MMSEA Section 111
Medicare Secondary Payer
Mandatory Reporting

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

Version 3.2
August 17, 2011

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.
February 22, 2010	3.0	Changes listed in Section 1.
July 12, 2010	3.1	Changes listed in Section 1.
August 17, 2011	3.2	Changes listed in Section 1.

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1 Summary of Version 3.2 Updates

NOTE: This Version 3.2 of the NGHP User Guide has been updated to include the current language in various alerts posted to the Section 111 website (www.cms.gov/MandatoryInsRep) since publication of Version 3.1 to bring it in line with all published material. As indicated on prior Section 111 NGHP Town Hall teleconferences, CMS continues to review some of this language and will post any applicable updates in the form of revised alerts and User Guide revisions at a later date.

- Section 2 was updated to provide the e-mail address for the Section 111 Resource Mailbox where comments and policy-related inquiries may be sent. This was also added to Section 18.
- Sections 6, 11.1, 11.4, 11.6, and 11.10.2 were updated to incorporate the extension for reporting liability insurance (including self-insurance) TPOCs per the alert dated November 9, 2010 ("I. Revised Implementation Timeline for TPOC Liability Insurance… II. Extension of Current Dollar Thresholds…")
- Section 7.1 was updated to add information from the "Alert for Foreign Insurers" dated February 7, 2011.
- Sections 8.2 and 20 were updated to state that starting as of January 2012, the RRE's profile report will be e-mailed to the Authorized Representative annually, based upon the receipt date of the last signed profile report. The RRE will be asked to confirm via e-mail that their current information is correct. Failure to confirm this information may result in deactivation of the RRE ID
- Section 9.2 was updated to remove parentheses from the alphanumeric data type and a new data type of "Alphanumeric Plus Parens" was added. The only fields where parentheses are currently accepted include Claim Input File Policy Number (Field 74), Claim Number (Field 75) and Plan Contact Department Name (Field 76). The corresponding data types for these fields were updated in Appendix A. The following note was added to the numeric data type - *Note: the last two positions of dollar amount fields reflect cents. For example, in an 11 byte numeric field, an amount of 10,000 (ten thousand) dollars and no cents must be submitted as "00001000000"*. This note was also added to applicable field descriptions in Appendix A for TPOC Amount fields and No-Fault Insurance Limit (Field 81).
- Information related to submission of ICD-9 diagnosis codes was updated in Section 11.2.5. In particular, RREs should note that the list of valid ICD-9 diagnosis codes used for Section 111 reporting is now posted under the Reference Materials menu option on the Section 111 COBSW. RREs may (but are not required to) download the list of valid codes from the COBSW rather than using the files posted to the previously referenced CMS.gov website page.
- A new Section 11.2.5.1, "Special Default Diagnosis Code for Liability", was added to provide information published in the "Special Default ICD-9 Code for RREs" alert dated November 12, 2010.
- A note concerning CMS' use of addresses submitted on the TIN Reference File was added to the end of Section 11.3.
- Section 11.3.2 was added to reflect information published in the "TIN Reference Response File and Address Validation Information" alert dated April 1, 2011 (Revised May 17, 2011).

- Section 11.4 was updated to extend the interim reporting thresholds per the alert dated November 9, 2010 (“I. Revised Implementation Timeline for TPOC Liability Insurance… II. Extension of Current Dollar Thresholds…”)
- Section1 11.7.2 and 11.7.4 were updated to state that the “delete/add” process should only be performed to correct the CMS Date of Incident (Field 12), Plan Insurance Type (Liability, No-Fault, Workers’ Compensation in Field 71), and ORM Indicator (Field 98). Do not perform a delete/add to correct or change any other fields. Simply submit an update transaction to correct non-key fields as described in Section 11.7.3 and noted in the Event Table in Section 11.7.4. Also see the special note concerning HICN changes.
- The Event Table in Section 11.7.4 was updated to remove references to the Description of Illness/Injury (Field 57). This field became obsolete as of January 1, 2011. Changes were also made to the Event Table to accommodate the new 10/1/2011 TPOC Date requirement for liability insurance. A new event was added to reflect a scenario where ORM is assumed for one injury and a TPOC established for a second injury on the same claim. Another new event was added to cover a scenario where ORM ends for one or more injuries on a previously reported claim but continues for one or more other injures.
- A new Section 11.7.5 was added to document some Claim Input File reporting “Dos and Don’ts”.
- The note at the end of Section 11.8 was changed to state that the system will now accept an ORM Termination Date that is less than 30 days after the CMS Date of Incident. The system will also accept an ORM Termination Date equal to the CMS Date of Incident.
- Section 11.8 was also updated with information on how to make an immediate report of ORM Termination via the COBC Call Center. This report does not apply to DDE submitters. This verbal report is not required. It must be followed up with a subsequent update transaction with the ORM Termination Date on the RRE’s next quarterly Claim Input File.
- Section 11.10.2 was updated to reflect the information published in the alert dated October 14, 2010 regarding the “timeliness of reporting” NGHP TPOCs. In addition, it was noted that RREs should start making use of the “Funding Delayed Beyond TPOC Start Date” fields when reporting of a TPOC is delayed due to these circumstances. Note that the use of this field was not part of the October 14, 2010 alert. The system will be updated at a later date to change the calculation used for late TPOC reporting reflected by Compliance Flag value ‘01’ so that this calculation uses the later of the TPOC Date or corresponding “Funding Delayed Beyond TPOC Start Date”. In the meantime, RREs should ignore erroneous late compliance flags received in this situation until the correction can be made.
- The description for disposition code ‘50’ in Section 12.1 was updated. The paragraph formerly entitled “All Other Disposition Codes” was deleted and instructions were added to this and Section 12.2 to instruct RREs to notify their EDI Representative in the event they receive an undocumented disposition or error code.
- Section 12.2 was rewritten and information concerning error codes SP 47, SP48, SP49, and SP50 added. SP47 and SP50 are errors that were previously possible but had not been documented in the user guide.

- Section 12.3.2 was updated to add the following new threshold error: “TPOC Amounts or NGHP Claim No-Fault Insurance Limit Amount entered exceeds $100,000,000.00 for a single claim.”
- A new Section 13.4 (Upgrade of Query Files and HEW Software to Version 5010A1) was added to provide information published in the “Upgrade of Query Files and HEW Software to ASC X12 270/271 Version 5010A1 as of January 1, 2012” alert on the MMSEA 111 Alerts page dated April 5, 2011.
- Section 13.5 (Querying Using the Beneficiary Lookup on the COBSW) was added.
- Section 15.2 was updated to correct information related to the setup for the Connect:Direct file transmission method.
- Section 15.5 was updated to reflect the implementation date of July 11, 2011 for Direct Data Entry (DDE). This section was also updated to coincide with the three DDE alerts dated February, 14, 2011 and to note that computer-based training modules are available on this topic.
- Section 17 was updated to provide additional information on using the Section 111 COBSW.
- The field description for the CMS Date of Incident (Field 12) was updated in Appendix A to include information from the alert dated October 14, 2010 concerning the date of incident for cumulative injury.
- The description for State of Venue (Field 17) on the Claims Input File was updated to note: “If the applicable law that controls the resolution of the claim is federal law (such as the Federal Tort Claim Act or the Federal Employee Compensation Act), then submit ‘US’. Otherwise if the applicable law is state law, supply the code for that state.”
- Descriptions for the Alleged Cause of Injury, Incident, or Illness (Field 15) and ICD-9 Diagnosis Code 1 (Field 19) were updated to reflect that these fields are required for all add and update transactions (as of 1/1/2011), and to document the default code that may be used on liability reports under limited circumstances.
- The description for Injured Party Gender (Field 9) of the Claim Input File Detail Record layout in Appendix A was updated to remove the note that the system defaults a value of ‘0’ to ‘1’ for matching purposes. The system only defaults the gender to a value of ‘1’ when processing a query transaction submitted with a value of ‘0’. It does not change a submitted gender value of ‘0’ when processing and matching information submitted on a Claim Input File Detail Record. RREs are advised to obtain a valid gender (‘1’ for male and ‘2’ for female) from the injured party or the query process prior to submitting claim reports and not submit the value of ‘0’ for an unknown gender.
- The Description of Illness/Injury (Field 57) in the Claim Input File Detail Record layout in Appendix A was changed to “Reserved for Future Use”. This field became obsolete as of January 1, 2011. Other references to this field throughout the User Guide were modified accordingly.
- The description for Self Insured Type (Field 65) in Appendix A was updated to add space as a valid value and provide more information on proper submission of this field. The descriptions for No Fault Insurance Limit (Field 81) and Exhaust Date for Dollar Limit for No-Fault Insurance (Field 82) were also further clarified.
- Field descriptions for all City fields in Appendix A and B were updated to note that numeric characters are not accepted. Fields were left as data type alphanumeric since certain special characters are acceptable.

- Various updates were made to the field descriptions on the Claim Input File Detail and Auxiliary Record layouts to bring these in line with associated error code descriptions. In particular, changes were made to note that certain fields in Representative, Claimant and Claimant Representative sections must contain spaces or default values when the corresponding Representative, Claimant, or Claimant Representative ***Indicator*** is blank. Some minor changes were made to error code descriptions in Appendix F to be consistent. These changes do not represent any actual system changes. They were made to add clarity based on existing requirements.
- The descriptions for TIN/Office Code Mailing Name (Field 5), TIN/Office Code Mailing Address Line 1 (Field 6) and TIN/Office Code Mailing Address Line 2 (Field 7) on the TIN Reference File Detail Record were updated in Appendix B to provide recommended formatting standards. It was also noted that that the first two characters the TIN/Office Code Mailing Name must be non-blank. The corresponding error code description was updated accordingly.
- A new Appendix D was added to document the TIN Reference Response File layout effective October 1, 2011. Subsequent appendices were renamed accordingly.
- Layouts for Version 1.2.0 of the HEW software were removed from Appendix E. Both Versions 1.2.0 and 2.0.0 of the HEW may be used until January 1, 2012. At that point, due to the upgrade to ASC X12 270/271 Version 5010A1, only Version 3.0.0 of the HEW software may be used. Appendix E was also updated to show that the file layouts used for HEW Version 3.0.0 (effective October 1, 2011) are exactly the same as those used for HEW Version 2.0.0.
- The table of Claim Response File Compliance Flag Codes in Appendix F was updated to add the values documented in the alert dated November 18, 2010 “TIN Reference File Address Validation Information for NGHP RREs”. These TIN and TIN address compliance flags will be disabled with the TIN Reference Response File implementation on October 1, 2011.
- The Claim Response File Error Code Table in Appendix F was updated to mark the following codes as obsolete: CP14, CP15, CP16, CP17, CP18, CP19, CP20, CP21, CP22, and CP23, CI24. Error code CJ06 was updated to remove the requirement that the ORM Termination Date must be at least 30 days greater than the CMS Date of Incident. CI25 was updated to remove references to the Description of Illness/Injury (former field 57). Error codes CI03 and CI05 – CI23 were updated to reflect current requirements related to submission of ICD-9 diagnosis codes. Error code descriptions for all Representative, Claimant and Claimant Representative Address Line 2 fields were updated to note the valid characters accepted in these fields. Error code descriptions related to all Representative TIN, Claimant TIN and Claimant Representative sections were updated to note that default values should be supplied if the corresponding indicator field is blank. Error descriptions for all City fields were updated to note that numeric characters are not accepted. Error code SP47 was added which should be treated in exactly the same fashion as SP48 and SP49. Error code SP50 was added. See the explanations for error codes SP47 – SP50 in Section 12.2.
- The TIN Reference Response File Error Code Table was added to Appendix F to reflect error codes that will be returned on the new TIN Reference Response File as of October 1, 2011.

- ICD-9 Diagnosis Codes E9670 – E9679 were removed from the list of Excluded ICD-9 Diagnosis Codes in Appendix I. These codes are ***now valid and accepted*** in the Alleged Cause of Injury, Incident, or Illness (Field 15) on the Claim Input File Detail Record.

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.

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. At times, certain information may be released in the form of an alert document. Any alert dated subsequent to the date of the currently published User Guide supersedes the applicable language in the User Guide. All updated Section 111 policy and technical reporting requirements published in the form of an alert will be incorporated into the next version of the User Guide. Until such time, RREs must refer to the current User Guide and any subsequently dated alerts for complete information on Section 111 reporting requirements.

Please check the CMS Section 111 Web page often at www.cms.gov/MandatoryInsRep for the latest version of this guide and for other important information such as the aforementioned alerts. In order to be notified via e-mail of updates to this Web page, click on the "For e-mail updates and notifications" link on the Web site and add your e-mail address to the distribution list.

All information pertinent to Section 111 reporting is posted to the various pages/tabs found at www.cms.gov/MandatoryInsRep. Additional information related to Section 111 can be found on the login page of the Section 111 Coordination of Benefits Secure Web site (COBSW) at www.section111.cms.hhs.gov.

To submit a policy-related comment or inquiry to CMS regarding Section 111 Mandatory Reporting, please send an e-mail to the Section 111 Resource Mailbox at PL110-173SEC111-comments@cms.hhs.gov. All technical questions should be directed to your COBC EDI Representative as explained in Section 18.1.

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. The TPOC Date is not necessarily the payment date or check issue date. The TPOC Date is the date the 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. 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.
- Liability insurance (including self-insurance), no-fault insurance, and workers' compensation are often collectively referred to as "non-Group Health Plan" or "NGHP."

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 G of this guide. Section 111 authorizes CMS implementation by program instruction or otherwise. All implementation instructions, including this User Guide, are available on (or through a download at) CMS' dedicated Web page: http://www.cms.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 of Health and Human Services (HHS) 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 and Section 7.1 of this guide in order to determine if you are an 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 http://www.cms.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 H 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.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 H 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 Electronic Data Interchange (EDI) 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 H is critical.

Additional information can be found at www.cms.gov/manuals/IOM. The MSP Manual is CMS Publication 100-05. Chapter 1 can be found at www.cms.gov/manuals/downloads/msp105c01.pdf.

There are also computer based training (CBT) modules available for Section 111 RREs that cover basic MSP topics. See Section 19 for how to enroll in these courses free of charge.

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 of HHS in a form and manner (including frequency) specified by the Secretary. The Secretary requires data for both Medicare claims processing and for MSP recovery actions, where applicable. 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 takes place between the RREs and the CMS Coordination of Benefits Contractor (the COBC). The COBC manages 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.

The COBC maintains an application on the Section 111 COB Secure Web site (COBSW) for Section 111 processing. The URL is www.section111.cms.hhs.gov. RREs will use this application on the COBSW to register and maintain reporting account information for Section 111. More information on the COBSW can be found in Section 17.

Section 111 RREs are required to register with the COBC on the Section 111 COBSW and choose an appropriate data submission method. RREs may submit claim information via an electronic file exchange or, if the RRE has a low volume of claim information to submit, a manual direct data entry (DDE) process on the COBSW. More information on data exchange options can be found in Section 15. RREs that select an electronic file submission method must fully test the file exchange process and will be assigned a quarterly file submission timeframe during which they are to submit production Claim Input Files.

Once in a production mode, RREs will submit claim information for all no-fault insurance, and workers' compensation claims involving a Medicare beneficiary as the injured party where the **TPOC Date** for the settlement, judgment, award or other payment date is **October 1, 2010**, or subsequent, and which meet the reporting thresholds described in Section 11.4. Information is also to be submitted for all liability insurance (including self-insurance) claims involving a Medicare beneficiary as the injured party where the **TPOC Date** for the settlement, judgment, award or other payment date is **October 1, 2011**, or subsequent, and which meet the reporting thresholds described in Section 11.4. In addition, RREs must submit information related to no-fault insurance, workers' compensation, and liability insurance (including self-insurance) claims for which **ongoing responsibility for medical** payments exists as of **January 1, 2010** and

subsequent, regardless of the date of an initial acceptance of payment responsibility (see the Qualified Exception in Section 11.9).

Ongoing DDE and quarterly file submissions are to contain only new or changed claim information using add, delete and update transactions.

An RRE using a file submission method 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.

An RRE using the DDE submission method will manually enter and submit individual claim reports one at a time using an interactive Web application on the Section 111 COBSW instead of submitting an electronic file. The COBC processes each claim submission as described above and provides the results back for the RRE to view on the COBSW.
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 Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN) must be included on Section 111 claim reports 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 HICN or SSN, 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 current 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.

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.

Note: All requirements in this guide apply equally to RREs using a file submission method or DDE, except those specifically related to the mechanics of constructing and exchanging an electronic file or as otherwise noted.

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.
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.
TIN Reference Response File	This is the data set transmitted from the COBC to the RRE after the information supplied in the RRE's TIN Reference File has been processed. Effective October 1, 2011.
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.

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

General:

- 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."

- You must use the information in this Section as well as the applicable statutory language in conjunction with Appendix H (Definitions and Reporting Responsibilities) in order to determine if you are a RRE for purposes of these new provisions. The statutory language is available in Appendix G.

  See Appendix H for changes made to the second paragraph under "Liability Self-Insurance" and the paragraph for "Workers' Compensation Law or Plan".

- 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**.

- **Corporate structure and RREs:**

  1. An entity may not register as an RRE for a sibling in its corporate structure.

  2. An entity may register as an RRE for itself or for any direct subsidiary in its corporate structure.

  3. A parent entity may register as an RRE for any subsidiary in its corporate structure regardless of whether or not the parent would otherwise qualify as an RRE.

4. For purposes of this rule regarding corporate structure and RREs, a captive is considered a subsidiary of its parent entity and a sibling of any other subsidiary of its parent.

5. A subsidiary may not register as an RRE for its parent.

6. The general concept is that an entity may only register for another entity if that second entity is below it in the direct line of the corporate structure. For example an entity may register for a direct subsidiary or the subsidiary of that subsidiary.

7. Example:
   - Facts –
     - Parent Company/Holding Company "A" has 4 subsidiaries (S1, S2, S3, S4).
     - "A" does not meet the definition of an RRE.
     - S1, S2, S3, and S4 meet the definition of an RRE for self-insurance or otherwise.
     - S1 has a captive insurance company (S1 Captive).
     - S1 Captive meets the definition of an RRE.

   - "A" may register as RRE for any combination of S1, S2, S3, S4. (See #3 above.)
   - "A" registers as the RRE for S1, it may report for any of S1's subsidiaries such as S1 Captive. (See #2 & #3.)
   - "A" may, but is not required to, designate S1, S2, S3, S4 or S1 Captive as its agent for reporting purposes for the subsidiaries for which it registers as an RRE. (See Section 7.2 on Use of Agents.)
   - S1, S2, S3, S4 and S1 Captive may each register separately as RREs and designate "A" or any of its sibling subsidiaries or S1 Captive as its agent for reporting purposes. (See #2 above & Section 7.2 on Use of Agents.)
   - S1, S2, S3, and S4 may not register as the RRE for each other. (See #1 above.)
   - S2, S3, and S4 may not register as the RRE for S1 Captive. (See #4 above.)
   - S1 Captive may not register as the RRE for S1 (its parent) or for any of the other subsidiaries. (See # 5 & #6.)

- **"Deductible" vs. "Self-Insured Retention" (SIR):**

  - "Deductible" refers to the risk the insured retains with respect to the coverage provided by the insurer.

  - "Self-Insured Retention" refers to the risk the insured retains that is not included in the coverage provided by the insurer.

- **<u>"Payment"</u>:**

  When referring to **"payment"** of an ORM or TPOC **in this "Who Must Report" section,** the reference is to actual physical payment rather than to who/which entity ultimately funds the payment.

- **Third Party Administrators (TPAs):**

  - 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 State established "assigned claims funds."

  - Although it may contract with a TPA or other entity as its agent for actual file submissions for reporting purposes, the RRE is limited to the "applicable plan". An RRE may not by contract or otherwise limit its reporting responsibility. 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 to act as its agent for reporting purposes.

  - Example**:** A Liability insurer hires a TPA to process claims. The TPA is a separate legal entity, makes payment decisions based upon the facts of each case, and issues payment. The RRE is the liability insurer. The liability insurer may not shift its RRE responsibility to the TPA.

<u>Acquisition/ Divestiture or Sale (Not Under Bankruptcy Liquidation)</u>:

An entity which is an RRE is acquired by another entity. The acquiring entity is the RRE as of the effective date of acquisition. The acquiring entity is the RRE with respect to **acquired** claims, including ORM.

<u>Bankruptcy:</u>

Where an RRE has filed for bankruptcy, it remains the RRE to the extent that settlements, judgments, awards or other payments are paid to or on behalf of the injured party after approval by a bankruptcy court. However, bankruptcy does not eliminate reporting obligations for bankrupt companies or their insurer, regardless of whether a bankrupt company or insurer is the RRE, for payments made pursuant to court order or after lifting the stay.

Deductible Issues vs. Re-insurance, Stop Loss Insurance, Excess Insurance, Umbrella Insurance, etc.:

- **Generally, the insurer is the RRE for Section 111 reporting.**

- See the change to the second paragraph under "Liability Self-Insurance" in Appendix H ("Definitions and Reporting Responsibilities") of this User Guide.

- Where an entity engages in a business, trade, or profession, deductible amounts are self-insurance for MSP purposes. **However,** where the self-insurance in question is a deductible, and the insurer is responsible for Section 111 reporting with respect to the policy, it is responsible for reporting both the deductible and any amount in excess of the deductible. The deductible is not reported as "self-insurance"; it is reported under the applicable policy number. The total of both the deductible and any amount in excess of the deductible is reported. (Please note that government entities are considered to be entities engaged in a business.)

- If an insured entity engages in a business, trade, or profession and acts without recourse to its insurance, it is responsible for Section 111 reporting with respect to those actions. For example: A claim is made against Company X which has insurance through Insurer Y. Company X settles the claim without informing its insurer. Company X is responsible for Section 111 reporting for the claim regardless of whether or not the settlement amount is within the deductible or in excess of the deductible.

- 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 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 a settlement, judgment, award or other payment to or on behalf of the injured party and no reporting is required by the insurer reimbursing the self-insured entity.

- See also, the subsection addressing Workers' Compensation.

Foreign Insurers (Including Self-Insurance):

The following information related to foreign RREs does not pertain to liability self-insurance or self-insured workers' compensation. CMS will issue a separate ALERT regarding foreign individuals/entities that are self-insured as defined by 42 U.S.C. 1395y(b).

For purposes of this Section 111 NGHP User Guide, the term "foreign insurer" refers to an insurer which does not have a United States Tax Identification Number (TIN) and/or a United States address.

