the error codes discussion, we want to mention a few other common errors.

SP24 – This error is for an invalid coverage type. RREs should review the valid coverage types in the GHP User Guide, update, and resubmit the record on the MSP Input File.

SP30 – This error is for an invalid policy number or no insurer policy number. On the MSP Input Detail Record, RREs must submit either the Policy Holder's Social Security Number (SSN) (Field 15) or Individual Policy Number (Field 18). RREs are encouraged to use Field 18 instead of Field 15 if possible. Field 18 should reflect the unique identifier the RRE uses for the individual being reported on the record. In most cases this is the identification number shown on the individual's insurance card. The value supplied in these fields will be placed on any related recovery demand notifications for the RRE to use to identify the GHP coverage for the individual reported on the record.

SP91 – This error is for an invalid employer size. This is a required field and must contain a numeric character. The field cannot be blank, contain spaces, or alpha characters. An RRE should review the acceptable characters listed in the GHP User Guide, update, and resubmit.

Slide 11: Submitting Subsequent MSP Files

Submission of subsequent MSP files can sometimes be confusing, so here are some tips.

Include disposition code 50s, which indicate that a record is still being processed by CMS, from the previous submission. Also include disposition code 51s, which indicate the Active Covered Individual could not be matched to a Medicare beneficiary, if the coverage is still active.

Be sure to include corrections to the SP Error Codes that you've received in your previous MSP Response Files.

Include any new additional coverage that should be reported, like new enrollees, existing members that recently became 45 years old, and any members under 45 years old that Medicare Beneficiary Identifiers (MBIs) have been recently obtained for.

Once all these things are completed, you are ready to resubmit. Please note that RREs do not need to send a TIN Reference File with every MSP Input File submission. After the initial TIN Reference File is processed, it only needs to be resubmitted if there are changes or additions to make. Only new or changed TIN records need to be included on subsequent submissions. However, many RREs choose to submit a full TIN Reference File with each MSP Input File submission. All TINs will be verified so it is imperative that accurate information be provided in the file.

Slide 12: File Submission Timeframes

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

MSP Input Files must be submitted on a quarterly basis by RRE IDs in a production status during the RRE ID’s 7-day file submission timeframe. RREs are assigned their quarterly file submission timeframe at the completion of the registration process.

However, we want to clarify that GHP RREs may submit multiple files within a single quarter. The two limitations that apply to this are:

1. Subsequent file submissions will not be processed until the prior file submission has completed and a response file has been generated. RREs should not submit a subsequent file until the prior file’s response file has been received.
2. RREs will receive a threshold error and must work with their Electronic Data Interchange (EDI) Representative to ensure the off-cycle file is released for processing.

Slide 13: Query File Reminders

We also want to mention query files. Query input files should be sent quarterly.

Currently, some larger GHP RREs are set up to submit a query input file on a monthly basis, and we do our best to accommodate that.

However, it should be noted that as the size of these files continues to increase, there may come a point where these files will not be able to be processed monthly. We recommend that RREs that do submit monthly make the necessary changes in how they submit to accommodate quarterly processing.

Slide 14: Health Reimbursement Arrangements (HRA) Reminders

We often see confusion around submission of HRA coverage. So, we wanted to offer some reminders around them.

An HRA is a GHP arrangement and is subject to the MSP reporting provisions. All HRAs, including Individual Coverage HRAs, Qualified Small Employer Health Reimbursement Arrangements, and excepted benefit HRAs, are subject to the applicable MSP provisions regardless of whether or not they have an end-of-year carryover or rollover feature.

HRA coverage should be reported in the RRE's regular quarterly MSP Input File. Only HRA coverage that reflects an annual benefit value of $5,000 or more that is available to a specific Medicare beneficiary to pay medical claims should be reported.

Amounts rolled over from the previous plan year's coverage must be included when calculating the current year's annual benefit value.

Important: The RRE should not delete HRA MSP Records when benefits are exhausted. Instead, termination dates should be submitted when the covered individual loses or cancels coverage, or when the annual benefit value to pay medical claims is exhausted and no additional funds will be added to the HRA for the remainder of the HRA's current benefit coverage term. Terminations should be included as an update in the RRE's next regularly scheduled MSP Input File submission.

Once the HRA benefit period is renewed, the RRE should submit a new add record on the MSP Input File.

Full details on HRA submission information are available in the GHP User Guide.

Slide 15: To Delete or Not to Delete…That is the Question

A common occurrence the BCRC sees is the incorrect use of a delete transaction. Deletes should only be used to remove an MSP occurrence that was created in error. Delete transactions only need to be submitted for records that resulted in a "01" disposition code on a previous corresponding response file record. If the record was not returned with a "01," then an MSP occurrence was not created and there is nothing to delete from Medicare's files.

RREs should only report employer-sponsored group health plans based on active employment. When coverage for an active covered individual previously sent and accepted by the BCRC ends, the RRE should send an update transaction with the Termination Date (Field 11).

The BCRC will then update the MSP occurrence Termination Date and Medicare will become the primary payer after that date. A delete transaction should not be sent in these cases. A delete transaction will remove the MSP occurrence entirely, as though Medicare was always supposed to be the primary payer, and claims will be paid erroneously.

Slide 16: Coming Soon

We wanted to let you know about a few upcoming changes.

First, in July we will be making a change to what information an RRE can receive when performing a beneficiary lookup in the S111 COB Secure website (COBSW). Beginning in July, when a query is submitted to determine if an insured party is a Medicare beneficiary, the RRE will also be provided with MSP coverage information. This should make it more efficient for RREs to determine Medicare primacy, without having to contact the BCRC.

We should also note that along with this change, COBSW GHP RRE users will no longer be limited to 500 queries per month.

Slide 17: Additional Resources

Before we end the presentation and start the Q&A section of the call, we want to remind you of other resources available to you.

The EDI Department is available to assist you with reporting questions and issues at 646-458-6740.

You can also find assistance on CMS.gov where the GHP User Guide and GHP Training materials are located. Lastly, if you have other S111 related questions, you can submit them to the Section 111 mailbox. As a reminder, please do not submit any Personally Identifiable Information (PII) or Personal Health Information (PHI) in your email.

Slide 18: Questions & Answers