For purposes of the Medicare Secondary Payer (MSP) provisions, "[a]n 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." (42 U.S.C. 1395y(b)(2)(A))
"Deductibles" are technically self-insurance under the Medicare Secondary Payer provisions. However, for purposes of this discussion for foreign insurers, the terms "self-insurance" and "self-insured" mean "self-insured" or "self-insurance" other than through a deductible.

The term "United States" includes the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands.

Foreign insurer/workers' compensation RREs must report pursuant to Section 111:

- If they are "doing business in the United States", or

- If a court of competent jurisdiction in the United States has taken jurisdiction over the insurer with respect to a specific liability insurance claim, no-fault insurance claim, or workers' compensation claim.

For purposes of implementing Section 111, foreign insurers are "doing business in the United States" if:

- They are registered in one or more of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, or the Virgin Islands as conducting business functions related to insurance.

- They are not so registered in one or more of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, or the Virgin Islands but are otherwise engaged in doing business in the United States through a definite presence in the United States. This includes (whether by mail or otherwise):

    - Issuing or delivering insurance contracts to residents of or corporations licensed (or otherwise authorized if licensure is not required) to do business in one or more of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, or the Virgin Islands.
    - Soliciting applications for insurance contracts registered in one or more of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, or the Virgin Islands.
    - Collecting premiums, membership fees, assessments, or other considerations for insurance contracts in one or more of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, or the Virgin Islands.
    - Transacting any other insurance business functions in one or more of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, or the Virgin Islands.

An insurer or workers' compensation entity which is defending against a liability insurance claim, no-fault insurance claim, or workers' compensation claim is not subject to Section 111 reporting solely on the basis of its actions in defending the insured.

However, if a court of competent jurisdiction in the United States specifically takes jurisdiction over the insurer or workers' compensation entity, the insurer or workers' compensation entity is subject to Section 111 reporting for the matter at issue.
With respect to privacy issues, please note that by regulation Medicare beneficiaries have already consented to the release of information required for coordination of benefit purposes.

> *Release of information.* The filing of a Medicare claim by or on behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes. (42 C.F.R. 411.24(a))

Fronting Policies:

The intent with "fronting" policies is that the insurer will not ultimately retain any risk under the insurance policy. The expectation of both the insured and the insurer is that the insured will retain the ultimate risk under the insurance policy for all claims. Where the insured pays the claim, the insured is the RRE. Where the insurer pays the claim, the insurer is the RRE.

Liquidation (settlement, judgment, award or other payment obligation against the entity in liquidation):

- To the extent that settlement, judgment, award, or other payment to or on behalf of the injured party is **funded** from the assets of the entity in liquidation, the entity in liquidation is the RRE.

- To the extent that a portion of a settlement, judgment, award or other payment obligation to or on behalf of the injured party is **funded** by another entity from that other entity's assets (for example, payment by a state guarantee fund), the entity that makes payment is the RRE.

- To the extent that a payment does not fully satisfy the entity in liquidation's debt to the injured party, the amount reported is the amount paid. Any subsequently approved interim or final payments would be handled in the same manner. That is, they would be reported as additional TPOC amounts.

Multiple Defendants:

- Where there are multiple defendants involved in a settlement, an agreement to have one of the defendant's insurer(s) 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 a settlement, judgment, award or other payment with joint and several liability, each insurer must report the total settlement, judgment, award, or other payment – not just its assigned or proportionate share.

Multi-National Organizations, Foreign Nations, American Indian, Alaskan Native Tribes:

Liability insurance (including self-insurance), no-fault insurance and workers compensation plans associated with multi-national organizations, foreign nations, American Indian and Alaskan Native tribes are subject to the MSP provisions and must be reported accordingly.

Self-Insurance Pools:

- RRE for liability insurance or workers' compensation self-insurance pools -- Entities self-insured in whole or in part with respect to liability insurance or workers' compensation may elect, where permitted by law, to join with other similarly situated entities in a self-insurance pool such as a joint powers authority (JPA).

- "Review or approval authority" means that the self-insured entity has the ability to affect the payment or other terms of the settlement, judgment, award or other payment (including ORM).

- If all three of the characteristics below are met, the RRE is the self-insurance pool:

    1. The self-insurance pool is a separate legal entity.
    2. The self-insurance pool has full responsibility to resolve and pay claims using pool funds.
    3. The self-insurance pool resolves and pays claims without review or approval authority by the participating self-insured entity. When a self-insured entity in the self-insurance pool (including, for example, a JPA) has the review or approval authority for the payment of claims and/or negotiated resolutions, the self-insurance pool is not the RRE, the individual self-insured members are the RREs.

- Exception: Where the statute authorizing the establishment of a self-insurance pool stipulates that said self-insurance pool shall be licensed and regulated in the same manner as liability insurance (or workers' compensation, where applicable), then the self-insurance pool is the RRE. Absent meeting this exception, unless all three of the characteristics specified under the preceding bullet apply to the self-insurance pool, the participating self-insured entity is the RRE.

- Where the individual members are the RREs, each of the members would have the option of using the self-insured pool (or another entity) as its agent for purposes of Section 111 reporting.

- Example**:** A self-insurance pool meets the three characteristics specified above for some members of the pools but not for others. The self-insurance pool provides administrative services only (ASO) for certain members. The RRE is the self-insurance pool only for those members for which it meets the three

characteristics specified above. Each member who receives ASO from the self-insurance pool is a separate RRE for its settlements, judgment, awards, or other payments. The self-insurance pool is not the RRE for such members.

State established "assigned claims fund": 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:

- "Review or approval authority" means that the State agency has the ability to affect the payment or other terms of the settlement, judgment, award or other payment (including ORM).

- 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. (Note: This would be an example of the rare situation where a TPA entity would also be an RRE for NGHP.)

- 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.

- Example: A State agency pays no-fault claims using a State fund which is not under the agency's control. Additionally, the State agency designates an insurance carrier to resolve liability insurance claims, but the State agency retains payment responsibility. The State agency is the RRE for both the liability insurance and the no-fault insurance. It may report both types of insurance under a single RRE ID # or obtain a separate RRE ID # for each type of insurance.

Subrogation by an Insurer:

- Fact pattern:
    - Insurer A pays claim of its insured under the terms of its contract. The insurer is the RRE and reports the payment.
    - Insurer A may file a subrogation claim (on behalf of its insured/the injured party) against another insurer B.
    - Assume insurer B indemnifies insurer A for the payment it previously made. The indemnification payment is not reportable by either insurer.

Workers' Compensation:

- See the "Workers' Compensation Law or Plan" paragraph of Appendix H ("Definitions and Reporting Responsibilities") in this User Guide.

- Appendix H 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 "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 following rules apply:*

    - Where the applicable law or plan authorizes an employer to purchase insurance from an insurance carrier and the employer does so, follow the rules in the subsection for "Deductible Issues vs. Re-insurance, Stop Loss Insurance, Excess Insurance, Umbrella Insurance, etc."

    - Where the applicable law or plan authorizes an employer to self-insure and the employer does so independently of other employers, follow the rules in the subsection for "Deductible Issues vs. Re-insurance, Stop Loss Insurance, Excess Insurance, Umbrella Insurance, etc." (Here the reference is to "self-insurance" other than a "deductible.")

    - Where the applicable law or plan authorizes employers to join with other employers in self-insurance pools (e.g., joint powers authorities) and the employer does so, follow the rules in the subsection for "Self-Insurance Pools".

    - 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.

    - In situations where the 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 –

        - "Review or approval authority" means that the agency has the ability to affect the payment or other terms of the settlement, judgment, award or other payment (including ORM).

- 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.

- Where "workers' compensation law or plan" refers to "*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"* follow the rules for insurer or self-insured, as applicable, including the rules for self-insurance pools. (Here the reference is to "self-insurance" other than a "deductible.")

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 or before reporting via DDE may commence. Through the registration process, the COBC will obtain the information needed to:

- Validate information provided by the RRE registrant
- Identify the method (file submission or DDE) an RRE will use to submit claim information to meet Section 111 reporting requirements
- Assign a Section 111 Responsible Reporting Entity Identification Number (RRE ID) to each RRE file and DDE submitter
- 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 file submission timeframe for Claim Input File submission to each entity selecting an electronic file submission method
- Establish the necessary file transfer mechanisms
- Assign a COBC Electronic Data Interchange Representative (EDI Rep) to each entity to assist with ongoing communication, use of the COBSW 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 an 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 Account 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 Materials" menu option. You must be logged into the application to gain access to the Section 111 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 registration to be completed and a full quarter for file testing, as applicable, if they have future situations where they have a reasonable expectation of having to report. Once an RRE that is set up as a file submitter has completed testing, the RRE ID is set to a production status. The RRE must then commence production Claim Input File submissions. Claim Input Files are submitted once per quarter for each RRE ID during the assigned file submission timeframe unless the RRE has nothing to report in that quarter. An RRE that is set up as a DDE submitter will not perform testing. It must submit claim information via the Section 111 COBCSW according to requirements documented in this guide.

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, which includes 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 can occur when a reporting entity has multiple RRE IDs under which they will report separate Claim Input Files or when the entity chooses to name an agent 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 data submission 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 submit and view claim information if the RRE has specified the DDE option.
- 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, known as Account Designees, to register as users of the COBSW associated with the RRE's account. Account Designees assist the Account Manager with the reporting process. Account Designees may be RRE employees or agents. There is no limit to the number of Account Designees associated with one RRE ID.

The Account Designee:

- Must register on the 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 submit and view claim information if the RRE has specified the DDE option.
- 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 claim information 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 data 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. Most DDE submitters will only need one RRE ID, since multiple users can have access to the same RRE ID account.

For example, if an RRE will use one agent to submit workers' compensation claims in one file and another agent to submit liability and no-fault claims in another file, 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 Claim Input Files, or provide claim information using the Direct Data Entry (DDE) option, for every RRE ID you establish. Note that RREs do not need to submit a file for a particular quarter if they have nothing to report according to the requirements specified in this guide.

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 RRE ID. Your Account Manager must invite and identify Account Designees who 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 for existing and new RREs. 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 Representative to have it deactivated.

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 Representative.

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 report 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. 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 on the Section 111 COBSW.

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. 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.

If you do attempt to provide subsidiary information during the New Registration step, all TINs supplied for subsidiaries under one RRE ID must be unique. In other words, all TINs for the RRE ID and subsidiaries listed in the New Registration step must be different within one specific RRE ID. You can use the same TIN for multiple, different RRE IDs. TINs just need to be unique within the same RRE ID. For example, if you are one entity with one TIN registering five different RRE IDs, you can use the same TIN for all five distinct RRE IDs. If you have trouble with data entry on the corporate structure/subsidiary page, since this page is not required in order to complete the New Registration step, you may simply click on the Continue button to bypass this page.

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.

Note: Please see Section 8.2.1 for information on how foreign entities may register 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 data transmission method (file or DDE)
- Provide file transmission information needed if the Connect:Direct transmission method is selected. Refer to Section 15.2 for more information. ***You must have destination dataset names 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 Representative.

This step must be repeated for each RRE ID.

Step 5: Return Signed RRE Profile Report – Authorized Representative

Once account setup has been completed by the Account Manager on the COBSW 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 e-mail to your Account Manager indicating that testing can begin.

The status of your RRE ID will be updated by the system as each step of the registration process is completed. Once the COBC receives your signed profile report, your RRE ID will be placed in a "testing" status. Once testing is completed (See Section 14), your RRE ID will be placed in a "production" status. RRE IDs are expected to move to a production status within 180 days after initiation of the registration process (completion of the New Registration step). No testing is required for the DDE option. RRE IDs for DDE submitters will be set to a production status after the signed profile report is received at the COBC and production reporting may begin immediately thereafter.

As of January 2012, the RRE's profile report will be e-mailed to the Authorized Representative annually, based upon the receipt date of the last signed profile report. The RRE will be asked to confirm via e-mail that their current information is correct. Failure to confirm this information may result in deactivation of the RRE ID.

8.2.1 Foreign RRE Registration

This section provides information on how RREs who have no IRS-assigned TIN and/or US mailing address (including Guam, Puerto Rico, and the US Virgin Islands as part of the US) may register for Section 111 reporting on the COBSW. Please review the 5 steps above and then follow these additional instructions.

CMS encourages foreign entities that do not have a U.S. TIN or EIN to apply for a U.S. EIN by completing the Internal Revenue Service (IRS) SS-4 Application and use that number to register if possible.

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.

- If the RRE has a valid IRS-assigned TIN, provide that number. If the RRE does not have an IRS-assigned TIN, then enter a fake or pseudo-TIN in the format of 9999xxxxx where 'xxxxx' is a 5-digit number created by the RRE.
- Supply a valid e-mail address for the Authorized Representative.
- If the RRE does not have a mailing address in the United States, enter 'FC' in the RRE state code and leave the other RRE address fields blank.
- If the Authorized Representative does not have a mailing address in the United States, enter 'FC' in the Authorized Representative state code and leave the other address fields blank.
- After successfully completing the New Registration step on the COBSW, a page will display with your RRE ID and assigned Section 111 EDI Representative.
- You must contact your EDI Representative or call the COBC EDI Department at 646-458-6740 to continue with the registration process.
- Provide your EDI Representative with the actual valid international addresses for the RRE, Authorized Representative and Account Manager as applicable. You may be asked to provide other supporting documentation depending on the circumstances.
- A letter will then be sent to your Authorized Representative with the PIN needed to complete the Account Setup step on the COBSW.
- Upon receipt of the PIN, the Account Manager for the RRE must go to the Section 111 COBSW Login page and click on the "Account Setup" button to continue with the registration process.
- If your Account Manager does not have a mailing address in the US, then he/she may enter 'FC' in the Account Manager state code field and leave the rest of the address fields blank.
- After the Account Manager has completed the Account Setup step on the COBSW and the registration has been accepted by the COBC, an e-mail will be sent to the RRE's Authorized Representative and Account Manager with a profile report.
- Once the Authorized Representative has signed and returned the profile report to the COBC and its receipt has been noted by your EDI Representative in the system, the status for the RRE ID will be set to "testing" (or directly to "production" in the case of DDE submitters) and data submission may commence as for other RREs.

The assigned RRE ID will be the primary identifier used by the COBC for a foreign entity that registers with a pseudo-TIN. That RRE ID must be submitted on all input files as is the case with all RREs. Foreign RREs, who have registered with a pseudo-TIN, will be able to use the pseudo-TIN created for registration in the TIN Field 72 of the Claim Input File Detail Record and in the TIN Field 3 of the TIN Reference File Detail Record. International addresses for the RRE must be provided in the Foreign Address Lines 1-4 (Fields 12-15) on the TIN Reference File Detail Record. Please refer to Section 11.3 and Appendix B for more information on formatting the TIN Reference File.

Regardless of when a foreign RRE completes registration and testing, it is required to adhere to retroactive reporting requirements documented in Section 11.10.2, as applicable, when submitting its initial Claim Input File.

8.3 Changes to RRE Registration and Reporting

This section provides information regarding steps RREs must take if changes occur after initial Section 111 registration is completed.

8.3.1 Abandoned RRE IDs

If you erroneously registered for an RRE ID that you no longer need or have abandoned due to starting the registration process over, and you will not use the RRE ID for Section 111 file submission, please contact your assigned EDI Representative to have that number deleted. Unused RRE IDs may trigger automated warning notifications and follow-up by the COBC to the associated Authorized Representative and/or Account Manager. ***Delete*** requests should only be made for RRE IDs that have ***never*** been used for production file submission.

8.3.2 Ceasing and Transitioning Reporting

If you have been reporting production Section 111 files under an RRE ID but will cease reporting under it in the future due to changes in your reporting structure, changes to what entity is the RRE, ceasing business operations or other reasons, then please contact your assigned EDI Representative. Inform your EDI Representative of circumstances affecting the change. Since the RRE ID was used for production reporting, it will ***not*** be deleted. You and your EDI Representative will create a transition plan and your EDI Representative will change the status of your RRE ID to an "inactive" status after your last production file/DDE submission has been processed. Once the status is changed, information for the RRE ID will remain in the COBC Section 111 system. However, production data submissions will no longer be accepted or expected. This change in RRE ID status will prevent the automatic generation of the Late File Submission e-mails and subsequent follow-up contact by the COBC to your Authorized Representative and Account Manager related to Section 111 reporting compliance.

The transition of reporting responsibility from one RRE to another is the responsibility of the RREs involved. The COBC cannot supply a file of previously submitted and accepted records for use in the transition by the new or former RRE or their reporting agents. The new RRE may register for a new RRE ID or report the transitioned claim records under one of its existing RRE IDs. ***The new RRE may update and delete records previously submitted by the former RRE under a different RRE ID as long as the key fields for the records match.*** The RRE IDs do not need to match. The former RRE must ***NOT*** delete previously submitted and accepted records. If the ORM previously reported has ended, then update transactions should be sent with applicable ORM Termination Dates. The new RRE may send add transactions for new ORM and new claims with TPOCs or update transactions to change existing records with new information such as the new RRE TIN. Please see Sections 11.7 and 11.8 for more information on submitting claims with ORM and submitting add, delete and update transactions.

If an RRE is changing reporting agents, the new agent should continue to submit files under the RRE's existing RRE ID(s). Again, the COBC cannot supply a file of previously submitted and accepted records for the RRE IDs. It is the RRE's responsibility to coordinate the transition of reporting from the former agent to the new agent. Individuals from the new reporting agent should be given access to the RRE ID on the Section 111 COBSW (http://www.section111.cms.hhs.gov/). This can be done by the Account Manager for the RRE ID by using the Designee Maintenance action off the RRE Listing page and inviting these individuals as Account Designees. The new agent may then use their COBSW login IDs for access to the RRE ID on the COBSW as well as for the HTTPS and SFTP file transmission methods. The Account Manager should remove any Account Designees associated with the former agent from their RRE ID account on the COBSW.

If you have questions regarding your specific circumstances related to ceasing or transitioning reporting, please contact your EDI Representative.

8.3.3 Changing RRE Information

After registration is completed on the Section 111 COBSW, your Account Manager may update certain information related to the RRE profile. After logging on to the COBSW (www.section111.cms.hhs.gov), Account Managers may use the RRE Information action off the RRE Listing page to update the RRE name, address and telephone information. Account Managers may also invite new Account Designees and remove Account Designee access to the RRE ID as appropriate. Account Managers may also change from the HTTPS or SFTP file submission method to DDE (if the RRE indicated they had less than 500 paid claims per year during registration as specified in Section 15.5).

Updates to other information such as changing reporting agent, changing from one file transmission method to another, changing from DDE to a file transmission method, overriding the 500 claim limit for DDE, or changing the TIN associated with the RRE ID must be requested through your EDI Representative. You must also contact your EDI Representative to change your Authorized Representative or Account Manager to a different individual.

Note that all users of the COBSW may update their own personal information associated with their login ID such as e-mail address or phone number after logging on to the site.

9 File Format

This section pertains to those RREs choosing a file submission method, not DDE.

9.1 General File Standards

The Claim Input File and TIN Reference Files are transmitted in a flat, text, 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 free 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 E 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 is documented in an X12 270/271 companion guide that can be downloaded from the NGHP page of www.cms.gov/MandatoryInsRep. Note that the COBC is currently using the 4010A1 version of the X12 270/271 but will transition to the 5010A1 version by January 1, 2012 (see Section 13.4). RREs will continue to be given at least 6 months advance notice for any future upgrades.

With the exception of the X12 270/271, all input files submitted for Section 111 must be fixed width, flat, text files. All records in the file must be the same length as specified in the file layouts. If the data submitted ends prior to the end of the specified record layout, the rest of the record must be completely filled or padded with spaces. 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. A carriage return/line feed (CRLF) character is in the byte following the end of each record layout defined in the appendices (2221st byte of the line if the record is defined as 2220 bytes). 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. The file submission date supplied on the header record must match the date supplied on the corresponding file trailer record.

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. ***These standards apply unless otherwise noted in specific file layouts.***

Data/Field Type	Formatting Standard	Examples
Numeric	Zero through nine (0 - 9) Right justified. **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. ***Note: the last two positions of dollar amount fields reflect cents. For example, in an 11 byte numeric field specified as a dollar amount, an amount of 10,000 (ten thousand) dollars and no cents must be submitted as "00001000000".***	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 last name fields.	Alpha (12): "TEST EXAMPLE" Alpha (12): "EXAMPLE " Alpha (12): "SMITH-JONES " Alpha 12): "O'CONNOR "

Data/Field Type	Formatting Standard	Examples
	First name fields may only contain letters and spaces.	
Alphanumeric	A through Z (all alpha) + 0 through 9 (all numeric) + special characters: Comma (,) Ampersand (&) Space ( ) Hyphen/Dash (-) Period (.) Single quote (‘) Colon (:) Semicolon (;) 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. Parentheses () are not accepted.	Text (8): “AB55823D” Text (8): “XX299Y “ Text (18): “ADDRESS@DOMAIN.COM” Text (12): “ 800-555-1234” Text (12): “#34 “
Alphanumeric Plus Parens	Same as above but including Parentheses ()	“Department Name (DN)”
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.	

10 File Submission Timeframe

This section pertains to those RREs choosing a file submission method, not DDE.

Production Claim Input Files must be submitted on a quarterly basis during your assigned, 7-day file submission timeframe unless the RRE has nothing to report for a particular quarter. Test files may be submitted at any time with an unlimited frequency. TIN Reference Files must be submitted prior to or with your initial production Claim Input File. They are optional with subsequent production Claim Input File submissions absent any changes to TIN Reference File Detail Records. 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. It also is displayed on the RRE Listing page after logging on to the Section 111 COBSW. 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. The file receipt date is based on when it is recognized by the daily batch cycle. Files submitted prior to 6pm (EST) on business days will be marked as received on that day. Files received after Friday at 6pm (EST) will not be marked as received until the next business day which would be Monday (or Tuesday in the event of a Federal holiday). 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.

TIN Reference Files may be sent as often as needed at any time during a calendar quarter. Many RREs choose to submit a TIN Reference File with every Claim Input File submission. Since information from the TIN Reference File is needed for successful processing of the Claim Input File, your TIN Reference File must be submitted and successfully processed before or at the same time as your Claim Input File.

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.
- RREs in a testing status may submit test Claim Input Files.
- 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, excluding those with only liability insurance (including self-insurance) TPOCs to report, were to submit their initial production Claim Input File during their assigned file submission timeframe during the first calendar quarter (January - March) 2011.
- RREs are required to commence reporting of liability insurance (including self-insurance) TPOCs with TPOC Dates of 10/1/2011 and subsequent on quarterly production Claim Input Files according to assigned file submission timeframes during the first calendar quarter (January – March) of 2012.
- Regardless of when an RRE completes registration and testing, it is required to adhere to retroactive reporting requirements documented in Section 11.10.2, as applicable, when submitting its initial Claim Input File.

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

This section pertains to **both** DDE and those RREs choosing a file submission method, with the exception of information that pertains specifically to the physical creation and transmission of electronic files. DDE submitters must submit the same data elements and adhere to essentially the same Section 111 reporting requirements as file submitters. DDE submitters enter claim information manually on the Section 111 COBSW while file submitters transmit this same information in the form of an automated electronic 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. Claim information is to be submitted for no-fault insurance and workers' compensation claims that are addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award or other payment on or after **October 1, 2010** that meet the reporting thresholds described in Section 11.4. Claim information is to be submitted for liability insurance (including self-insurance) claims that are addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award or other payment on or after **October 1, 2011** that meet the reporting thresholds described in Section 11.4. A TPOC single payment obligation is reported in total regardless of whether it is funded through a single payment, an annuity or a structured settlement. RREs must also report claim information where ongoing responsibility for medical services (ORM) related to a no-fault, workers' compensation or liability claim was assumed by the RRE on or after **January 1, 2010**. In addition, claim information is to be transmitted for no-fault, workers' compensation and liability claims for which ORM exists on or through January 1, 2010, regardless of the date of an initial acceptance of payment responsibility (see the Qualified Exception in Section 11.9). Refer to Section 5 "MSP Overview", Section 11.10.2 "What Claims Are Reportable/When Are Such Claims Reportable?" and Appendix H ("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. Field descriptions in Appendix A apply to both file submission and the information submitted via DDE.

The Claim Input File is submitted on a quarterly basis during the RRE's assigned file submission timeframe. Claim information can be submitted by DDE RREs on the COBSW at any time but at least within 45 days of establishing a TPOC or assuming ORM. The COBC will use this information to determine if the injured party reported can be identified by CMS as a Medicare beneficiary based upon the information submitted

and whether the beneficiary's coverage under Medicare continued or commenced on or after the date of incident (DOI) (as defined by CMS). See Section 11.1.1 for more information on how the COBC matches records to its database of Medicare beneficiaries.

RREs were to submit initial, production Claim Input Files during their assigned file submission timeframe in the first calendar quarter of 2011 (January – March 2011). DDE submitters were to commence production reporting in July of 2011. Initial submission must include retroactive reporting according to the dates specified above for TPOC Amounts and ORM.

If the claim information provided on the Claim Input File or submitted via DDE 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 COBC will commence creation of the response file as soon as all submitted records have finished processing but no later than 45 days after file submission**.** Response files may take up to 48 days to be created and transmitted to the RRE. Responses are also produced for DDE claim submissions, but results are displayed on the "Claim Listing" page of the COBSW. ***RREs must react and take action on the information returned in the response file or displayed on the DDE Claim Listing page.*** 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. DDE submitters must correct and resubmit erroneous claims on the COBSW as soon as possible. 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 to be submitted per liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim where the injured party is a Medicare beneficiary. Records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by RRE, etc. 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. See Section 11.8 for more information on reporting ORM.

RREs must implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary. See Section 13 for more information on the query process available for this purpose. RREs must submit either the Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN) for the injured party on all Claim Input File Detail Records. RREs are to report only with respect to Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award, or other payment). If a reported individual is not a Medicare beneficiary or CMS is unable to validate a particular HICN or SSN based upon the submitted information, CMS will reject the record for that individual. The Applied Disposition Code (Field 27) on the corresponding Claim Response File Detail Record will indicate the reason for rejection. Complete response file processing is covered in Section 12.

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 be submitted prior to or with 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

11.1.1 Matching Records to Medicare Beneficiaries

To determine whether an injured party is a Medicare beneficiary, the COBC must match your data to Medicare's. This matching can be done using either an individual's Medicare Health Insurance Claim Number (HICN) or by using an individual's Social Security Number (SSN). The Medicare HICN is preferred and once the HICN is returned on a response file, the RRE is required to use it on all subsequent transactions. You must send either a HICN or an SSN as part of the injured party's record in the Claim Input File or the Query Input File. 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 HICN or SSN. 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, current HICN. You must store this HICN on your internal files and are required to 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.

Note that if an RRE submits a value of '0' for an unknown gender for an individual, the COBC will change this value to a '1' for matching purposes and may return that changed value of '1' on the response record even if a match is not found.

HICNs may be changed by the Social Security Administration (SSA) at times but the COBC is able to crosswalk the old HICN to the new HICN. The COBC will always return the most current HICN on response records and RREs are to update their systems with that information and use it on subsequent record transmissions. However, updates and deletes sent under the original HICN/SSN will still be matched to the current HICN.

If an RRE submits **both** the SSN and HICN on a claim or query record, the system will **only use the HICN** for matching purposes and the SSN will be ignored. The system will attempt to match the HICN to any previously assigned HICN for the individual, since HICNs can change or be reassigned by SSA, but if no match is found using the HICN it will not then make a second attempt to match using the SSN provided.

You should send the most recent, most accurate information you have in your system for name, date of birth and gender. The best source of this information is the beneficiary's Medicare Insurance Card. 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.

In most cases the Medicare HICN is constructed by SSA using an SSN. However, the SSN used may not always be the SSN assigned to the Medicare beneficiary. In some cases the SSN used for the unique HICN may instead be the SSN of the beneficiary's spouse followed by a suffix to make it unique. For example, suppose there is a married couple where only the husband worked outside the home. Suppose the husband's SSN is 111111111 and his spouse's SSN is 222222222. When both of these individuals turn age 65 and become covered by Medicare, SSA could assign the husband a HICN of 111111111A and the spouse a HICN of 111111111B. Suppose later, the husband dies. At some point after that, SSA might assign a new HICN to the spouse of 222222222A or 111111111D if she never worked outside the home. This is only one example of many complicated possibilities. The important thing to remember is that every Medicare beneficiary receives a unique HICN assigned specifically to them. Even if it is based on another related individual's SSN, it will have a unique prefix or suffix. For Section 111 reporting, always report information for the actual injured party using that injured party's information (SSN, HICN, name, date of birth, gender). If that information is matched to a Medicare beneficiary, you will be returned the HICN for that individual and must use that HICN going forward.

11.1.2 Matching Claim Records

Because Medicare stores information on claims submitted previously by certain key information, the following fields on a delete or update record must match the original, accepted add record sent previously in order for the delete or 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)

The COBC passes claim information on to several Medicare systems. One such system is the Common Working File (CWF) which is used in the Medicare claims payment process. The COBC provides this system information regarding claims reported with ORM so that this information can be used to prevent Medicare from making erroneous primary payment for a medical claim that should be covered by Workers' Compensation, No-Fault Insurance or Liability Insurance ORM instead. The key fields listed above are the key fields used by CWF. However, ***all*** claim records are passed to the MSPRC for recovery consideration and that system recognizes differing policy and claim numbers on the claim records it receives. 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 and update records should be submitted with the same policy and claim numbers as submitted on the original add record for the claim unless the policy and claim numbers associated to the claim were changed by the RRE after the initial claim report was made. In the case of a changed or corrected policy or claim number, an RRE must submit the most current, accurate policy and claim number associated with the claim on subsequent updates and deletes. A change in policy or claim number does not in and of itself trigger the need for an update, but updates to this information will be accepted. See the conditions for update and delete requirements specified in the Event Table in Section 11.7.4.

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. You must adhere to all requirements specified for a field as documented in the record layout field descriptions and associated error codes in Appendix F.

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. The date on the header record must match the date supplied on the corresponding trailer record.

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. DCNs are automatically generated by the system for those RREs using DDE.

Records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by claim 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 automobile insurance policy if the policy were reporting a med pay or PIP (considered to be no-fault) assumption of ongoing responsibility for medicals (ORM) and/or exhaustion/termination amount as well as a liability insurance (bodily injury coverage) 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. The file submission date must match the date supplied on the corresponding 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

All add and update records on Claim Input Files and DDE submissions must include International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes considered valid for Section 111 reporting in the Detail Record Alleged Cause of Injury, Incident or Illness (Field 15) and in at least the first of the ICD-9 Diagnosis Codes 1-19 beginning in Field 19. These fields are used as a means to provide a description of the alleged illness, injury or incident claimed and/or released by the settlement, judgment, award, or for which ORM is assumed. RREs may use diagnosis codes submitted on medical claim records they receive from the injured party related to the claim and/or derive ICD-9 Diagnosis Codes from the claim information the RRE has on file. Again these codes may be derived by the RRE and do not have to be diagnoses specifically made by a provider or supplier of medical services (e.g. physician, hospital, etc.) They are used by Medicare to identify claims Medicare may receive related to the incident for Medicare claims payment and recovery purposes. An exact match to ICD-9 diagnosis codes is not required during this identification but RREs are encouraged to supply as many related codes in the ICD-9 Diagnosis Code 1-19 Fields

as possible to ensure Medicare identifies the applicable medical claims it receives. Field descriptions are provided in the record layout in Appendix A. This section provides more information concerning the requirements for these fields.

Acceptance of text in the Description of Illness/Injury (former Field 57) instead of valid ICD-9 Diagnosis Codes was discontinued as of January 1, 2011. Field 57 is no longer used.

Valid ICD-9 Diagnosis Codes

Text and Excel files containing the list of valid ICD-9 diagnosis codes used for validating Section 111 files are available for download on the Section 111 COBSW at www.section111.cms.hhs.gov. RREs may obtain this list by clicking on the link found under the Reference Materials menu option. The files are updated by the COBC in January of each year.

Once an ICD-9 diagnosis code is considered acceptable for Section 111 reporting, it will not be removed from the list of valid codes and may continue to be submitted on subsequent update transactions unless unforeseen updates are made to the list of excluded codes. Decimal points are not to be included.

If an invalid ICD-9 diagnosis code is submitted, the record will be rejected with an error associated to the field in which the code was submitted, even if valid codes are supplied in one or more of the remaining ICD-9 Diagnosis Code fields. More specific requirements are given below.

The files of valid ICD-9 diagnosis codes used for Section 111 reporting were created by the COBC using the following methodology. This information is provided as background information only as it is no longer necessary for RREs to create their own files. **RREs are advised to use the list of valid ICD-9 diagnosis codes posted to the Section 111 COBSW and incorporate the refreshed list after it is posted to the Section 111 COBSW each January by the COBC**.

CMS publishes a list of valid ICD-9 diagnosis codes once per year at http://www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. These are the codes providers (physicians, hospitals, etc.) and suppliers must use when submitting claims to Medicare for payment. These codes are the basis of those used for Section 111 reporting with some exceptions applied. The COBC will consider any ICD-9 diagnosis code found in any of Versions 25 and subsequent posted to this website as valid as long as that code does not appear on the list of Excluded ICD-9 Diagnosis Codes in Appendix I and does not begin with the letter 'V'. The COBC will add codes from the new versions by **January 1st** of the next year. For example, Version 28 which was posted on the CMS website as effective October 1, 2010, was incorporated into Section 111 processing as of January 1, 2011. 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 on any of the files incorporated into the COBC Section 111 process, from Versions 25 and subsequent, is not a code found on the list of exclusions in Appendix I and is not a code that begins with the letter 'V'.

As of this writing, the COBC is using the following files to validate ICD-9 codes with the exceptions as noted above:

CMS28_DESC_LONG_DX.txt (from Version 28)
CMS27_DESC_SHORT_DX.txt (from Version 27)
V26 I-9 Diagnosis.txt (from Version 26)
I9diagnosesV25.txt (from Version 25)

To download a copy of these files:

- Go to www.cms.gov/ICD9ProviderDiagnosticCodes/06_codes.asp
- Download the following ".zip" files displayed on that page:
  - Version 29 Full and Abbreviated Code Titles – Effective October 1, 2011
  - Version 28 Full and Abbreviated Code Titles - Effective October 1, 2010
  - Version 27 Abbreviated Code Titles - Effective October 1, 2009 Version 26 Effective October 1, 2008 Version 25 Effective October 1, 2007
- Unzip the files and use:
  - Version 29 (effective 1/1/2012): Any of the text or Excel files with "DX" in the name
  - Version 28: Any of the text or Excel files with DX in the name
  - Version 27: CMS27_DESC_SHORT_DX.txt
  - Version 26: V26 I-9 Diagnosis.txt
  - Version 25: I9diagnosesV25.txt

Note: Starting with Version 27, CMS also provides Microsoft Excel spreadsheets with the same list of valid diagnoses in the ".zip" files on this Web page. You may use the text files listed above or the Excel (".xls") files. They contain the same set of ICD-9 diagnosis codes. **Be sure to use the diagnosis files that include "DX" in the names and *not* the procedure code files that include "SG" in the names.**

Again, RREs are advised to simply download the file of valid ICD-9 diagnosis codes used for Section 111 reporting from the Reference Materials menu option on the Section 111 COBSW at www.section111.cms.hhs.gov once per year in January rather than going through the process of creating their own version using the methodology described above.

CMS recognizes that there will not always be an E-Code that matches the circumstance for the Alleged Cause of Injury, Incident or Illness. When this occurs, a code for Field 15, the Alleged Cause of Injury, Incident or Illness must still be submitted. When there is not a good E-Code match, the ICD-9 Code(s) reported starting in Field 19 becomes even more critical and must accurately describe the injury, incident or illness being claimed or released or for which ORM is assumed. If an RRE searches ***all*** available E Codes and determines none fits the actual Alleged Cause of Injury, Incident or Illness, it is suggested that one of the following codes be submitted:

E0008 – External cause status NEC
E0009 – External cause status NOS
E8498 - Accidents occurring in other specified places
E8499 - Accidents occurring in unspecified place

Excluded ICD-9 Diagnosis Codes

CMS has determined that certain ICD-9 diagnosis codes published on the files listed above do not provide enough information related to the cause and nature of an illness, incident or injury to be adequate for Section 111 reporting and are therefore must be excluded from claim reports. A list of these codes is provided in Appendix I and is referred to as the list of "Excluded ICD-9 Diagnosis Codes". These codes will NOT be accepted in the Alleged Cause of Injury, Incident or Illness (Field 15) or in the ICD-9 Diagnosis Codes beginning in Field 19.

All "V Codes" (ICD-9 diagnosis codes beginning with the letter 'V') are considered invalid for Section 111 reporting. They are not listed singly on the exclusion list in Appendix I. No V Codes will be accepted for Section 111 reporting.

Excel and text files containing the list of Excluded ICD-9 Diagnosis Codes found in Appendix I may be downloaded from the Section 111 COBSW at www.section111.cms.hhs.gov by clicking on the link found under the Reference Materials menu option.

Requirements

- When there is a **TPOC** settlement, judgment, award or other payment, RREs are to submit ICD-9 codes to reflect **all the alleged illnesses/injuries claimed and/or released**. Where **ORM** is reported, RREs are to submit ICD-9 codes for **all alleged injuries/illnesses for which the RRE has assumed ORM**.
- If, due to a subsequent ruling, an ICD-9 diagnosis code previously submitted no longer applies to the claim, RREs may send an update transaction without the particular ICD-9 diagnosis code but must include all ICD-9 diagnosis codes that still apply.
- 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.
- ICD-9 codes are to be submitted with no decimal point.
- Codes must be left justified and any remaining unused bytes filled with spaces to the right.
- Leading and trailing zeroes must be included only if they appear that way on the list of valid ICD-9 diagnosis codes (see below). Do not add leading or trailing zeroes just to fill the 5 positions of the field on the file layout.
- Valid ICD-9 diagnosis codes can be 3, 4 and 5 digits long but no partial codes may be submitted. In other words, you may not submit only the first 3 digits of a 4-digit code.
- The downloadable list of ICD-9 codes considered valid by CMS for Section 111 reporting is posted under the Reference Materials menu option of the Section 111 COBSW at www.section111.cms.hhs.gov. The submitted code must ***exactly*** match the first 5 bytes/characters of a record on this list.
- 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 Fields beginning in Field 19 on all add and update records. ICD-9 diagnosis code edits are not applied to delete transactions.

- 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 Excluded ICD-9 Diagnosis Codes provided in Appendix I. See Section 11.2.5.1 for a default code that may be used under only very limited circumstances.
- To be considered valid, values submitted in ICD-9 Diagnosis Code 1-19 fields must be on the list of valid ICD-9 codes for Section 111 reporting. They may not begin with the letter 'E'. They may not begin with the letter 'V'. Values submitted in ICD-9 Diagnosis Code 1-19 fields must NOT be on the list of Excluded ICD-9 Diagnosis Codes provided in Appendix I. See Section 11.2.5.1 for a default code that may be used under only very limited circumstances.
- At least one valid ICD-9 Diagnosis Code must be provided on add and update records in Field 19. Additional ICD-9 Diagnosis Codes 2-19 are optional but RREs must provide as many as possible to adequately describe the injury/illness associated with the TPOC and/or ORM reported as specified above.
- If more than one ICD-9 Diagnosis Code is supplied, all must be valid. If any one code submitted is invalid, the entire record will be rejected with the associated error code for the field in error.
- Any unused ICD-9 Diagnosis Code fields should be filled with spaces.
- If any of these requirements are not met, the record will be rejected and an 'SP' disposition code and associated error code(s) will be returned on the corresponding Claim Response File Detail Record. For example, if two diagnosis codes are submitted and one is valid but the other is not, the applicable error code will be posted to the response record and the **entire record will be rejected** with an 'SP' disposition code even though one diagnosis code was valid.
- An RRE may add or remove ICD-9 Diagnosis Codes on subsequent update records after the initial add record has been submitted and accepted. Update records should include the previously submitted ICD-9 Diagnosis Codes that still apply to the claim report along with any new codes the RRE needs to submit.

More information related to ICD-9-CM may be found at: http://www.cdc.gov/nchs/icd/icd9cm.htm. In addition, RREs and reporting agents may find it helpful to search the Internet where many sources of information regarding ICD-9 diagnosis codes may be found including online and downloadable search lists and free software to assist with deriving codes applicable to specific injuries.

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.gov/ICD10/.

11.2.5.1 Special Default Diagnosis Code for Liability

This section provides information related to a default code that may be used under **extremely limited and specific circumstances** when reporting liability insurance (including self-insurance).

As documented in Section 11.10.2 and elsewhere in this guide:

"Information is to be reported for claims related to liability insurance (including self-insurance), no-fault insurance, and workers' compensation where the injured party is (or was) a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment ***has the effect of releasing medicals****."*

There are certain, very limited liability situations where a settlement, judgment, award or other payment releases medicals or has the effect of releasing medicals, but the type of alleged incident typically has no associated medical care and the Medicare beneficiary/Injured Party has not alleged a situation involving medical care or a physical or mental injury. This is frequently the situation with a claim for loss of consortium, an errors or omissions liability insurance claim, a directors and officers liability insurance claim, or a claim resulting from a wrongful action related to employment status action is alleged.

Current instructions require the RRE to report claim information in these circumstances. However, in these very limited circumstances, when the claim report does **not** reflect ongoing responsibility for medicals (ORM) and the insurance type is liability, a value of "NOINJ" may be submitted in both Field 15 Alleged Cause of Injury, Incident, or Illness and Field 19 ICD-9 Diagnosis Code 1 ("NOINJ" must be put in both the alleged cause and first diagnosis field and all the rest of the diagnosis fields must be blank). All other fields must be submitted on the claim report as required.

Important Considerations:

- This default code of 'NOINJ' may not be submitted on claim reports reflecting ORM. If a Claim Input File Detail Record is submitted with Y in the ORM Indicator (Field 98) and either the Alleged Cause of Injury, Incident, Illness (Field 15) or any ICD-9 Diagnosis Codes 1-19 (starting at Field 19) contain 'NOINJ', the record will be rejected.
- This default code of 'NOINJ' may only be used when reporting liability insurance (including self-insurance) claim reports with L in the Plan Insurance Type (Field 71). If the Plan Insurance Type submitted is not L, the record will be rejected.
- 'NOINJ' will only be accepted in Fields 15 and 19 on the Claim Input File Detail Record. If 'NOINJ' is submitted in any of the ICD-9 Diagnosis Codes 2-19 starting in Field 21, the record will be rejected.
- If 'NOINJ' is submitted in Field 15 then 'NOINJ' must be submitted in Field 19. If 'NOINJ' is submitted in Field 19, then 'NOINJ' must be submitted in Field 15. If 'NOINJ' is not submitted in both fields, the record will be rejected.
- If 'NOINJ' is submitted in Field 19 then all remaining ICD-9 Diagnosis Code 2-19 (Fields 21 – 55) must be filled with spaces. If Fields 21-55 contain values other than spaces, the record will be rejected.

- If the above conditions are not met, the record will be rejected with the CI25 error code.
- CMS will closely monitor the use of the 'NOINJ' default code by RREs to insure it is used appropriately. RREs using this code erroneously are at risk of non-compliance with Section 111 reporting requirements.

11.2.6 Foreign Addresses

Contact information outside the United States may not be provided in any address or telephone number field on the Claim Input File. Guam, Puerto Rico, and the US Virgin Islands are considered inside the US. Foreign address fields for the RRE are available as of April 5, 2010 on the TIN Reference File (see Section 11.3 and Appendix B). 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. In the case of an RRE not based in the United States and without a valid IRS-assigned TIN, it may be a fake or pseudo-TIN created by the RRE during the Section 111 COBSW registration process in the format of 9999xxxxx where 'xxxxx' is any number of the RRE's choosing (see Section 8.2.1). CMS encourages foreign entities (RREs that have no IRS-assigned TIN and/or US mailing address) to apply for a TIN by completing the Internal Revenue Service (IRS) SS-4 Application and using that number to register and report if possible. Note that Guam, Puerto Rico, and the US Virgin Islands are considered within the US and have US addresses.

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 prior to or 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 submitted on the TIN Reference File Detail 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.

Foreign RREs that have no US address, must submit the value 'FC' in the TIN/Office Code State (Field 9) and supply the international address of the RRE in the Foreign RRE Address Lines 1-4 (Fields 12-15). Since there are numerous differences in the format of international addresses, these alphanumeric fields are 32 bytes each and the RRE may provide the address using these fields in a "free form" manner of their choosing as long as at least the Foreign Address Line 1 (Field 12) is supplied. Components of the address (e.g. street, city) should be separated by spaces or commas.

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, non-zero, 9-digit number 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, the Office Code/Site ID must be filled with nine spaces on the Claim Input File Detail Record and corresponding TIN Reference File Record***.***

NOTE: If you choose to use the Office Code field, it must be submitted as a non-zero 9-digit number right justified and padded with zeroes ('123456789' or '000000001'). If you choose not to use it, the Office Code must be filled with spaces.

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 will be submitted with TIN of '123456789' and Office Code of '000000001' and a second record submitted with the same TIN of '123456789' but Office Code of '000000002'. Different mailing addresses may be submitted on the TIN Reference File Detail 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 as a completely separate physical file. It has its own header and trailer records. It must be sent prior to or at the same time as your first Claim Input File. Note that TIN and TIN address information is required when entering claim information on the COBSW using DDE.

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 in Fields 72 and 73 must be included on a record in the TIN Reference File in order for the Claim Input File Detail Record to process.

There is currently 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. This often results in a significant number of Claim Input File Detail Record rejections or compliance errors. Your EDI Representative can provide you with detailed information regarding TIN Reference File errors as needed.

CMS is implementing a TIN Reference Response File along with associated, specific TIN error codes on October 1, 2011. Please refer to Section 11.3.2.

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 TIN Reference File is successfully 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. However, many RREs choose to submit a full TIN Reference File with each Claim Input File submission. All TINs will be verified so it is imperative that accurate information be provided in the file.

Note: As stated above, addresses submitted on the TIN Reference File are used in subsequent processing by CMS. This subsequent processing includes Medicare claims payment activity and recovery activity performed by the MSPRC. The address may be shared with providers and suppliers who submit medical claims to Medicare to assist them in directing their claims to the proper primary payer. The address is also used by the MSPRC to direct demand packages and other recovery-related notifications. RREs must be prepared to receive information of this nature at the addresses provided on the TIN Reference File and make sure it is directed to the proper RRE resources for handling.

11.3.1 TIN Validation

- 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 Detail Record. (The Office Code can be left blank if it is not used.)

- All RRE TINs submitted in Field 72 must be valid IRS-assigned tax IDs (except for foreign RRE pseudo-TINs). Only the TIN will be used in this validation. The name and address do not have to match the name and address associated with the TIN by the IRS.
- If you receive a compliance flag on a TIN you believe to be valid, then please contact your EDI Representative. Upon receipt of appropriate documentation, your EDI Representative will mark the TIN as valid in the system and the TIN will be accepted on subsequent file submissions.
- No validation is done on RRE-assigned pseudo-TINs submitted for foreign RREs other than to check for a 9-digit number beginning with '9999'.

11.3.2 Address Validation and TIN Reference Response File

Prior to October 1, 2011

- If a TIN Reference File is submitted at the same time as a Claim Input File, the TIN Reference File is processed and TINs validated first before the Claim Input File is processed. RREs may also submit a TIN Reference File without submission of a Claim Input File and the system will proceed with processing the TIN file in the next scheduled batch cycle. There is no file submission timeframe associated with a separately submitted TIN Reference File.
- TIN Reference File Detail Records are edited according to the field descriptions in the file layout in Appendix B.
- No TIN Reference Response File is produced prior to October 1, 2011.
- Errors found on TIN Reference File Detail Records are returned as compliance flags on associated Claim Response Records that have RRE TIN/Office Codes that match the TIN record in error.
- In some cases, errors on insurer TIN Reference Detail Records will result in the rejection of claim records with a non-specific error code of CP13. In other cases, the claim record is accepted but returned with compliance flags.
- RREs are to make corrections to resolve error codes and compliance flags and resubmit updated TIN Reference File Records with their next quarterly file submission or as instructed by their EDI Representative.
- RREs must contact their EDI Representatives to obtain more specific information on errors related to their TIN Reference File and how to resolve them.
- Refer to TIN and TIN address compliance flag codes in the Claim Response File Compliance Flag Codes table in Appendix F.
- RREs that receive compliance flag 02 on TINs they believe to be valid should contact their EDI Representative. If the RRE can provide documentation that demonstrates the TIN is valid, the EDI Representative is able to update the system so that the TIN is marked as valid for subsequent submissions.

October 1, 2011 and Subsequent

Basic Field Validation

- If an RRE submits a TIN Reference File at the same time as their Claim Input File, the COBC will process the TIN Reference File first and process the Claim Input File after the TIN Reference File processing is complete. RREs may also submit a TIN Reference File without submission of a Claim Input File and the system will proceed with processing the TIN file in the next scheduled batch cycle. There is no file submission timeframe associated with a separately submitted TIN Reference File.
- Basic field validations will be performed according to the field descriptions in the TIN Reference File layouts in Appendix B.
- Each RRE TIN will be validated to ensure it is a valid IRS-assigned tax ID. Only the TIN will be used in this validation. The name and address do not have to match the name and address associated with the TIN by the IRS.
- If an error is found on an input TIN Reference File Detail Record during the basic field validation step, the TIN record will be rejected and returned on the new TIN Reference Response File with a 'TN' disposition code and error codes specific to the errors identified (See the TIN Response File Error Codes table in Appendix F.)
- As with other Section 111 file processing, certain severe errors will be generated and notification returned to RREs via e-mail alerts for TIN Reference Files. These include severe errors for missing header or trailer records, incorrectly formatted header and trailer records, an invalid record count on the trailer, and empty files. In the event of a severe error, RREs must contact their assigned EDI Representative and resubmit a corrected TIN Reference File as instructed.
- Use of TIN and TIN address-related compliance flag codes used prior to October 1, 2011 will be discontinued as of October 1, 2011.

Address Validation

- TIN Reference File records that pass the basic field validation edits will be further processed by the COBC using a postal software tool. This tool will be 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. This will involve changes like correcting misspellings, changing the order of the individual components of the primary address line, and applying standard postal abbreviations such as RD for "Road".
- After the address is standardized, it will be matched to the postal database. This matching will include Delivery Point Validation (DPV). If an address is matched to one that is considered an undeliverable address, such as a vacant lot, the address will not be considered valid.
- When a match to a deliverable address is confirmed, the address is considered a valid address.
- The general return codes from the postal software will be translated into more descriptive error codes that will indicate why the address failed to be validated in

this step. These errors include TN18 – TN23 as shown in the TIN Response File Error Codes table in Appendix F.

- Address validation will be applied to the TIN/Office Code Mailing Address submitted on the TIN Reference File Detail Record in Fields 6 – 11 where the TIN/Office Code State (Field 9) is not equal to 'FC' for records that have passed all the basic field validations.
- Foreign RRE Addresses, submitted in Fields 12 – 15 on TIN Reference File Detail Records where the State code in Field 6 equals 'FC', will not be validated in this step. Only the basic field validations will apply to the Foreign RRE Address.

TIN Reference Response File

- TIN Reference Response Files will start with a header record, followed by detail records for each submitted TIN Reference File Detail Record, and end with a trailer record containing a detail record count. Each record is a fixed length of 1000 bytes. The file layout is shown in Appendix D.
- The TIN Reference Response File Detail Record will contain the submitted TIN/Office Code, a disposition code, ten error code fields, the submitted mailing address, applied mailing address, submitted foreign RRE address, and an indicator to show whether the system applied changes to the mailing address fields.
- If a TIN Reference File Detail Record ***fails*** the TIN and/or TIN address validation, it will be rejected and a corresponding TIN Reference Response File Detail Record returned with:
  - A value of 'TN' in the TIN Disp Code (Field 22)
  - Associated errors in the TIN Error 1-10 (Fields 23 - 32) as documented in the TIN Response File Error Codes table in Appendix F
  - TIN Reference File TIN, Office Code, name and mailing address in the Submitted TIN, Submitted Office Code/Site ID, Submitted TIN/Office Code Mailing Name and Address (Fields 3 - 11)
  - Spaces in the Applied TIN/Office Code Mailing Address (Fields 12 - 17)
  - Spaces in the TIN/Office Code Address Change Flag (Field 33)
- If a TIN Reference File Detail Record ***passes*** the TIN and TIN address validation, it will be accepted and a TIN Reference Response File Detail Record returned with:
  - A value of '01' in the TIN Disp Code (Field 22)
  - Spaces in the TIN Error 1-10 (Fields 23 - 32)
  - TIN Reference File TIN, Office Code, name and mailing address in the Submitted TIN, Submitted Office Code/Site ID, Submitted TIN/Office Code Mailing Name and Address (Fields 3 - 11)
  - Addresses the COBC will use for subsequent processing in the corresponding Applied TIN/Office Code Mailing Address (Fields 12 - 17)
  - If the Applied TIN/Office Code Mailing Address (Fields 12 - 17) is different from the Submitted TIN/Office Code Mailing Address (Fields 6 – 11), the TIN/Office Code Address Change Flag (Field 33) will be set to 'Y'. If they are the same, Field 33 will be set to 'N'.
- If there was a TIN Reference File Detail Record previously submitted that matches the new TIN Reference File Detail Record being processed, the new record will overlay the prior record on the COB database and the new record will

be used for subsequent Claim Input File processing, regardless of the TIN Disp Code returned. New TIN records in error can replace previously existing TIN records that were determined to be valid and vice versa. ***Errors on TIN Reference File records will result in rejection of subsequently processed Claim Input File Detail Records with matching RRE TIN/Office Codes.*** TIN records returned with errors must be corrected and resubmitted in order for the corresponding Claim Input File Detail Records to process correctly.

- The system will take approximately 3 business days to process a TIN Reference File and create the TIN Reference Response File. If an RRE submits a TIN Reference File with its Claim Input File, the system will process it and produce the TIN Reference Response File first. RREs may also submit a TIN Reference File without submission of a Claim Input File and the system will proceed with processing the TIN file in the next scheduled batch cycle.
- TIN Reference Response Files will be created for both test and production TIN Reference File submissions.
- RREs are encouraged, but not required, to update their internal systems with the applied address fields returned.
- RREs are encouraged to pre-validate RRE addresses using postal software or online tools available on the USPS website pages such as http://zip4.usps.com/zip4/welcome.jsp.

Processing TINs on the Claim Input File

- The TIN and Office Code/Site ID (Claim Input File Fields 72 and 73) will be matched to the COB database table of valid, **accepted** TIN Reference File records submitted by the RRE.
- If a match is found, the TIN/Office Code information will be used in subsequent processing of the claim information by Medicare and passed to the MSPRC.
- If a match is not found to a valid TIN record, the Claim Input File Detail Record will be ***rejected*** and returned on the Claim Response File with a 'SP' disposition code and a TN99 error code indicating that a valid TIN/Office Code record could not be found. This error will not provide information as to why the TIN record was rejected. **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, and resubmit the corresponding Claim Input File Detail Records that were rejected, in their next file submission or as instructed by their EDI Representative.

Direct Data Entry (DDE) TIN and TIN Address Validation

Although NGHP DDE reporters do not submit TIN Reference Files, the same TIN information is submitted online. The Section 111 COBSW handles some basic editing of the TIN and associated address and will continue to do so.

- All TIN edits applied to TIN Reference File records will be applied in the batch process to TIN information submitted via DDE after the claim has been submitted.
- Checks to ensure the TIN is a valid, IRS-assigned TIN (except for a foreign RRE pseudo-TIN) and address validation will only be performed in batch.

- If a TIN error is found during batch processing of DDE information, the claim will be marked complete but an 'SP' disposition will be returned. The associated TN errors will be displayed on the Claim Confirmation page and must be corrected by editing the invalid fields. Once corrected, the claim report must be resubmitted for processing.
- Refer to the TIN Response File Error Codes table in Appendix F for a list of possible TIN errors that could be returned for a claim submitted via DDE.
- TIN information from DDE submissions will be added to the COB database TIN table and transmitted to the MSPRC in the same fashion as is done for TIN Reference File processing.
- RREs are encouraged to pre-validate RRE addresses using postal software or online tools available on the USPS website pages such as http://zip4.usps.com/zip4/welcome.jsp.

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 and DDE submissions. These thresholds are solely for 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" for 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. **RREs are only required to report no-fault insurance TPOCs with dates of October 1, 2010 and subsequent. No-fault ORM assumed as of January 1, 2010 and subsequent must be reported.**

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. **Liability ORM assumed as of January 1, 2010 and subsequent must be reported.**

Workers' Compensation ORM

- **Workers' Compensation ORM assumed as of January 1, 2010 and subsequent must be reported.** For workers' compensation ORM, claims meeting ***ALL*** of the following criteria are excluded from reporting for file submissions due through December 31, 2012:
  - 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 workers' compensation TPOCs with dates of October 1, 2010 and subsequent.** Therefore, only workers' compensation TPOCs with dates of October 1, 2010 and subsequent need to be included in the total for the threshold check. However, workers' compensation TPOCs with dates prior may be included at the RRE's discretion. Again, workers' compensation TPOCs with dates prior to 10/1/2010 do NOT have to be reported and do NOT have to be included in the threshold calculation but an RRE may report and include them if they want. **The COBC will total all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.**
  - **RREs are only required to report liability insurance (including self-insurance) TPOCs with dates of October 1, 2011 and subsequent.** Therefore, only liability TPOCs with dates of October 1, 2011 and subsequent need to be included in the total for the threshold check. However, liability TPOCs with dates prior may be included at the RRE's discretion. Again, liability TPOCs with dates prior to 10/1/2011 do NOT have to be reported and do NOT have to be included in the threshold calculation but an RRE may report and include them if they want. **The COBC will total 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.
- Liability and workers' compensation claim reports, where the last (most recent) TPOC Date is **prior to January 1, 2013** 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, 2013 with a total TPOC amount less than or equal to $5000.00 will be rejected.
- Liability and workers' compensation claim reports where the last (most recent) TPOC Date is **January 1, 2013 through December 31, 2013** 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, 2014 with a total TPOC amount less than or equal to $2000.00 will be rejected.
- Liability and workers' compensation claim reports where the last (most recent) TPOC Date is **January 1, 2014 through December 31, 2014**, 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, 2015 with a total TPOC amount less than or equal to $600.00 will be rejected.
- No threshold applies to claims where the last (most recent) TPOC Date is January 1, 2015 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. Before submitting multiple TPOC Amounts, remember that a TPOC is a single payment obligation reported **in total** regardless of whether it is funded through a single payment, an annuity or a structured settlement.

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. However, if you intend to remove or zero out **all** TPOCs 2 – 5 on the Auxiliary Record, resubmitting the Detail Record as an update without including the Auxiliary Record will have the same effect as submitting the Auxiliary Record with zeroes in the TPOC fields. If you have nothing else to report on the Auxiliary Record, subsequent updates do not need to include that record.

If more than five TPOCs need to be reported for a single claim, then add the sixth and subsequent TPOC amounts to the amount reported in TPOC Amount 5 on the Auxiliary Record, put the most recent TPOC Date in TPOC Date 5, and submit it with the corresponding Detail Record as an update transaction. This circumstance will be very rare. Remember that you are NOT to report every payment related to individual medical services, procedures and supplies – you should be reporting ORM if you have assumed responsibility to pay directly. If you have a TPOC settlement, judgment, award or other payment which includes payment to a provider, physician, or other supplier on behalf of a beneficiary, you should report such payment(s) as part of the total TPOC amount. Also, the total TPOC amount is reported after settlement, judgment or award or other payment, not individual installment payments for that TPOC.

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. Retroactive reporting is required as described below. This information also applies to DDE submitters with the exception that information is submitted on a claim by claim basis on the Section 111 COBSW instead of on an electronic file.

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, award, or other payment had the effect of releasing medicals)*** and which are addressed/resolved (or partially addressed/resolved) through a no-fault insurance or workers' compensation settlement, judgment, award or other payment with a TPOC Date on or after October 1, 2010 or through a liability insurance (including self-insurance) settlement, judgment, award or other payment with a TPOC Date on or after October 1, 2011, regardless of the assigned date for your first submission. Claim reports with earlier TPOC Dates will be accepted but not required. A "Total Payment Obligation to the Claimant" (or TPOC) single payment obligation is reported in total 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 October 1, 2010 (no-fault and workers' compensation) or on or after October 1, 2011 (liability). 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 January 1, 2010 and subsequent, even if the assumption of responsibility occurred prior to January 1, 2010. Where the assumption of ongoing responsibility for medicals occurred prior to January 1, 2010, and continued on or through January 1, 2010, reporting is required. ORM that was in effect on or after January 1, 2010 must be reported even if ORM was terminated prior to your initial reporting date.

See Sections 11.8, 11.9, and 11.10 for specific exceptions 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.

The following table provides a set of examples related to your initial Section 111 submission but is not intended as an all-inclusive list of reporting 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, 2011; there is no court involvement.	No report of settlement for Section 111	The liability insurance "Total Payment Obligation to the Claimant" (TPOC) Date is prior to October 1, 2011. 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.

INITIAL FILE SUBMISSION EXAMPLES				
No.	**Situation**	**Additional Facts**	**Section 111 Report**	**Rationale**
1B	Same basic facts as 1A	The beneficiary sues. A settlement for $10,000 is signed by both parties on June 3, 2011. However, the settlement requires court approval, which is not obtained until October 10, 2011.	Report settlement for Section111	The liability "Total Payment Obligation to the Claimant" (TPOC) Date is on or after October 1, 2011 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.
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 January 1, 2010. 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 January 1, 2010, or later. See sections 11.8 and 11.9 for exceptions and information regarding termination of workers' compensation ORM.

INITIAL FILE SUBMISSION EXAMPLES				
No.	**Situation**	**Additional Facts**	**Section 111 Report**	**Rationale**
2B.	Same basic facts as 2A	There was a judgment or award for $50,000 by the WC court issued on June 23, 2010. This judgment or award left the medicals open.	Report the ongoing medicals responsibility for Section111. You are not required to report the judgment or award. (However, if a workers' compensation TPOC prior to 10/1/2010 is reported in conjunction with a reportable ORM, the TPOC will not be rejected.)	See 2A for why the ongoing responsibility for medicals is reported. The workers' compensation settlement, judgment, award, or other payment, which was separate from the ongoing responsibility for medicals, is not required to be reported because the applicable TPOC date is prior to October 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 September 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) and is no-fault insurance as defined by CMS. The med pay cap is reached as of December 15, 2009.		Do not report the ongoing responsibility for medicals information for Section 111.	ORM terminated prior to January 1, 2010.

INITIAL FILE SUBMISSION EXAMPLES				
No.	**Situation**	**Additional Facts**	**Section 111 Report**	**Rationale**
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 under the liability (bodily injury) component of the policy on October 3, 2011.	Do not report the ongoing responsibility for medicals information for Section 111. Report the $50,000 liability TPOC information.	No-fault insurance ORM terminated prior to January 1, 2010. The liability TPOC date is on or after October 1, 2011 and exceeds the reporting threshold.
3C	Same basic facts as 3A/3B **except that state law requires life-time medicals.**	Same additional facts as 3B	Report both the no-fault ongoing responsibility for medicals and the liability settlement on separate claim reports by insurance type.	No-fault ORM continued in effect January 1, 2010. Liability TPOC date on or after October 1, 2011 and exceeded the reporting threshold.

Your initial Claim Input File must contain "retroactive" reporting for:

- All no-fault insurance and workers' compensation TPOC amounts meeting the interim reporting thresholds described in Section 11.4 with TPOC dates on or after October 1, 2010
- All liability insurance (including self-insurance) TPOC amounts meeting the interim reporting thresholds described in Section 11.4 with TPOC dates on or after October 1, 2011
- Assumptions of ongoing responsibility for medicals (ORM) for no-fault insurance, workers' compensation and liability insurance (including self-insurance) on or after January 1, 2010
- Initial reports of ORM assumed prior to January 1, 2010, that continued at least through January 1, 2010.

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 were to submit their initial production Section 111 Claim

Input File during the **first calendar quarter (January - March) of 2011** during their assigned submission timeframe, unless the RRE had no applicable claim information to report. For RREs that selected the DDE option, reporting commenced on July 11, 2011 (See Section 15.5 and posted alerts). When you register for Section 111 reporting and select a file submission method, you will be assigned a 7-day window for your quarterly file submission. Your required 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. Those RREs registering for DDE will be set to a production reporting status immediately after completing the registration process and must commence production reporting of applicable claims on the Section 111 COBSW, including the retroactive reporting described above.

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

11.7 Quarterly File Submissions

The information in this section also applies to DDE submitters with the exception that information is submitted on a claim by claim basis on the Section 111 COBSW instead of as records in an electronic file.

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 with an ‘01’ or ‘02’ disposition code 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 unless you are specifically requested to do so by your EDI Representative. 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’ or ‘02’.

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 prior to or with your quarterly Claim Input File submission.

If you have no new information to supply on a quarterly update file, you **may, but are not required to,** submit an “empty” Claim Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count. When submitting

an empty file, no TIN Reference File is required, but if submitted, will be accepted and processed. No Claim Response File is produced for empty Claim Input Files.

See also, Sections 11.8, 11.9, and 11.10 for specific exceptions 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 insurance 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 Representative 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)

Please see Section 11.1.2 for more information on matching claim records.

Deleting Erroneous Record Submissions

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.

Correcting Key Fields – Delete/Add

The other case when a delete record will be sent is when you need to correct 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. This is often referred to as the "delete/add" process.

Only perform a delete/add to correct the following previously submitted fields:

- **CMS Date of Incident (Field 12)**
- **Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 71)**
- **ORM Indicator (Field 98)**

Do not perform a delete/add to correct or change any other fields. Simply submit an update transaction to correct non-key fields as described in Section 11.7.3 and noted in the Event Table in Section 11.7.4.

NOTE 1: RREs only need to correct the HICN/SSN in cases where an ***incorrect person*** was submitted and accepted on the input record. HICNs may be changed by the Social Security Administration at times but the COBC is able to crosswalk the old HICN to the new HICN. Therefore in those instances where the correct person was

previously submitted and the HICN changes for that person at a later date, the RRE does ***not*** need to correct the record. In fact, updates may continue to be sent under the original HICN submitted. The COBC will always return the most current HICN on response records and RREs are encouraged to update their systems with that information and use it on subsequent record transmissions. The new HICN may be used on all subsequent transactions without the RRE performing the "delete/add" procedure.

NOTE 2: If a record was previously submitted and accepted with only a SSN, and the RRE obtains the HICN on the response file, the RRE should ***not*** send a "Delete" and "Add" to update the beneficiary's information with the HICN. The record has already been stored under both the SSN and HICN by the COBC. Subsequent transactions for the record must be submitted with the HICN.

Example 2: A claim record was submitted for a liability insurance 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)

See Section 11.1.2 for more information on matching claim records.

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)
- 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 <u>not</u> trigger the update requirement. You <u>may</u> send an update to change other information but it is <u>not required</u>.

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. Note that an update record is sent to report the ORM Termination Date, **not** a delete transaction. Also note that the ORM Indicator should be reported with a value of 'Y' on the update record.

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 insurance 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 insurance 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 Detail 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.

Only perform a delete/add to correct the following previously submitted fields:

- **CMS Date of Incident (Field 12)**
- **Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 71)**
- **ORM Indicator (Field 98)**

Do not perform a delete/add to correct or change any other fields. Simply submit an update transaction to correct non-key fields as described in Section 11.7.3 and noted in the Event Table in Section 11.7.4.

* **NOTE:** RREs only need to correct the HICN/SSN in cases where an ***incorrect person*** was submitted and accepted on the input record. HICNs may be changed by the Social Security Administration at times but the COBC is able to crosswalk the old HICN to the new HICN. Therefore in those instances where the correct person was previously submitted and the HICN changes for that person at a later date, the RRE does ***not*** need to correct the record. In fact, updates may continue to be sent under the original HICN/SSN submitted. The COBC will always return the most current HICN on response records and RREs are encouraged to update their systems with that information and use it on subsequent record transmissions. The new HICN may be used on all subsequent transactions without the RRE performing the "delete/add" procedure.

Event	RRE Action
Single Report – No ORM • Claim with settlement, judgment, award or other payment TPOC date on or after **10/1/2010 (no-fault or workers' compensation) or 10/1/2011 (liability insurance including self-insurance).** • 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 earlier dates 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 (**same** insurance type, same injuries) • Claim with settlement, judgment, award or other payment TPOC date on or after **10/1/2010 (no-fault or workers' compensation) or 10/1/2011 (liability insurance including self-insurance).** • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 11.4). TPOCs with earlier dates 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 **1/1/2010** 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). • Both ORM and TPOC are for the **same** insurance type and apply to all injuries reported.	Send Add Record: • '0' (add) in the Action Type • 'Y' in the ORM Indicator • TPOC Dates and Amounts

Event	RRE Action
Initial Report – with ORM and TPOC (**same** insurance type, ORM for one injury, TPOC and no ORM for another injury) • Two (or more) injuries claimed/alleged on the same claim under the same insurance type. • RRE assumes ORM for one (or more) alleged injury, but not all injuries claimed/alleged. • RRE settles with a TPOC settlement, judgment, award or other payment for other alleged injuries claimed and/or released, not covered by ORM. • ORM and TPOC meet the interim reporting thresholds documented in Section 11.4. • Both ORM and TPOC are for the **same** insurance type, policy, and claim number but different injuries.	Send Two Add Records First Add Record for ORM: • '0' (add) in the Action Type • ICD-9 Diagnosis Code(s) describing all alleged injuries/illnesses for which ORM was assumed • 'Y' in the ORM Indicator • No TPOC Dates and Amounts Second Add Record for TPOC: • '0' (add) in the Action Type • ICD-9 Diagnosis Code(s) describing all alleged injuries claimed and/or released related to the TPOC • 'N' in the ORM Indicator • TPOC Dates and Amounts Both records may be sent in the same file submission in any order.

Event	RRE Action
Initial Report – with ORM and TPOC (**different** insurance types) • Claim with settlement, judgment, award or other payment TPOC date on or after **10/1/2010 (no-fault or workers' compensation) or 10/1/2011 (liability insurance including self-insurance).** • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 11.4). TPOCs with earlier dates may be included at the RREs discretion. • RRE has or had ORM on or after **1/1/2010** 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). • ORM and TPOC are for **different** insurance types (i.e. an automobile accident where for the same injured party ORM is covered under the no-fault coverage of the policy and TPOC is covered under the bodily injury/liability coverage on the same policy).	Send **Two** Add Records: ORM Record • '0' (add) in the Action Type • 'Y' in the ORM Indicator • No TPOC Dates or Amounts • Applicable Plan Insurance Type (i.e. 'D' for No-Fault) TPOC Record • '0' (add) in the Action Type • 'N' in the ORM Indicator • TPOC Date and Amounts • Applicable Plan Insurance Type (i.e. 'L' for Liability) Both records can have the same Injured Party information, Date of Incident, Policy Number, Claim Number, etc. as applicable.
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 **1/1/2010** 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

Event	RRE Action
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
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 for the same injuries • Total TPOC Amount meets the threshold requirements for the latest, most recent TPOC Date associated with the claim (See Section 11.4). TPOCs with earlier dates 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 **1/1/2010** 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 (same insurance type, same injuries) • Claim with settlement, judgment, award or other payment TPOC amount • With ORM assumed on or after **1/1/2010** 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 earlier may be included at the RREs discretion. Total TPOC Amount may be less than the threshold at the RREs discretion. • Both ORM and TPOC are for the same insurance type and injuries. • Claim **not** previously reported and accepted • ORM has ended prior to initial report but on or after **1/1/2010**. (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 (Correction) – 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:
 	
  • 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 and updated as required

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
  • 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
	  •
	  • 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

Event	RRE Action
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)
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

Event	RRE Action

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, policy, claim number, 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

ORM Reopens or Change in ORM Termination Date
 	
• Claim previously submitted and accepted with ORM Indicator (Field 98) = 'Y', non-zero ORM Termination Date (Field 99)
• 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)
	  • 'Y' in 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

Event	RRE Action

ORM Ends for One Injury, Continues for Another
 	
• Claim previously submitted and accepted with ORM Indicator (Field 98) = 'Y', non-zero ORM Termination Date (Field 99), multiple ICD-9 Diagnosis Codes reflecting ORM assumed for multiple injuries
• RRE's ORM subsequently ends for one or more injuries but ORM continues on the claim for one or more other injuries
	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)
	  • 'Y' in ORM Indicator (Field 98)
	• Zeroes in the ORM Termination Date (Field 99)
	• ICD-9 Diagnosis Codes reflecting injuries for which the RRE continues to have ORM (ICD-9 Diagnosis Codes related to injuries for which ORM ended removed)
	• Be sure to submit a valid value, not spaces, in ICD-9 Diagnosis Code 1 (Field 19)
	• Same or updated information for all other fields
	• **Note:** Submit ORM Termination Date on subsequent update only when ORM ends for **all** alleged injuries for which the RRE assumed ORM

11.7.5 Claim Input File Reporting Dos and Don'ts

The following list includes some helpful reminders for RREs to consider when submitting Claim Input Files or providing claim information via DDE.

- Delete transactions should only be submitted to 1) remove an entire record that was created in error or 2) **correct** a key field as specified in the Event Table. Do not send a delete transaction when the RRE's ORM ends. Instead, send an update transaction with a 'Y' in the ORM Indicator and the date ORM ended in the ORM Termination Date.
- RREs are encouraged to pre-validate RRE addresses using postal software or online tools available on the USPS website pages such as http://zip4.usps.com/zip4/welcome.jsp. In general, USPS standards limit name and address lines to 40 characters with 8 separate words per line. Even though the TIN/Office Code Name and Address Lines 1 and 2 on the TIN Reference File Detail Record are longer, RREs should try to use standard abbreviations and attempt to limit data submitted in these fields to the first 40 characters. The address validation enhancements effective in the COBC Section 111 system in

October 2011 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.

- Be sure to submit ICD-9 Diagnosis Codes (starting in Field 19) that exactly match the first 5 positions of a code on the list of valid ICD-9s (See Section 11.2.5). Partial codes are not accepted. Retain leading and trailing zeroes but do not add leading or trailing zeroes if they are not shown for the code in the list of valid ICD-9s. Do not include the decimal point but be sure to include any digits that may follow the decimal point.
- The ORM Indicator (Field 98) is not an on/off switch. If the claim ever involved ORM, it should be reported with a ‘Y’ in the ORM Indicator even after ORM has terminated. When submitting an update with an ORM Termination Date, the ORM Indicator should be submitted as ‘Y’.
- Be sure to submit an ORM Termination Date (Field 99) in addition to the Exhaust Date for Dollar Limit for No-Fault Insurance (Field 82) on a no-fault insurance claim report (Plan Insurance Type ‘D’) when no-fault limits are reached and ORM is terminated. Failure to submit an ORM Termination Date results in improper payment or medical claims submitted to Medicare after no-fault limits are reached.
- Add records submitted with ‘N’ in the ORM Indicator must contain TPOC Amounts that exceed the interim reporting thresholds. There is no TPOC threshold applied to no-fault claims. However, there is no circumstance under which an RRE would submit ‘N’ in the ORM Indicator and no TPOC information. This will result in rejection of the record with the CJ07 error. Information is to be reported ***after*** the RRE assumes ORM or ***after*** there is a TPOC settlement, judgment, award or other payment.
- The Policy Number (Field 74) is a required data element. In the case of self-insurance where the RRE has no policy number associated with the claim, this field must be filled with all zeroes, not left blank.
- Values in the Plan Insurance Type (Field 71), Self Insured Indicator (Field 64), and Self Insured Type (Field 65) must correspond. If the Plan Insurance Type is ‘E’ or ‘L’, the Self Insured Indicator must equal ‘Y’ or ‘N’. If Plan Insurance Type is ‘D’, the Self Insured Indicator must equal ‘N’ or blank. If the Self Insured Indicator is ‘Y’, the Self Insured Type must equal ‘I’ or ‘O’. If the Self Insured Indicator is ‘N’ or blank, the Self Insured Type must be blank.

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. This 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 often applies to no-fault and workers' compensation claims, but may occur in some circumstances related to liability insurance (including self-insurance).

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 party for specific medical procedures, treatment, services, or devices like a doctor's visit, surgery, ambulance transport, etc. These medicals are often being paid by the RRE as they are submitted by a provider or injured party. Payments like these are NOT reported individually under Section 111 as TPOCs. Even when ORM payments are aggregated and paid to a provider or injured party in a single payment, this aggregation does not constitute a TPOC just because it was paid in a "lump sum". For example, an injured party might incur medical expenses in excess of a no-fault insurance (e.g. automobile PIP or Med Pay) shortly after an automobile accident. The RRE may reimburse the provider of these medical services or injured party via one payment or check since the no-fault limit was already reached, but the payment still reflects ORM, not a TPOC settlement, judgment or award. The RRE would not have paid these medical expenses without specific medical expenses being incurred by the injured party.

The dollar amounts for ORM are not reported, just the fact that ORM exists or existed. 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 TPOC for a settlement, judgment, award, or other payment 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 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) and the ICD-9 Diagnosis Codes (starting in Field 19) to determine what specific medical services claims, if submitted to Medicare, should be paid first by the RRE and considered only for secondary payment by Medicare. The ICD-9 codes provided in these fields must provide enough information for Medicare to identify medical claims related to the underlying claim reported by the RRE.

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 that 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 RRE 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. This scenario of reporting both the assumption

of ORM and termination of ORM on one add record may also occur if no-fault insurance policy limits are reached shortly after or on the date of incident. 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 or injury 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, there is separate TPOC information to be reported, or another event occurs that triggers the need for an update (see the Event Table in Section 11.7.4).

The only exceptions 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 in Section 11.7.4 to determine what would trigger an additional update or delete. One example may be that the RRE reported an incorrect diagnosis for the description of the 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 would otherwise be "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 or No-Fault claim be left open for medicals indefinitely, the second report may never be submitted***. RREs are not to submit an expected, anticipated, or contingent ORM Termination Date. ORM Termination Dates should only be***

submitted when the termination of ORM is certain. Future-dated ORM Termination Dates can be dated no more than 6 months after the file submission date (ORM Termination Date cannot be more than 6 months greater than the file submission date).

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.

NOTE: Previously, the COBC was unable to accept an ORM Termination Date (Field 99) less than 30 days after the CMS Date of Incident (Field 12). RREs were instructed to default the ORM Termination Date to accommodate this limitation. This is no longer the

case and this restriction has been lifted. RREs should provide the actual ORM Termination Date as defined in the field description in Appendix A. RREs are not required to go back and change/correct records reported previously with default dates due to the former restrictions.

Making an Immediate Report of ORM Termination

Since CMS uses reports of ORM in the Medicare claims process, it is imperative that ORM Termination be reported promptly. See Sections 11.10.1 and 12.4 for the related timely ORM reporting requirements. If an RRE wishes to make an immediate report of ORM Termination prior to its next quarterly file submission, a representative from the RRE may contact the COBC Call Center and report an ORM Termination Date for a single claim report previously submitted and accepted via a Section 111 Claim Input File. However, **the RRE must still submit the report of ORM Termination on its next quarterly Claim Input File submission.** The COBC Call Center may be contacted Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-800-999-1118 or TTY/TDD: 1-800-318-8782 for the hearing and speech impaired. Do not make this report of ORM Termination to your EDI Representative. RREs using the DDE option may update a claim originally entered via DDE with an ORM Termination Date at any time using the Section 111 COBSW and therefore do not need to contact the COB Call Center.

11.9 Special Qualified Reporting Exception for ORM Assumed Prior to January 1, 2010 Where Such ORM Continues as of January 1, 2010

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 January 1, 2010, if the claim was actively closed or removed from current claims records prior to January 1, 2010, the RRE is not required to identify and report that ORM under the requirement for reporting ORM assumed prior to January 1, 2010. 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 January 1, 2010, the RRE needs only look back to the status of claims as of January 1, 2010. If the claim was removed from the RRE's current/active claim file prior to January 1, 2010, it does not need to be reported unless it is reopened. RREs may report ORM on claims they consider closed prior to January 1, 2010 at their discretion. "Older" ORM claims will not be rejected.

ORM Assumed Prior to January 1, 2010 Qualified Exception Examples

Claim Example	**Reporting Requirement**
RRE assumed ORM March 5, 2009 and is still making payments for medicals as of 10/1/2010.	Report this claim since payment for medicals continues as of January 1, 2010. The claim is on the active claim file as of January 1, 2010 and subsequent.
RRE assumed ORM March 5, 2009, is not making payments as of January 1, 2010 but didn't consider the claim "closed" until after January 1, 2010. As of January 1, 2010 and subsequent, the claim is still "technically" open and ORM continues, but the RRE hasn't made a payment since August of 2009. The RRE considers this claim actively closed and removed it from their file of current open/active claims ***on February 15, 2010.***	Report this claim since the claim was not actively closed or removed from current claim records until ***after*** January 1, 2010. The claim was on the active claim file as of January 1, 2010.

Claim Example	Reporting Requirement
RRE assumed ORM March 5, 2009, is not making payments as of January 1, 2010 and considered the claim “closed” prior to January 1, 2010. As of January 1, 2010 and subsequent, the claim is still “technically” open and ORM continues, but the RRE hasn’t made a payment since August of 2009. The RRE considers this claim actively closed and removed it from their file of current open/active claims ***on October 1, 2009.***	Do not report this claim since it was actively closed or removed from current claims records prior to January 1, 2010. The claim was not on the active claim file as of January 1, 2010.

11.10 Additional Requirements

Note: All requirements in this guide apply equally to RREs using a file submission method or DDE, except those specifically related to the mechanics of constructing and exchanging an electronic file or as otherwise noted.

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, unless an RRE has nothing to report for a particular quarter.

- Claim Input Files must be submitted within the RRE's 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 Representative intervention.

- RREs must register on the Section 111 COB Secure Web site (COBSW) 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 is required before an RRE ID can be set to a production status (except for the DDE option) and production files submitted. See Section 14.

- Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation RREs that elected to use one of the file submission methods were required to commence production Section 111 Claim Input File reporting during the **first calendar quarter (January - March) of 2011** during their assigned submission timeframe. RREs with only liability insurance (including self-insurance) TPOCs to report must commence production Section 111 Claim Input File reporting during the first calendar quarter (January – March) of 2012 during their assigned submission timeframe.

- RREs that have elected the DDE reporting option were required to commence reporting on the Section 111 COBSW as of July 11, 2011 per the claim reporting requirements documented in this guide. DDE claim record submissions are required within 45 calendar days of the TPOC Date of a reportable TPOC Amount or within 45 calendar days of assuming ORM. ORM Termination Date submission must be reported via DDE within 45 calendar days of the ORM Termination Date. RREs using the DDE option must complete registration on the COBSW. No testing is performed for DDE.

- Foreign RREs (RREs that have no IRS-assigned TIN and/or US mailing address) must register on the COBSW and commence production reporting as specified above.

- 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 that has data to report for that quarter, and no more than one file may be submitted for each RRE ID per quarter unless instructed otherwise by an EDI Representative.

- All reporting is to be through electronic file exchanges or Direct Data Entry (DDE) as described in this guide and the Section 111 COBSW User 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 CMSNet. RREs with very few claim reports to make per year may choose to submit claim information using the DDE method on the Section 111 COBSW. 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 Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN) for the injured party on all Claim Input File Detail Records. RREs are to report only with respect to Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award or other payment). If a reported individual 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. Please refer to the description of the query process later in this guide.

- RREs must store the HICN returned on response files in their internal systems and are required to use it on future transactions. The SSN may be submitted initially for an individual if the RRE does not have the HICN, but once a HICN is returned after matching the individual to a Medicare beneficiary, it must be used going forward on all subsequent record submissions for the claim. The HICN is CMS's 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) instead of the SSN whenever possible. .

- A TIN Reference File must be submitted prior to or 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, 2011, and the file submission period for the second calendar quarter of 2011 is June 1-7, 2011, then the RRE may delay reporting that claim until the third calendar quarter file submission during September 1-7, 2011. However, if the TPOC Date is April 1, 2011, then the RRE must include

this claim on the second calendar quarter file submission during June 1-7, 2011. 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, unless you are specifically instructed to do so by your EDI Representative.

- If you have no new information to supply on a quarterly update file, you **may, but are not required to,** submit an "empty" Claim Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count. No Claim Response File is returned for empty files. When submitting an empty file, no TIN Reference File is required, but if submitted, will be accepted and processed.

- 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. DCNs are automatically generated by the system for RREs using the DDE option.

- The COBC will commence creation of the Claim Response File directly after all records have completed processing, or no later than 45 days after the Claim Input File receipt date, if some records are still in process. RREs can expect to receive Claim Response Files within 48 days of their Claim Input File receipt date.

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

- Information is to be reported for claims related to liability insurance (including self-insurance), no-fault insurance, and workers' compensation **where the injured party is (or was) a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals**.

- RREs must report on **no-fault insurance and workers' compensation** 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 payment with a **TPOC Date on or after October 1, 2010**, that meet the interim reporting thresholds, regardless of the assigned date for a particular RREs first submission. This reporting requirement date of October 1, 2010 applies to the TPOC Date (see the definition of Claim Input File Detail Record Field 100), ***NOT*** necessarily when the actual payment was made or check was cut. A TPOC is reported in total 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 on **liability insurance (including self-insurance)** 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 payment with a **TPOC Date on or after October 1, 2011**, that meet the interim reporting thresholds, regardless of the assigned date for a particular RREs first submission. This reporting requirement date of October 1, 2011 applies to the TPOC Date (see the definition of Claim Input File Detail Record Field 100), ***NOT*** necessarily when the actual payment was made or check was cut. A TPOC is reported in total 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 **no-fault insurance, workers' compensation and liability insurance (including self-insurance) claim information where ongoing responsibility for medicals (ORM) related to a claim was assumed on or after January 1, 2010**. In addition, RREs must report claim information for claims considered open by the RRE where ongoing responsibility for medicals **exists on or through January 1, 2010**, regardless of the date of an initial assumption of ORM (the assumption of ORM predates January 1, 2010). See Sections 11.4, 11.8 and 11.9 for special exemptions and exceptions 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.

- "Timeliness" of reporting -- NGHP TPOC settlements, judgments, awards, or other payments are reportable once the following criteria are met:

- The alleged injured/harmed individual to or on whose behalf payment will be made has been identified.
- The TPOC amount for that individual has been identified.

Where these criteria are not met as of the TPOC date, retain documentation establishing when these criteria are met. RREs should submit the date these criteria were met in the corresponding "Funding Delayed Beyond TPOC Start Date" field.

Example:
- There is a settlement involving an allegedly defective drug.
- The settlement contains/provides a process for subsequently determining who will be paid and how much. Consequently, the fact that there will be payment to or on behalf of a particular individual and/or the amount of the settlement, judgment, award or other payment to or on behalf of that individual is not known as of the TPOC date.
- Timeliness of MMSEA Section 111 reporting for a particular Medicare beneficiary will be based upon the date there is a determination both that payment will be made to or on behalf of that beneficiary and a determination of the amount of the settlement, judgment, award or other payment to or on behalf of that beneficiary.
- Submit the date of the settlement in the TPOC Date field and the date when there is a determination both that payment will be made to or on behalf of that beneficiary and a determination of the amount of the settlement, judgment, award or other payment to or on behalf of that beneficiary in the corresponding Funding Delayed Beyond TPOC Start Date field.

- 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 by RRE ID, on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by claim number, 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. Where there are multiple defendants and they each have separate settlements with the plaintiff, the applicable RRE reports that separate settlement amount. For a settlement, judgment, award or other payment with joint and several liability, each RRE must report the total settlement, judgment, award, or other payment – not just its assigned or proportionate share.

- 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 ongoing responsibility for medicals.

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

- In situations where the applicable workers' compensation or no-fault law or plan requires the RRE to make regularly scheduled periodic payments, pursuant to statute, for an obligation(s) other than medical expenses, to or on behalf of the claimant, the RRE does not report these periodic payments as long as the RRE separately assumes/continues to assume Ongoing Responsibility for Medicals (ORM) and reports this ORM appropriately. Otherwise, such scheduled periodic payments are considered to be part of and are reported as ORM. For example, if an RRE is making periodic "indemnity only" payments to the injured party to compensate for lost wages related to the underlying workers compensation or no-fault claim, the RRE has implicitly, if not explicitly, assumed ORM. Therefore, the RRE shall report the ORM. The periodic payments to compensate for lost wages are not reported as TPOCs. In summary, under the aforementioned circumstances, one claim report record is submitted reflecting 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 as a single aggregate total (one TPOC Amount) 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.

- Accident & Health, Short Term Travel and Occupational Accident Products are considered no-fault insurance by CMS and reportable as such under Section 111.

- When payments are made by sponsors of clinical trials for complications or injuries arising out of the trials, such payments are considered to be payments by liability insurance (including self-insurance) and must be reported. The appropriate Responsible Reporting Entity (RRE) should report the date that the injury/complication first arose as the Date of Incident (DOI).

The situation should also be reported as one involving Ongoing Responsibility for Medicals (ORM).

- Risk Management Write-Offs and Other Actions - As a risk management tool to lessen the probability of a liability claim against it and/or to facilitate/enhance customer good-will, entities may reduce charges for items and services (write-off) or provide something of value (e.g., cash, gift card, etc). If an entity takes such actions, it may or may not constitute a reporting obligation (as a TPOC) as explained below.

    - For the purposes of the Medicare Secondary Payer provisions, "[a]n 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." (42 U.S.C. 1395y(b)(2)(A)). Risk management write-offs (including a reduction in the amount due as a risk management tool) constitute liability self-insurance for the purposes of the Medicare Secondary Payer provisions.

    - In instances where a provider, physician or other supplier has reduced its charges or written off some portion of a charge for items or services provided to a Medicare beneficiary as such a risk management tool, the provider, physician or other supplier is expected to submit a claim to Medicare reflecting the unreduced permissible (e.g., limiting charge) charges and showing the amount of the reduction provided or write-off as a payment from liability insurance (including self-insurance). Medicare's interests with respect to this particular TPOC amount have been protected through this billing procedure; the provider, physician or other supplier shall not report the reduction or write-off as a TPOC.

    - In instances where a provider, physician, or other supplier has provided property of value (other than a reduction in charges or write-off) to a Medicare beneficiary as such a risk management tool when there is evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the value of the property provided as a TPOC from liability insurance (including self-insurance). If the value of the property provided is less than the TPOC reporting threshold, it need not be reported under Section 111.

    - In instances where any other entity has reduced its charges, written off some portion of a charge or provided other property of value to a Medicare beneficiary as such a risk management tool when there is evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the reduction, write-off or property of value provided as a TPOC from liability insurance (including self-insurance). If the amount of the reduction, write-off or property of value provided is less than TPOC reporting threshold, it need not be reported under Section 111.

- The points above address risk management write-offs by providers, physicians, and other suppliers as well as by non-provider/supplier entities.

12 Claim Response File

The information in this section also applies to DDE submitters with the exception that response information is returned by the COBC on a claim by claim basis and displayed on the Section 111 COBSW instead of on records in an electronic file.

For every non-empty Claim Input File you send to the COBC for Section 111 reporting that is successfully transmitted without severe errors, 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 48 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 must 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 Detail 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' and '02'):
  - 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. You must use the Applied Injured Party HICN to update your internal system and submit this HICN on any subsequent transactions for the 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. Your response file for a given quarterly report must be processed before submission of your subsequent quarterly Claim Input File. Disposition, Claim Input/Response File error codes, TIN Reference Input/Response File error codes, and compliance flag codes are documented in Appendix F.

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 F of this guide along with the actions the RRE must take upon receipt of each disposition code, if any.

Every Claim Input File Detail Record will receive a disposition code on the corresponding Claim Response File Detail Record. Records rejected due to errors receive an 'SP' disposition code and must be resubmitted. Error-free records returned with an '01', '02' or '03' disposition code because the injured party was identified as a Medicare beneficiary based upon the information submitted 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** unless otherwise specified in the error code description. No interim Claim Input File submissions will be accepted without approval from your EDI Representative. Associated error codes will be placed in Fields 28 - 37. Edits performed and associated error codes are documented in Appendix F.

- **‘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.
  - RREs must validate the injured party information used for matching (HICN/SSN, name, date of birth, and gender) to make sure it was correctly submitted and entered in the proper fields. Injured party information must be accurate and submitted in the correct fields.
  - 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 this claim again for Section 111 reporting unless subsequent TPOC payments are made.
  - ***If the claim represents ongoing responsibility for medicals (ORM), you must continue to monitor the Medicare status of the injured party*** as long as the ORM 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, use of the Section 111 Query process described in Section 13, and/or use of the Beneficiary Lookup feature on the Section 111 COBSW.) When the RRE determines the injured party becomes covered by Medicare, 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 terminates and 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 11.8 regarding reporting termination of ORM is met. One final query or claim report should be submitted after an ORM Termination Date has been reached.

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

- **'03' Disposition Code – Record for Individual Matched to a Medicare Beneficiary but Outside Medicare Coverage Period**
  Records returned with an '03' disposition code were found to be error-free and the injured party submitted was matched to 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 unless a subsequent TPOC Amount is established at a later date.

  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 with ORM 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 reached.

When resubmitting claim reports that previously were returned with an '03' disposition code, supply the most current claim information you have available at the time of resubmission.

- **'50' Disposition Code – Record Still in Process at the COBC**
  A record returned with a disposition code '50' indicates that the COBC did not finish processing the record in time to create a response record within the required 45-day turnaround. Only the records on the file that did not complete processing 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 disposition codes described above.

  A record returned with a '50' will continue to be processed to completion by the COBC but in order to receive the final disposition code, **an RRE must resubmit it on the next quarterly update file.** As a rule, you should check these records for accuracy, update non-key fields as needed, and resubmit with the same action type sent previously. 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. Note that the system will treat a resubmitted add like an update if the original add record was accepted after the '50' was returned. If the key fields didn't change, you resubmit the add or update record again and the system will process it to completion and return a definitive disposition code.

  In the case of key fields changing (See Sections 11.7.2 and 11.7.4) after getting a disposition code '50' but before resubmission, assume the record was accepted with an '01' or '02' disposition code. In the next quarter send the delete and add transactions to change the key fields. If the original record that was returned with disposition code '50' was actually processed and accepted by the system after the response was returned, then the delete will match up with the original and process normally. The add transaction will add the claim report back with the changed keys. If the original record returned with disposition code '50' was NOT accepted by the system after the '50' was returned, then the delete will NOT match a previously accepted record. The delete will be returned with an 'SP' disposition code and a SP47, SP48 or SP49 error. All of these error codes indicate that a delete can't be matched to a previously accepted record. You can then ignore them and assume there is nothing to delete since the original record was never accepted. The add record with the new key fields will be treated like any other add and process normally.

Remember, if the key fields did not change, just resubmit the record with the original transaction type, the original key fields and the most current information you have for non-key fields in the next quarter's file. Only go through the delete/add process if a key field changed between submissions.

Note: If you receive a disposition code other than those documented above, report this immediately to your EDI Representative.

12.2 Error Codes

Up to ten error codes may be returned on a Claim Response File Detail Record. Error codes are documented in Appendix F. Review both the error code descriptions in Appendix F and the field descriptions in the file layouts documented in Appendix A.

In most cases, RREs must correct information on records returned in error and resubmit them on their next quarterly Claim Input File. DDE submitters must correct and resubmit claims returned in error as soon as possible on the COBSW. A few errors, as specified in the error code descriptions, do not require correction and/or resubmission. If a large percentage of records are rejected in error, your EDI Representative will advise you as to whether immediate correction and resubmission of these records outside of your assigned file submission timeframe is required.

Note that errors that result in rejection of TIN Reference File Detail Records may subsequently cause rejection of Claim Input File Detail Records. Your TIN Reference File must be processed successfully prior to or in conjunction with your Claim Input File (See Section 11.3). You may need to correct and resubmit records on your TIN Reference File in order to resolve errors (e.g. TN99) on your Claim Input File.

RREs are advised to contact their EDI Representatives directly with any questions related to disposition and error codes returned or error handling. If you receive an error code other than those documented in Appendix F, report this immediately to your EDI Representative.

Special Consideration for SP31 Error Code

The COBC usually receives entitlement information for individuals in advance of their Medicare entitlement date. If an individual is to become entitled to Medicare on 7/1/2010 and a query record is processed on 6/10/2010 the query response record disposition code will most likely be '01' since the record will be matched to a Medicare beneficiary, albeit a future one. If you then send a Claim Input File Detail Record for this person and it is processed prior to 7/1/2010, it will be rejected with an SP disposition code and the SP31 error. **No correction on the part of an RRE is necessary** for an SP31 error. RREs only need to **resubmit the record** on their next quarterly Claim Input File and it will be processed and returned with the appropriate disposition. SP31 errors are not included in the 20% Error threshold described in Section 12.3.2.

Special Consideration for SP47, SP48 and SP49 Error Codes

Error codes SP47, SP48 and SP49 indicate that a delete transaction could not be matched to a previously submitted and accepted claim report. The distinction between the three errors is only meaningful internally to the COBC and not important to an RRE. Your handling of all three errors is the same. These may be caused by:

- the RRE submitting incorrect key matching fields on the delete transaction
- the claim report has already been deleted by the RRE or by the COBC based on information from another entity
- the original claim report was not previously accepted and returned with an '01' or '02' disposition code

Your error handling for SP47, SP48 and SP49 should include:

- A check to make sure that the key fields submitted were correct
- If key fields were incorrect, correct and resubmit the delete transaction
- If key fields were correct, take no further action.

Special Consideration for SP50 Error Code – Locked ORM Records

Error code SP50 (not to be confused with Disposition Code 50) may be returned on a Claim Response File Detail Record when the COBC already has a matching record of a claim with ORM and that matching record has been locked by the COBC to prevent subsequent changes by any entity other than the COBC. This may occur under limited circumstances particularly when problems arise related to the payment of a beneficiary's Medicare claims in relation to the ORM record.

If the correct key matching fields were submitted, do **NOT** attempt to resubmit a claim report returned with an SP50 error. Keep a record of the rejected claim report for future reference as documentation of your attempt to report. Contact your EDI Representative with questions. If you believe changes to this existing ORM record are necessary, contact the COBC Call Center Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-800-999-1118 or TTY/TDD: 1-800-318-8782 for the hearing and speech impaired. Be prepared to supply your RRE ID when making this call.

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 Representative (see Section 18.1) to resolve the situation. Files with severe errors will be deleted by your EDI Representative and you must resend a corrected file as instructed by your EDI Representative.

- 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.

The following table provides some additional information for each severe error an RRE may receive. However RREs must always contact their EDI Representative in the case of a severe error.

Severe Error	**Correction**
File has invalid RECFM/Record Format	Files must be submitted in a fixed-block format with all records of the same fixed length.
File has invalid LRECL/records with invalid record lengths	The record length of each record on the file must match that specified in the record layouts found in the appendices of this guide. All unused fields and filler at the end of the record must be filled with spaces to the end of the record length of 2220 bytes.
File empty	A file with no records was transmitted to the COBC. Transmission may have failed or there was a problem at the RRE with the creation of the file. If you have nothing to report for a quarter, submit a header record, no detail records and a trailer record with a zero record count or no file at all.
Header record was missing	Header record was not present prior to encountering a detail or trailer record.

Severe Error	Correction
Header record does not match filename – or- Header record RRE ID does not match mailbox RRE ID	The RRE ID on the file header record does not match the RRE ID under which it was uploaded. The file was uploaded via HTTPS under the wrong RRE ID or sent to the wrong SFTP mailbox.
Header record not formatted properly	Refer to the file layouts in the appendices for proper header record formats. In particular, the header record identifier and file type must be valid, RRE ID must be numeric with leading zeroes as appropriate, date fields must contain a valid date and be formatted as MMDDYYYY.
Trailer record missing	No trailer record was found at the end of the file or prior to encountering the header of the TIN Reference File.
Trailer record not formatted properly	Refer to the file layouts in the appendices for proper trailer record formats. In particular, the trailer record identifier and file type must be valid, RRE ID must be numeric with leading zeroes as appropriate, date fields must contain a valid date and be formatted as MMDDYYYY, and the record count must be numeric with leading zeroes as appropriate.
Trailer record does not match header record	The RRE ID and/or file submission dates on the header and trailer records are not the same.
Trailer record count does not match count of records in file	The trailer record count should only include the number of detail and auxiliary records on the file. Do not include the header and trailer records in this count.
Test file with more than 200 records	Claim Input test files must be limited to 200 detail and auxiliary records or less. Resubmit a new test file with fewer records.
Production file reporter status not equal to P	A production file was received for an RRE ID that is not in a production status. Make sure your profile report has been signed by your Authorized Representative and returned to the COBC. Verify testing requirements have been met. If so, contact your EDI Representative to request that your RRE ID be changed to a production status.
Claim detail record does not match header record	Detail records must have type of NGCD or NGCE.
TIN detail record does not match header	Record Identifier must be NGTD.

Severe Error	Correction
record	
Reporter in discontinued/inactive status	A test or production file was received but your RRE ID has been deactivated. File submitted in error. Check to see that the proper RRE ID was used and that the file was sent to the proper RRE ID mailbox/dataset. If this RRE ID is still in use, ask your EDI Representative to correct the status of your RRE ID.

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 5% 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 Representative. An e-mail will be sent to your Account Manager to inform him/her of this suspension. You must contact your assigned EDI Representative to discuss and resolve file threshold errors. Your file may be released for processing or, if sent in error, deleted by your EDI Representative in which case you may need to resend a corrected file as instructed by your EDI Representative.

The following table provides some additional information for each threshold error an RRE may receive. However RREs must always contact their EDI Representative in the case of a threshold error.

Threshold Error	Correction
5% or more of records are delete transactions	Examine use of the delete function. Do not submit deletes when ORM ends. Submit updates with ORM Termination Dates instead. Only submit deletes to remove erroneous records previously accepted with an '01' or '02' disposition code. Very small files may suspend for very few delete records. If the delete transaction was used correctly, your EDI Representative will release the file for normal processing.
20% or more of records failed record level	Error messages will display in the e-mail.

Threshold Error	Correction
edits	Contact your EDI Representative to discuss the most common errors found. Your EDI Representative will provide further instruction. Very small files may suspend for very few records in error. In that case, your EDI Representative will release the file for processing.
Multiple files submitted. Exceeds allowed submission frequency.	Only one Claim Input File may be submitted per calendar **quarter**. Only one Query Input File may be submitted per calendar **month.**
File submitted prior to assigned submission period	Claim Input Files received up to 14 days prior to the start of the RRE's assigned file submission timeframe will be considered early and placed in a hold status. Once the file submission timeframe arrives, the file will be automatically released for processing. If this file should be processed immediately, contact your EDI Representative.
Another file in process for/still processing from prior submission period	A file of the same type submitted previously is still processing. This file must complete before the new file can be released by your EDI Representative.
Late submission of file	File Receipt date is after the current submission period. No file correction is needed. Files must be submitted timely to prevent this error. Contact your EDI Representative to have the file released for processing.
File held via watch list	Your RRE ID has been put on a watch list by the COBC due to past issues with erroneous file submissions. Contact your EDI Representative to resolve.
TPOC Amounts or NGHP Claim No-Fault Insurance Limit Amount entered exceeds $100,000,000.00 for a single claim.	An amount over 100 million dollars was submitted in the total of the TPOC Amounts or the No-Fault Insurance Limit (Field 81). This threshold error can occur if only one record on the file meets this condition. Note that a value of all 9's used as a default in Field 81 will not trigger this threshold error. Check the amounts submitted in these fields, make needed corrections and contact your EDI Representative.

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 F. 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.

Another possible value you may receive in a Compliance Flag field is ‘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. The actual date of when the RRE assumed ORM is not collected as part of the claim report. 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.

Note: Use of TIN and TIN Address Compliance Flag Code values of 02 and 04 - 09 will be discontinued as of October 1, 2011.These codes are being replaced by error codes that will be returned on the TIN Reference Response File. See the Section 11.3.2 and the TIN Error Codes documented in Appendix F.

13 Query Files

This section does not apply to RREs using the DDE reporting option. Query functionality (beneficiary lookup) is built into the first step of the DDE claim submission process on the Section 111 COBSW.

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 Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN) for the injured party on all Claim Input File Detail Records. RREs are to report only with respect to Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award or other payment). If a reported individual is not identified as a Medicare beneficiary based upon the submitted information, the COBC will reject the record for that individual.

Two means of querying the Medicare status of an injured party are available to Section 111 RREs. The first is a file exchange with the COBC. The second is a limited online query feature on the Section 111 COBSW described in Section 13.5.

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 Detail Records must be submitted with the HICN or SSN, 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 Section 16 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 HICN or SSN. 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 must store this HICN on your internal files and use it on future Claim Input File 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 Detail 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. Note that if an RRE submits a value of '0' for an unknown gender for an individual, the COBC will change this value to a '1' for matching purposes and may return that changed value of '1' on the response record even if a match is not found.

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. If the information for the injured party is matched to a Medicare beneficiary, the response to the query will contain the updated HICN, name fields, DOB and gender according to Medicare's information. The COBC will never return an updated or corrected SSN on the Query Response File.

The Query Input and Response Files are transmitted using the ANSI X12 270/271 Entitlement Query transaction set (currently using 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 Versions 2.0.0 and 3.0.0 of the HEW software are documented in Appendix E 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 on the NHGP page of www.cms.gov/MandatoryInsRep ("270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide for NGHP Entities") 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.*** Even though a query file may be sent monthly, RREs need only query a particular injured party once per quarter and use the results of that query when creating the quarterly Claim Input File. For example, an RRE could set up a process to collect and save injured party information on a tracking file as ORM is assumed and as TPOCs are established. The injured party information for claims that require ongoing monitoring would be included as well. Then submit the query file once a quarter allowing enough time to receive and process the query file results for the

creation of that quarter's Claim Input File. Since the Query Response File is returned within 14 days, an RRE might consider submitting the query file one month before the Claim Input File is due. Please refer to Section 12.4 for more information on the timeliness of claim reports.

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 and maintained by the COBC) to submit a Query Input File and process the Query Response File.

Mainframe and Windows PC/Server-based versions of the HEW software are available. You may download the Windows version of the HEW software after logging on to the Section 111 COBSW at www.section111.cms.hhs.gov. You may request a copy of both the mainframe and Windows versions from your EDI Representative or by contacting the COBC EDI Department at 646-458-6740. The HEW software is maintained free of charge by the COBC. No source code will be provided.

Query Input and Response File specifications for the flat files that are the input and output of the HEW software can be found in Appendix E. The file format for the current (January 2010 Version 2.0.0) is provided there. The file format for the HEW Version 3.0.0, available as of October 1, 2011, is the same as Version 2.0.0. Versions 2.0.0 and 1.2.0 of the HEW software may be used until January 1, 2012. RREs using the HEW software must upgrade to Version 3.0.0 by January 1, 2012.

To use the HEW software, you first will create an input file according to the specifications in Appendix E. 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 E. 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.

The HEW Query Response File Detail Records contain a Disposition Code in Field 8. A value of '01' indicates that the injured party submitted on the input record was matched to a Medicare beneficiary. A value of '51' indicates that the information supplied on the query record could not be matched to a Medicare beneficiary.

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. Generally the mainframe version of the HEW will execute on the standard IBM mainframe operating systems such as z/OS and z/VM, but ***not*** the Unix-like operating systems such as Linux, AIX, etc. 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. APIs are not made available for the Windows version. However, effective with Version 2.0.0 released in January 2010, the

Windows PC/Server version of the HEW may be invoked using a command line interface. Instructions on how to invoke the HEW software from an automated process can be found in documentation that is contained in the software package download. Network communication ports are not part of the HEW application. The HEW only converts incoming/outgoing files. Telecommunications must be done separately. See Section 15 for more detailed information on file transmission options.

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.
- If more than one Query Input File is received during a calendar month or is received while a previous file is still processing, the new Query Input File will suspend with a threshold error. If the second file is suspended due to another file still in process, you must contact your EDI Representative to have the suspended file released for processing. If you send more than one file during a calendar month, the second file will be deleted and not processed.
- Query Response Files will be returned to you within 14 calendar days.
- An RRE ID must be in at least 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 Representative 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.
- The HEW Query Response Files have NO header and trailer records.
- Each query response will contain 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 HEW response record indicates that the injured party submitted on the input record is/was a Medicare beneficiary. A value of '51' in the HEW response record indicates that the individual could not be identified as a Medicare beneficiary based upon the information submitted. If you are using your own translator and

not using the HEW software, the matching algorithm is the same, but please refer to the X12 270/271 companion guide for information on interpreting query results.

- If a match is found, the response record will also contain the current 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 fields as they were submitted on the input record. No information is supplied regarding "partial matches" or why a match was not found.
- 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.
- If an RRE submits a value of '0' for an unknown gender for an individual, the COBC will change this value to a '1' for matching purposes and therefore may return that changed value of '1' on the response record even if a match was not found.
- Two RRE-defined, optional document control number (DCN) fields are available for use on the X12 270/271 and HEW Versions 2.0.0/3.0.0 Query Input/Response Files. The RRE DCN 1 and RRE DCN 2 fields are alphanumeric, may contain spaces, numbers, letters, and special characters as defined for an alphanumeric field type, are left justified and unused bytes must be space-filled. The COBC will always return query response records with whatever value the RRE submitted in these DCNs so that the RRE may use them to match response records to input records.

13.4 Upgrade of Query Files and HEW Software to Version 5010A1

The COBC is currently using the Version 4010A1 of the ASC X12 270/271. It will upgrade to Version 5010A1 starting October 1, 2011. The conversion will be completed by January 1, 2012. Only Version 5010A1 will be accepted as of January 1, 2012. The change will be minor.

- RREs using the HEW software will be required to upgrade to a new version of the HEW software (Version 3.0.0) by January 1, 2012.
    - A copy of the new PC/server Version 3.0.0 of the HEW software will be available for download on the Section 111 COBSW on October 1, 2011 at www.section111.cms.hhs.gov.
    - RREs using the mainframe version of the HEW may request a copy of new HEW Version 3.0.0 from their COBC EDI Representative as of October 1, 2011.
    - The layouts for the flat file input and output for HEW Version 3.0.0 will be the same as those used for HEW Version 2.0.0 as documented in appendices of the current versions of the Section 111 User Guides.
    - HEW Versions 1.2.0 and 2.0.0 will be discontinued as of January 1, 2012 and may no longer be used as of that date by Section 111 RREs.
- Section 111 X12 270/271 companion guides for those RREs using their own X12 translator software will be published by July 1, 2011.

- Test and production query files may be submitted using Version 5010A1 (and HEW Version 3.0.0) as of October 1, 2011.
- Test and production query files may continue to be submitted using Version 4010A1 (and HEW Versions 1.2.0 and 2.0.0) through December 31, 2011.
- The COBC will return the same version number on the 271 as submitted by the RRE on the 270. If an RRE submits Version 4010A1 and the file is accepted and processed, the COBC will return Version 4010A1. If an RRE submits Version 5010A1 and the file is accepted and processed, the COBC will return Version 5010A1. RREs must use the same version of the HEW software to process the query response files as they used to submit the query input files.
- The COBC will not accept files submitted using Version 4010A1 after December 31, 2011.
- Testing of the new version is recommended but not required.
- **RREs must upgrade to ASC X12 270/271 Version 5010A1 (or use HEW Version 3.0.0) no later than January 1, 2012.**
- Query files submitted on or after January 1, 2012 under Version 4010A1 (or created using HEW Versions 1.2.0 and 2.0.0) will be rejected with a severe error and not processed. Version 4010A1 query files (or query files created using HEW Versions 1.2.0 and 2.0.0) submitted and accepted by December 31, 2011, but processed on or after January 1, 2012 will be returned using Version 4010A1.

Section 111 X12 270/271 and HEW Software Upgrade to Version 5010	
Timeframe	**Activity**
July 1, 2011	• Section 111 ASC X12 270/271 Companion Guides for Version 5010A1 published for those RREs using their own X12 translators
October 1, 2011	• Mainframe and PC/Server versions of HEW software Version 3.0.0 for Version 5010A1 of ASC X12 270/271 available for all RREs
October – December 2011	• Testing Period • Version 5010A1 of X12 270/271 accepted for test and production Section 111 query files • Version 4010A1 continues to be accepted for test and production files • New version of HEW software (3.0.0) may be used • Old versions of the HEW software (2.0.0 and 1.2.0) may be used

Section 111 X12 270/271 and HEW Software Upgrade to Version 5010	
Timeframe	**Activity**
January 1, 2012	• All RREs must upgrade to Version 5010A1 for both test and production Section 111 query files • Version 3.0.0 of the HEW software must be used (by RREs not using their own X12 translator) • Prior versions of HEW software (2.0.0 and 1.2.0) may no longer be used • Query files submitted under Version 4010A1 no longer accepted

13.5 Querying Using the Beneficiary Lookup on the COBSW

When a Section 111 RRE has an immediate need to determine the Medicare status of an injured party, the Beneficiary Lookup feature on the Section 111 COBSW permits a user to submit an online query to find out if the individual can be matched to a Medicare beneficiary.

NGHP RREs, that have not selected the Direct Data Entry (DDE) reporting option and are in a production status, will have the Beneficiary Lookup action available on the RRE Listing page after logging on to the Section 111 COBSW (www.section111.cms.hhs.gov). The Beneficiary Lookup will utilize the same matching criteria and methodology as used for the Query Input File and the Claim Input File.

To use the Beneficiary Lookup action:

- Log on to the Section 111 COBSW
- The RRE Listing page will display
- Click on the Actions drop-down box for the RRE ID under which you wish to query
- Select the Beneficiary Lookup action from the list and click on the Go button
- The Beneficiary Lookup page will display
- On the Beneficiary Lookup page, enter the following required information
  - HICN or SSN
  - Injured Party First Name
  - Injured Party Last Name
  - Injured Party Date of Birth
  - Injured Party Gender
- Click on the Next button
- The system will attempt to match the information submitted to a Medicare beneficiary.
- If a match is found, the Beneficiary Lookup Response page will display.
- If the information entered cannot be matched to a Medicare beneficiary, the Beneficiary Not Found page will display.

Important Considerations:

- RREs are limited to 100 query requests per RRE ID per calendar month using the Beneficiary Lookup on the COBSW.
- Use of the Beneficiary Lookup action is limited to that prescribed by the Section 111 Data Use Agreement as documented in Section 16 of this User Guide and agreed to by the RRE's Authorized Representative on the signed Profile Report as well as by each user of the Section 111 COBSW.
- The Beneficiary Lookup action will only be available for RRE IDs in a production status.
- The Beneficiary Lookup action will not be available to RREs that have selected Direct Data Entry (DDE) as a submission method because this same functionality is offered within the DDE process.
- All users associated to the RRE ID (Account Manager and Account Designees) will be able to use the Beneficiary Lookup function.
- Use of the Beneficiary Lookup action is optional. It will be offered under all non-DDE RRE IDs. No special application or sign-up is required.
- RREs using the Beneficiary Lookup action may continue to submit the Query Input File.

14 Testing the Section 111 Reporting Process

This section does not apply to RREs that have chosen the DDE reporting option.

14.1 Testing Overview

RREs using a file submission method 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. No testing is done for the DDE option. 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, unless the DDE option is selected.

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 successful 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. There is no limit to the number of test files an RRE may submit. 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:

- 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.

- RREs must initiate registration on the COBSW early enough to allow for at least 90 days for file testing to be completed prior to having claims to report. See Sections 11.10.2 and 12.4 for more information on timely reporting. If you run the risk of not completing testing on time, please notify your EDI Representative 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. Once an RRE has moved to a production status, any subsequent test files received will continue to be processed by the COBC and results will be displayed on the COBSW. Test response files will be produced and transmitted. In other words, RREs may continue to submit test files after the RRE ID has changed to a production status and even after production files have been submitted. This will allow RREs to test subsequent changes to their internal reporting process without disruption to production reporting.
- 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 are available for RRE use in a downloadable file, as submitters may not know of real Medicare beneficiaries. This test data is comprised of only SSN, HICN, name, date of birth and gender for the test beneficiaries. It does not include claim information. Test beneficiary data may be downloaded from the Section 111 COBSW at www.section111.cms.hhs.gov. After accepting the Login Warning, the Section 111 COBSW Login page displays. Click on the Reference Materials menu option to view the files available for download which include test beneficiary data.
- 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 a combined total of 200 detail and auxiliary records (excluding the header and trailer). Test files with more than 200 detail/auxiliary 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.
- A test TIN Reference File must be submitted prior to or with your test Claim Input Files. RREs are advised to submit and complete successful processing of test TIN Reference Files prior to attempting submission of Claim Input Files as the TIN information is required for successful processing of Claim Input Files.
- RREs must submit at least the following test files:

    - A TIN Reference File with records for each TIN/Office Code combination that will be used on test Claim Input Files. Note that the Office Code must be a 9 digit number or filled with nine spaces if it is not used.
    - 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.
- 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:
    - Successfully process the TIN Reference File receiving an '01' disposition code back on TIN Reference Response File Detail Records as expected.
    - 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 and as advised by your EDI Representative.
- 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 Representative is kept informed of your testing progress and any issues that you have encountered.

Once Claim Input File testing has been completed and your COBC EDI Representative has moved the RRE ID to a production status, an e-mail will be sent to the RRE's

Authorized Representative and 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 by 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 to exchange the ASC X12 270/271 transaction set.

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 E (if using the HEW software) or as documented in the Section 111 X12 270/271 companion guide. The COBC will return a Query Response File to you within a week of receipt of test file 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:

- 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 four separate methods of data transmission that Section 111 RREs may utilize. Three involve the submission of electronic files. The fourth method is Direct Data Entry (DDE) on the Section 111 COBSW. 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, the method selected for the file type will be used to transmit the corresponding response file back to the RRE or its agent. If you select DDE, then you will enter claim information directly on the Section 111 COBSW instead of transmitting an electronic file. DDE is limited to RREs with few claims to report per year. See Section 15.5 for more information on the DDE method.

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.

15.2 Connect:Direct (NDM via the CMSNet)

RREs with a very large transmission volume may wish to consider using Connect:Direct (formerly known as Network Data Mover or NDM) via a connection to the CMS Extranet Network and CMS' private CMSNet network hosted by Verizon Business Networx Services. Please contact the COBC EDI Department at (646) 458-6740 or your COBC EDI Representative for information on how to establish this connectivity. ***You are encouraged to do this as soon as possible since this setup can take a significant amount of time.*** There are implementation costs and ongoing charges related to this transmission method.

During COBSW account setup, you will select the Connect:Direct option and provide the dataset names you want the COBC to use when sending back response files. You must then contact your EDI Representative to complete the setup. After your registration has been processed and connectivity established, the COBC will e-mail a

profile report to confirm your Section 111 destination dataset names to which you will send your input files. If you have already registered for Section 111 under another file transmission method and wish to change to Connect:Direct, contact your EDI Representative.

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.

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

- 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 destination dataset 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 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. Also note that passwords are exactly 8 characters and must be submitted that way when connecting to the SFTP server.

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

Note: TIN Reference Response Files (effective October 1, 2011) are placed in the "claim" folders.

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 of 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 Representative 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.Thhmmsscc.TXT
TIN Response: PCOB.BA.MR.NGHPTIN.RESP.Dccyymmdd.Thhmmsscc.TXT
Query Response: PCOB.BA.MR.NGHPQRY.RESP.Dccyymmdd.Thhmmsscc.TXT

Where 'Dccyymmdd' is 'D' followed by a date as century/year/month/day and 'Thhmmsscc' is 'T' followed by a time as hours/minutes/seconds/centiseconds.

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 Representative 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 when uploading 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 on the File Listing page of the Section 111 COBSW application.

Claim Response: PCOB.BA.MR.NGHPCLM.RESP.Dccyymmdd.Thhmmsscc.TXT
TIN Response: PCOB.BA.MR.NGHPTIN.RESP.Dccyymmdd.Thhmmsscc.TXT
Query Response: PCOB.BA.MR.NGHPQRY.RESP.Dccyymmdd.Thhmmsscc.TXT

Where 'Dccyymmdd' is 'D' followed by a date as century/year/month/day and 'Thhmmsscc' is 'T' followed by a time as hours/minutes/seconds/centiseconds.

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.

15.5 Direct Data Entry (DDE)

Detailed information on the Direct Data Entry (DDE) option can be found in the Section 111 COBSW User Guide available for download after login at www.Section111.cms.hhs.gov. There are also computer-based training modules (CBTs) available free of charge that provide an overview and step-by-step instructions for DDE. See Section 19 for information on how to enroll in the CBTs.

Who is the DDE Option Available To?

"Small Reporters" - A "Small Reporter" is an RRE that will submit **500 or fewer** NGHP claim reports per calendar year. (Please see "Query" discussion below for further information on how this total of 500 is counted.)

What is the DDE Option?

Small Reporters may use the Section 111 Coordination of Benefits Secure Website (COBSW) at http://www.section111.cms.hhs.gov/ to manually enter and submit individual NGHP claim reports online instead of submitting an electronic file. The DDE Option is in lieu of using one of the file submission methods (HTTPS, SFTP, Connect:Direct). Small Reporters will be required to report the same data elements as those required under the file submission methods by manually keying the information into COBSW pages/screens.

How Can "Small Reporters" Register for the DDE Option?

Small Reporters may register for DDE as a reporting option on the Section 111 COBSW.

- The DDE option is open to all current and new RREs that meet the definition of a Small Reporter.If an RRE has already registered under the current file transmission methods and wants to change to the DDE option, the Account Manager for the RRE ID should log into the COBSW and change the reporting method from a file transmission method to DDE. Select "Register for DDE" under the Actions dropdown box next to your RRE ID on the RRE Listing page. Contact your EDI Representative if you need assistance.
  .
- If an RRE has not previously registered, the Account Manager should select DDE during the Account Setup step of the registration process.

- Upon completion of registration, DDE reporters move directly into production status; testing is not required.

When Can "Small Reporters" Begin Reporting Using the DDE Option?

DDE became available to Small Reporters on July 11, 2011.

How Does the DDE Option Differ From the Current File Submission Method?

Testing:

- No testing will be required for RREs using the DDE option.

Submission of claim information:

- There is no assigned submission window.
- Claim information will be submitted one claim report at a time as soon as the conditions related to the claim require reporting under Section 111.
- Claim record submissions are required within 45 calendar days of the TPOC Date or within 45 calendar days of assuming ORM.
    - Exception: Since retroactive reporting is required for certain ORM (ORM exists at any time prior to 1/1/2010 and continues on or after 1/1/2010) and certain TPOC Amounts (no-fault insurance and workers' compensation TPOC dates from 10/1/2010 and subsequent) but DDE was not available until July 2011, an exception will be made for these claim records to be reported outside the 45 calendar day grace period. However, information for these ORMs and TPOCs must be submitted during the third calendar quarter of 2011. (Please refer to other sections of this User Guide for further details on these dates.)
- ORM Termination Date submission is required within 45 calendar days of the ORM Termination Date.

Query:

- A separate query function will not be available under the DDE option. However the initial step in the DDE process provides the same functionality.
- Injured party information will be matched real-time online to the COBC's file of Medicare beneficiary information as it is entered on the COBSW. The application will prompt the user performing the data entry to enter the injured party's information first. Then, the system will attempt to match it to a Medicare beneficiary. If no match is found and the user confirms that the information they entered was complete and accurate, no further data elements will be required at that time. A "non-match" will essentially be like receiving a "51" disposition code back on a Claim Response File.
- When an injured party's information does not match to a Medicare beneficiary during the DDE process, the claim submission WILL still count toward the RRE's limit of 500 claims per year.

Issues to Consider Before Selecting the DDE Option:

- Small Reporters that use the DDE option have the same responsibility and accountability as any other RRE.
- Small Reporters will be required to report the same data elements as those required under the current file submission methods (HTTPS, SFTP, Connect:Direct). Due to the number of data elements required, the manual data entry for a single claim report may take a considerable amount of time. Small Reporters should also consider the requirement for retroactive reporting during the third calendar quarter of 2011.
    - Note: Small Reporters will have the ability to save an individual claim report that is in progress (not yet submitted) for 30 calendar days before it will be deleted by the system.

- The DDE option is intended for RREs who expect to have only an occasional claim report to make. RREs that will have claims to report on a frequent and on-going basis are advised to use the current file submission methods instead of the DDE option to ensure that RREs are able to adhere to the timely reporting requirements.
- There is a very real limitation to RREs that select the DDE option because a Small Reporter may only submit 500 or less claim reports per calendar year, and claim reports resulting in a “no beneficiary match” count against the 500 claim report limit.
    - The DDE option is not an appropriate choice for RREs that may submit more than 500 claim reports per year and plan to rely upon the query capability for Section 111 reporting.

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. § 1395kk(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 Section 111 COB Secure Web Site (COBSW)

The COBC maintains an application on the Section 111 COB Secure Web site (COBSW) to support Section 111 reporting. Section 111 Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation RREs register and set up accounts on the COBSW. The COBSW URL is www.Section111.cms.hhs.gov.

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

- Complete the registration process. Obtain RRE IDs for each account under which the RRE will submit files. All information is 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. Alternatively, submit claim information via the Direct Data Entry option.
- View and update Section 111 reporting account profile information such as contacts and company information.
- View the status of current file processing such as when a file was marked as received and whether a response file has been created.
- View statistics related to previous file submission and processing.
- View statistics related to compliance with Section 111 reporting requirements such as whether files and records have been submitted on a timely basis.
- Utilize an online query function, the Beneficiary Lookup, to determine the Medicare status of an injured party.
- Extract a list of all RRE IDs to which the user is associated.

The registration and account setup processes are described in Section 8 of this guide.

Sources of Help Related to Using the Section 111 COBSW

To access the Section 111 COBSW, go to www.Section111.cms.hhs.gov using your Internet browser. Once you click on the "I Accept" link and accept the terms of the Login Warning, the homepage will display.

Information on the New Registration, Account Setup, and other processes can be found under the **"How To" menu option** at the top of the homepage. 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.

All pages of the Section 111 COBSW application provide access to **"Quick Help"** information. Click on the link for Quick Help and a new window will open with instructions and information needed to complete the page you are working on.

Once you have obtained a Login ID for the Section 111 COBSW, you may log into the application using the Login fields displayed on the right side of the homepage. After login, a detailed **Section 111 COBSW User Guide** is available under the "Reference Materials" menu option at the top of the page. You must be logged into the application to gain access to the COBSW User Guide.

Computer-Based Training (CBT) modules for the Section 111 application on the COBSW are available free of charge to RREs and their agents. See Section 19 for information on how to register for the CBT courses.

Contact your assigned **EDI Representative** for additional help and assistance using the COBSW. See Section 18.

Login IDs

Each person using the Section 111 COBSW must obtain their own Login ID and password. Your personal Login ID may be used for access to multiple RRE IDs. Your Login ID will also be used to transmit files via STFP (see Section 15). You can play one of two roles under an RRE ID with your single Login ID - Account Manager or Account Designee. Authorized Representatives **cannot** be users of the COBSW (See Section 8).

To obtain a Login ID, you must either perform the Account Setup step of the registration process for the RRE ID on the COBSW and become the **Account Manager** or be invited by an already established Account Manager to be associated to the RRE ID as an **Account Designee**. Refer to the information in Section 8 on the registration process and the "How Tos" referenced above for more information on obtaining Login IDs during the registration process.

If your organization has completed the registration process and you need a Login ID for the COBSW, contact your Account Manager and request that he or she add you as an Account Designee. You will receive an e-mail invitation to come to the site and set up your Login ID and password. Likewise, if you are a reporting agent and need access to a customer's COBSW account to assist with the reporting process, contact the RRE's Account Manager to be invited as an Account Designee.

Each RRE must assign or name an Account Manager. The Account Manager may be an employee of the RRE or a reporting agent. Each RRE ID can have only one Account Manager. This is the individual who controls the administration of an RRE's account and manages the overall reporting process. The Account Manager may choose to manage the entire account and data file exchange, or may invite other company employees or data processing agents to assist.

The Account Manager:

- Must register on the COBSW using the PIN for the RRE ID (See Section 8), 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 can occur when a reporting entity has multiple RRE IDs under which they will report separate Claim Input Files or when the entity chooses to name an agent as its Account Manager.
- Can invite other users to register on the COBSW as Account Designees for an RRE ID.
- Can manage the RRE's profile including selection of a file transfer method or DDE.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.

- Can use his/her Login ID and Password to transmit files if the RRE has specified SFTP as the file transfer method.
- Can submit claim information via DDE if the RRE has specified DDE as its submission method.
- Can review file transmission history.
- Can review file-processing status and file statistics.
- Can remove an Account Designee's association to an RRE ID account.
- Can change account contact information (e.g. address, phone, etc.)
- Can change his/her personal information.
- Cannot be an Authorized Representative for any RRE ID.
- Can query the Medicare status of an injured party using the Beneficiary Lookup feature.

At the RRE's discretion, the Account Manager may designate other individuals, known as Account Designees, to register as users of the COBSW associated with the RRE's account. Account Designees assist the Account Manager with the reporting process. Account Designees may be RRE employees or agents. There is no limit to the number of Account Designees associated with one RRE ID.

The Account Designee:

- Must register on the 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 submit claim information via DDE if the RRE has specified DDE as its submission method.
- Can review file transmission history.
- Can review file-processing statuses and file statistics.
- Can change his/her personal information.
- Cannot be an Authorized Representative for any RRE ID.
- Cannot invite other users to the account.
- Cannot update RRE account information.
- Can query the Medicare status of an injured party using the Beneficiary Lookup feature.

Note: Each user of the Section 111 application on the COBSW will have only one Login ID and password. With that Login ID and password, you may be associated with multiple RRE IDs (RRE accounts). With one Login ID, you may be an Account Manager for one RRE ID and an Account Designee for another. In other words, the role you play on the COBSW is by RRE ID.

Routine maintenance on the COBSW and Section 111 SFTP server is performed during the third weekend of each month as needed. During this time, access to the COBSW and SFTP will be limited. When the COBSW is unavailable, users attempting to login will

receive a page to notify them that the site is unavailable. This work usually commences on Friday at 8:00 p.m. (EST) and is completed no later than Monday at 6:00 a.m. (EST).

CMS advises all Section 111 COBSW users to implement the following best practices:

- Keep the personal computer Operating System and Internet Browser software (e.g. Internet Explorer or Firefox) at the most current patch level.
- Install and use the latest versions of anti-virus/spyware software to continuously protect personal computers.
- Use desktop firewall software on personal computers and ensure that file sharing is disabled.
- Never use a public computer (library, internet café, etc.) to login to CMS resources.

System-Generated E-Mails

The 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 Representative directly.

E-Mail Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	Sent after Account Setup step is complete on the COBSW. Includes attachment with profile report. The profile report must be signed by the RRE's Authorized Representative and returned to the COBC.
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 Representative.

E-Mail Notification	Recipient	Purpose
Successful File Receipt	Account Manager	Sent after an input file has been successfully received but not yet processed at the COBC. Informational only. No action required. ***Subsequent e-mails will be sent regarding the results of actual file processing that may require follow up action.***
Late File Submission	Authorized Representative, Account Manager	Sent 7 days after the end of the file submission period if no Claim Input File was received for the RRE ID. Send the file immediately and contact your EDI Representative. This e-mail may be ignored if you have nothing to report for the quarter.
Threshold Error	Account Manager	Sent after the Successful File Receipt e-mail when an input file has been suspended for a threshold error. Contact your EDI Representative to resolve.
Severe Error	Account Manager	Sent after the Successful File Receipt e-mail when an input file has been suspended for a severe error. Contact your EDI Representative to resolve.
Ready for Testing	Account Manager	Account setup is complete and the signed profile report has been received at the 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.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 Web page, click on the "For e-mail updates and notifications" link on the Web site and add your e-mail address to the distribution list.

To submit a policy-related comment or inquiry to CMS regarding Section 111 Mandatory Reporting, please send an e-mail to the Section 111 Resource Mailbox at PL110-173SEC111-comments@cms.hhs.gov. You will not receive a direct response from this e-mail address but CMS will review each submission received and follow up with additional outreach and education as needed.

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

Please note that e-mails from CMS or the COBC may come from @section111.cms.hhs.gov, @cms.hhs.gov, @ghimedicare.com and @ehmedicare.com addresses. Please update your spam filter software to allow receipt of these e-mail addresses.

18.1 EDI Representative

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

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

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 Representative should always be sought out first to help you find solutions for any questions, issues or problems you have.

If you have not yet been assigned an EDI Representative, please call the 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. It is imperative that RREs and their reporting agents follow this process so that COBC Management can address and prioritize issues appropriately.

- 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 Department 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 Department 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.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 Web page, click on the "For e-mail updates and notifications" link and add your e-mail address to the distribution list.
- 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 under the NGHP tab at www.cms.gov/MandatoryInsRep.
- CMS has made available a curriculum of computer-based training (CBT) courses to Section 111 RREs. These courses are offered free of charge and provide in-depth training on Section 111 registration, reporting requirements, the Section 111 COBSW, file transmission, file formats, file processing, and general MSP topics. The curriculum and instructions on how to sign up for these courses is posted on www.cms.gov/MandatoryInsRep under the MMSEA 111 Computer Based Training (CBT) tab on the left side of the page. 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: http://www.cms.gov/COBGeneralInformation, www.msprc.info, www.cms.gov/WorkersCompAgencyServices and http://www.cms.gov/manuals/IOM. The MSP Manual is CMS Publication 100-05.

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 participate in the 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 or if you qualify for DDE. If you choose HTTPS, you will transmit files via the Section 111 COBSW application. If you choose SFTP, you will transmit files to and from the Section 111 SFTP server. If you choose Connect:Direct, contact your EDI Representative for information on how to establish a connection to the COBC via the CMS Extranet and CMSNet, 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 TIN Reference and Claim Input File by your assigned production live date.
- Submit your Query File as needed but no more than once per calendar month ongoing.
- Submit your quarterly Claim Input File ongoing during your assigned submission periods.
- Monitor file processing and statistics on the Section 111 COBSW on a regular basis.
- Update passwords used for the Section 111 COBSW and SFTP on a regular basis (at least every 60 days).
- Monitor automated e-mails generated by the system regarding file processing status. These e-mails are sent to the Account Manager for the RRE ID who should forward these e-mails to Account Designees and reporting agents as necessary.
- Contact your EDI Representative when issues are encountered or assistance is needed.
- Notify your EDI Representative of issues that will prevent you from timely file submission.
- As of January 2012, the RRE's profile report will be e-mailed to the Authorized Representative annually, based upon the receipt date of the last signed profile report. The RRE will be asked to confirm via e-mail that their current information is correct. Failure to confirm this information may result in deactivation of the RRE ID.

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. Must match the date on the corresponding trailer record. 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 within the file submitted shall have a unique DCN. 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.**
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

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**
						dashes. May only contain digits 0 through 9, spaces, and/or letters. No special characters. **Required if SSN not provided.**
5	Injured Party SSN	9	33	41	Alpha-numeric	Social Security Number May contain only spaces or numbers. Fill with spaces if unknown and HICN provided. No dashes, hyphens or special characters allowed. **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. First position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space. **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. May only contain letters and spaces. **Required.**
8	Injured Party Middle Init	1	112	112	Alpha-betic	First letter of Injured Party middle 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**
						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: 0 = Unknown 1 = Male 2 = Female **Required.**
10	Injured Party DOB	8	114	121	Numeric Date	Date of Birth of Injured Party Must be numeric and contain a valid date prior to the current date. Field cannot contain spaces, alpha characters or all zeroes. Format: CCYYMMDD **Required.**
11	Reserved for Future Use	20	122	141	Alpha-numeric	Fill with spaces.
***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

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**
						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)***. For claims involving cumulative injury, the DOI is the earlier of the date that treatment for any manifestation of the cumulative injury began, when such treatment preceded formal diagnosis; or the first date that formal diagnosis was made by any medical practitioner. 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. Must be numeric and a valid date prior to or equal to the current COBC processing date. Field cannot contain spaces, alpha characters or all zeroes. Format: CCYYMMDD **Required.**
13	**Industry** Date	8	150	157	Numeric	Date of Incident (DOI) *used by*

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**
	of Incident (DOI): *DOI routinely used by the insurance/workers' compensation industry*				Date	*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. Field must contain all zeroes or a valid date prior to or equal to the current COBC processing date. Format: CCYYMMDD **Optional.**
14	Reserved for Future Use	1	158	158	Alpha-numeric	Fill with spaces. For future expansion to ICD-10 Codes.
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. **Required for add and update records (Action Type = 0 or 2).**

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**
						Left justify. Do not include decimal point. Must exactly match a code on the list of valid ICD-9 diagnosis codes posted under the Reference Materials menu option on the Section 111 COBSW at http://www.section111.cms.hhs.gov. **See Section 11.2.5 for complete information.** Must begin with the letter 'E'. ***Must NOT be on the list of Excluded ICD-9 Diagnosis Codes found in Appendix I.*** Special default for liability reporting: If, and only if: 1) the ORM Indicator (Field 98) is N, the Plan Insurance Type (Field 71) is L; 2) claim for loss of consortium, an errors and omissions liability insurance claim, a directors and officers liability insurance claim, or a claim resulting from a wrongful action related to employment status action was/is alleged; 3) there is no allegation of a situation involving medical care or a physical or mental injury; 4) the settlement, judgment, award or other payment releases or has the effect of releasing medicals; then a value of 'NOINJ' may be submitted. If 'NOINJ' is submitted in Field 15 then 'NOINJ' must be submitted in Field 19.
16	Reserved for	2	164	165	Alpha-	Fill with spaces. For future

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**
	Future use				numeric	expansion to ICD-10 Codes.
17	State of Venue	2	166	167	Alpha-betic	US postal abbreviation corresponding to the US State (including Guam, Puerto Rico, Washington DC and the US Virgin Islands) whose state law controls resolution of the claim. See http://www.usps.com If the applicable law that controls the resolution of the claim is federal law (such as the Federal Tort Claim Act or the Federal Employee Compensation Act), then submit 'US'. Otherwise if the applicable law is state law, supply the code for that state. 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

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**
						Codes.
19	ICD-9 Diagnosis Code 1	5	169	173	Alpha-numeric	ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) Diagnosis Code describing the alleged injury/illness. **Required for add and update records (Action Type = 0 or 2).** Left justify. Do not include decimal point. Must exactly match a code on the list of valid ICD-9 diagnosis codes posted under the Reference Materials menu option on the Section 111 COBSW at http://www.section111.cms.hhs.gov.**See Section 11.2.5 for complete information.** No "E Codes" or "V Codes" permitted (Cannot begin with the letter 'E' and cannot begin with the letter 'V'). ***Must NOT be on the list of Excluded ICD-9 Diagnosis Codes found in Appendix I.*** Special default for liability reporting: If, and only if: 1) the ORM Indicator (Field 98) is N, the Plan Insurance Type (Field 71) is L; 2) claim for loss of consortium, an errors and omissions liability insurance claim, a directors and officers liability insurance claim, or a claim resulting from a wrongful action related to employment status action was/is alleged; 3) there is no allegation of a situation involving medical care

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**
						or a physical or mental injury; 4) the settlement, judgment, award or other payment releases or has the effect of releasing medicals; then a value of 'NOINJ' may be submitted. If 'NOINJ' is submitted in Field 19 then 'NOINJ' must be submitted in Field 15. If 'NOINJ' is submitted in Field 19 then all remaining ICD-9 Diagnosis Code 2-19 must be filled with spaces.
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, valid ICD-9 Diagnosis Code as specified in the requirements for Field 19. **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.
25	ICD-9 Diagnosis Code 4	5	190	194	Alpha-numeric	See explanation for Field 19 and 21. **Required when 4 or more**

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**
						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.
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	2	230	231	Alpha-	Fill with spaces. For future

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**
	Future Use				numeric	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.
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.

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**
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.
57	Reserved for Future Use.	50	359	408	Alpha-numeric	Fill with spaces. Formerly used for the obsolete Description of Illness/Injury.
58	Product Liability Indicator	1	409	409	Alpha-numeric	Fill with spaces.
59	Product Generic Name	40	410	449	Alpha-numeric	Fill with spaces.
60	Product Brand Name	40	450	489	Alpha-numeric	Fill with spaces.
61	Product	40	490	529	Alpha-	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**
	Manufacturer				numeric	
62	Product Alleged Harm	200	530	729	Alpha-numeric	Fill with spaces.
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 H of this User Guide. You **must** use this definition of self-insurance for purposes of this reporting. Used by CMS if Plan Insurance Type (Field 71) is E or L (Workers' Compensation or Liability). Since the self-insurance rules applicable to Liability and WC do not apply to No-Fault, if Plan Insurance Type is D (no-fault), field must contain a default value of N or space. **Required.** ***If Plan Insurance Type is E or***

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**
						L, this field must equal Y or N. **If Plan Insurance Type is D, this field must equal N or space.**
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.) Space = Not applicable (Self Insured Indicator Field 64 is N or space ***Required and must contain a value of I or O if the Self Insured Indicator (Field 64) is Y. If the Self Insured Indicator is N or space, the Self Insured Type must equal space.***
66	Policyholder Last Name	40	752	791	Alpha-betic	Surname of policyholder or self-insured individual. Embedded hyphens (dashes), apostrophes and spaces accepted. **If Self-Insured Type (Field 65) = I, first position must be an alphabetic character and other positions may contain a letter, hyphen, apostrophe or space. If Self Insured Type is not equal to I, must be all spaces.**
67	Policyholder First Name	30	792	821	Alpha-betic	Given/First name of policyholder or self-insured individual.

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**
						May only contain letters and spaces. **If Self-Insured Type (Field 65) = I, must contain only letters and/or spaces. If Self Insured Type is not equal to I, must be all spaces.**
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. If supplied, must be at least 2 characters long. If Self Insured Type (Field 65) = I, must be blank.**
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. If supplied, must be at least 2 characters long. If Self Insured Type (Field 65) = I, must be blank.**
70	Reserved for Future Use	20	962	981	Alpha-numeric	Fill with spaces.
Plan Information						
71	Plan Insurance	1	982	982	Alpha-	Type of insurance coverage or

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**
	Type				numeric	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."
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.

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**
						Must contain a valid 9-digit IRS-assigned Federal Tax Identification Number or foreign RRE pseudo-TIN. Must be numeric. Include leading zeroes. Do not include hyphens. In the case of a foreign RRE without a valid IRS-assigned TIN, supply the pseudo-TIN created during Section 111 registration. 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 9-digit number 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. ***If not used, must be filled with spaces. If used, must be a non-zero 9-digit number, right justified and padded on the left with zeroes. No letters or***

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**
						special characters are accepted. ***Optional.***
74	Policy Number	30	1001	1030	Alpha-numeric Plus Parens	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. Must be at least 3 characters in length. ***Required.***
75	Claim Number	30	1031	1060	Alpha-numeric Plus Parens	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. May not be equal to all spaces. ***Required.***
76	Plan Contact Department Name	70	1061	1130	Alpha-numeric Plus Parens	Name of department for the Plan Contact to which claim-related communication and correspondence should be sent. Note that this name is used for informal communications and not used for recovery demand notifications. ***Optional.***
77	Plan Contact Last Name	40	1131	1170	Alpha-betic	Surname of individual that should be contacted at the Plan for claim-related communication and correspondence. Note that

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**
						this name is used for informal communications and not used for recovery demand notifications. If not left blank, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space. ***Optional.***
78	Plan Contact First Name	30	1171	1200	Alpha-betic	Given or first name of individual that should be contacted at the Plan for claim-related communication and correspondence. Note that this name is used for informal communications and not used for recovery demand notifications. May only contain letters and spaces. If not left blank, first position must be an alphabetic character. Other positions must contain letters or spaces. ***Optional.***
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). Must contain 10-digit numeric value. Fill with zeroes if not available.

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**
						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. Must be left-justified and unused bytes filled with spaces. Fill with all spaces if unknown or not applicable. ***Optional***
81	No-Fault Insurance Limit	11	1216	1226	Numeric	Dollar amount of limit on no-fault insurance. *S*pecify dollars and cents with implied decimal. No formatting (no $ or , or .) For example, a limit of $10,500.00 should be coded as 00001050000. Note: the ***last two positions reflect cents.*** For example, an amount of 500 dollars and no cents must be submitted as "00000050000", Field may not be blank (all spaces). Must contain a valid numeric amount, all zeroes or all 9's as specified below. **Required if Plan Insurance Type (Field 71) is D (No-Fault Insurance). If Plan Insurance Type is D and there is no such dollar limit, fill with all zeroes or all 9's, otherwise specify amount.**

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**
						If Plan Insurance Type (Field 71) is E (Workers' Compensation) or L (Liability Insurance), must be filled with all zeroes.
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 Field may not be blank (all spaces). Must contain a valid date or all zeroes as specified below. When a valid date is supplied in Field 82, the same date should be supplied in the ORM Termination Date (Field 99). **If Plan Insurance Type (Field 71) is D (No-Fault Insurance) and the limit has not yet been reached, fill with all zeroes. Otherwise, specify the date the limit was reached and the same date in the ORM Termination Date (Field 99).** **If Plan Insurance Type (Field 71) is E (Workers' Compensation) or L (Liability Insurance), must be filled with all zeroes.**
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 (Injured Party Representative Indicator is a space), default each field in this section to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 84-96) with spaces if not supplying Representative Information.***						
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 (Fields 84 – 96 must contain default values according to Data Type or all spaces) 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. Embedded hyphens (dashes), apostrophes and spaces accepted. **Either Representative Last Name *and* First Name – or – Representative Firm Name is required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 84) is 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**
86	Representative First Name	30	1296	1325	Alpha-betic	Given or first name of representative. May only contain letters and spaces. **Either Representative Last Name *and* First Name – or – Representative Firm Name is required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 84) is blank.**
87	Representative Firm Name	70	1326	1395	Alpha-numeric	Representative's firm name. **Either Representative Last Name *and* First Name – or – Representative Firm Name is required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 84) is blank.**
88	Representative TIN	9	1396	1404	Alpha-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). May contain only spaces or numbers. If no Representative TIN is available, fill with spaces or all zeroes. **Must be blank or all zeroes if Injured Party Representative Indicator (Field 84) is blank.** **Optional.**
89	Representative	50	1405	1454	Alpha-	First line of the mailing address

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**
	Mailing Address Line 1				numeric	for the representative named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 84) is blank.**
90	Representative Mailing Address Line 2	50	1455	1504	Alpha-numeric	Second line of the mailing address of the representative named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Must be blank if Injured Party Representative Indicator (Field 84) is blank.**
91	Representative City	30	1505	1534	Alpha-numeric	Mailing address city for the representative named above. Field may contain only alphabetic, Space, Comma, & - ' . @ # / ; : characters. No numeric characters allowed. 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**
						Required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 84) is blank.
92	Representative State	2	1535	1536	Alpha-betic	US Postal abbreviation State Code for the representative named above. See http://www.usps.com If no US address is available, supply 'FC'. Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses. **Required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 84) is blank.**
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. Must be blank or all zeroes if Injured Party Representative Indicator (Field 84) is blank.**
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). **Must be blank or all zeroes if Injured Party Representative Indicator (Field 84) is 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**
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. Must be blank or all zeroes if Injured Party Representative Indicator (Field 84) is blank.**
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. **Must be blank if Injured Party Representative Indicator (Field 84) is blank.**
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

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**
						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.**
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 exceptions regarding reporting ORM. Future dates are accepted but not more than 6 months greater than the file submission date. 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.

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**
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). 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.** Must be non-zero if a non-zero value is submitted in TPOC

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 1. Must be greater than the CMS Date of Incident (Field 12) and less or equal to the current COB processing date. No future dates allowed. Must be all zeroes if TPOC Amount 1 is all zeroes. **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 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.

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**
						Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as "00001000000". 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.** **Required for all other claim reports.** Must be non-zero if a non-zero value is submitted in TPOC Date 1. Must be filled with all zeroes if TPOC Date 1 is all zeroes. **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 TPOC Amount 1 is delayed, provide actual or estimated date of funding. Also see "Timeliness" of

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**
						reporting in Section 11.10.2. Format: CCYYMMDD Fill with all 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 (Claimant 1 Relationship is a space), default each field in this section* (Fields 104-118) *to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 104-118) with 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 Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity 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 (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 (Fields 104 – 118 must contain default values according to Data Type, or all spaces) **Required if injured party is deceased and claimant is not the injured party.**
105	Claimant 1 TIN	9	1638	1646	Alpha-numeric	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 1. May contain only spaces or numbers. Must not match other claimant(s) listed on the Auxiliary Record. **Required if injured party is deceased and claimant is not the injured party. If Claimant 1 Relationship (Field 104) is equal to a space, must contain all zeroes or all spaces.**
106	Claimant 1 Last Name	40	1647	1686	Alpha-betic	Surname of Claimant 1. Embedded hyphens (dashes), apostrophes and spaces accepted. **Required if injured party is deceased and claimant is not the injured party and Claimant 1 Relationship is 'E', 'F' or 'O'.**

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**
						If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.
107	Claimant 1 First Name	30	1687	1716	Alpha-betic	Given/First name of Claimant 1. May only contain letters and spaces. **Required if injured party is deceased and claimant is not the injured party and Claimant 1 Relationship is 'E', 'F' or 'O'. If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.**
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'. If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.**
109	Claimant 1 Entity/Organization Name	71	1647	1717	Alpha-numeric	Name of Claimant 1 Entity/Organization. Redefines Fields 106-108 (is made up of the same bytes, is in the same location as Fields 106-108). Use either Field 109 or Fields 106-108 depending on the Relationship code submitted. **Required if injured party is deceased and claimant is not the injured party and Claimant 1 Relationship is 'X', 'Y' or 'Z'. If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.**
110	Claimant 1 Mailing Address Line 1	50	1718	1767	Alpha-numeric	First line of the mailing address for the claimant named above. Street number and street 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**
						should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if injured party is deceased and claimant is not the injured party (Claimant 1 Relationship is not blank). If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.**
111	Claimant 1 Mailing Address Line 2	50	1768	1817	Alpha-numeric	Second line of the mailing address of the claimant named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.**
112	Claimant 1 City	30	1818	1847	Alpha-numeric	Mailing address city for the claimant named above. Field may contain only alphabetic, Space, Comma, & - ' . @ # / ; : characters. No numeric characters allowed. If no US address is available, fill

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**
						with spaces and supply 'FC' in the corresponding State Code. **Required if injured party is deceased and claimant is not the injured party (Claimant 1 Relationship is not blank). If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.**
113	Claimant 1 State	2	1848	1849	Alpha-betic	US Postal abbreviation State Code for the claimant named above. See http://www.usps.com If no US address is available, supply 'FC'. Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses. **Required if injured party is deceased and claimant is not the injured party (Claimant 1 Relationship is not blank). If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.**
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 if injured party is deceased claimant is not the injured party (Claimant 1 Relationship is not blank). If Claimant 1 Relationship (Field**

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**
						104) is equal to a space, must contain all spaces or all zeroes.
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). **If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces or all zeroes.**
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 if injured party is deceased and claimant is not the injured party (Claimant 1 Relationship is not blank). If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces or all zeroes.**
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. **If Claimant 1 Relationship (Field 104) is equal to a space, must contain all spaces.**
118	Reserved for	20	1874	1893	Alpha-	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**
	Future Use				numeric	
Claimant 1 Attorney/Other Representative Information						
This section is only required if Claimant 1 has a representative. ***If not supplying Claimant 1 Representative information (C1 Representative Indicator is a space), default each field in this section* (Fields 119-131) *to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 119-131) with 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 (Fields 119 – 131 must contain default values according to Data Type, or all spaces) If Claimant 1 has more than one representative, provide information for his/her attorney if available. **Required if Claimant 1 has a representative.**
120	C1 Representative Last Name	40	1895	1934	Alpha-betic	Surname of C1 representative. Embedded hyphens (dashes), apostrophes and spaces accepted. **Either C1 Representative Last Name *and* First Name – or – C1 Representative Firm Name is required if Claimant 1 has a representative. . If C1 Representative Indicator**

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**
						(Field 119) is equal to a space, must contain all spaces.
121	C1 Representative First Name	30	1935	1964	Alpha-betic	Given or first name of C1 representative. May only contain letters and spaces. **Either C1 Representative Last Name *and* First Name – or – C1 Representative Firm Name is required if Claimant 1 has a representative. If supplied, must contain at least 2 characters. If C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces.**
122	C1 Representative Firm Name	70	1965	2034	Alpha-numeric	C1 Representative's firm name. **Either C1 Representative Last Name *and* First Name – or – C1 Representative Firm Name is required if Claimant 1 has a representative. If C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces.**
123	C1 Representative TIN	9	2035	2043	Alpha-numeric	C1 Representative's Federal Tax Identification Number (TIN). If C1 representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the C1 representative's Social Security Number (SSN). May contain only spaces or numbers. If no C1 Representative TIN is available, fill with spaces or all zeroes. **If**

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**
						C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces or all zeroes. **Optional.**
124	C1 Representative Mailing Address 1	50	2044	2093	Alpha-numeric	First line of the mailing address for the C1 representative named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 1 has a representative. If C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces.**
125	C1 Representative Mailing Address 2	50	2094	2143	Alpha-numeric	Second line of the mailing address of the C1 representative named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **If C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces.**
126	C1 Representative	30	2144	2173	Alpha-numeric	Mailing address city for the C1 representative named above.

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**
	Mailing City					Field may contain only alphabetic, Space, Comma, & - ' . @ # / ; : characters. No numeric characters allowed. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 1 has a representative. If C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces.**
127	C1 Representative State	2	2174	2175	Alpha-betic	US Postal abbreviation State Code for the C1 representative named above. See http://www.usps.com If no US address is available, supply 'FC'. Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses. **Required if Claimant 1 has a representative. If C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces.**
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. If C1**

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**
						Representative Indicator (Field 119) is equal to a space, must contain all spaces or all zeroes.
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). **If C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces or all zeroes.**
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. If C1 Representative Indicator (Field 119) is equal to a space, must contain all spaces or all zeroes.**
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. **If C1 Representative Indicator (Field 119) is equal to a space, must contain all 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**
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. Additional Claimants are only reported if the injured party/Medicare beneficiary is deceased. 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	Alpha-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 (Claimant 2 Relationship is a space), default each field in this section* (Fields 7 - 21) *to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 7-21) with 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 (Fields 7 – 21 must contain default values according to Data Type, or all spaces) **Required if injured party is deceased and 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	Alpha-numeric	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 2. May contain only spaces or numbers. Must not match other claimant(s) listed on the Detail or Auxiliary Record. **Required if Claimant 2 Relationship (Field 7) is not equal to a space. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all zeroes or all spaces.**
9	Claimant 2 Last Name	40	121	160	Alpha-betic	Surname of Claimant 2. Embedded hyphens (dashes), apostrophes and spaces accepted. **Required if Claimant 2 Relationship is 'E', 'F' or 'O'. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**
10	Claimant 2 First Name	30	161	190	Alpha-betic	Given/First name of Claimant 2. May only contain letters and spaces. **Required if Claimant 2 Relationship is 'E', 'F' or 'O'. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**
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'. **If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**

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**
12	Claimant 2 Entity/Organization Name	71	121	191	Alpha-numeric	Name of Claimant 2 Entity/Organization. Redefines Fields 9-11 (is made up of the same bytes, is in the same location as Fields 9-11). Use either Field 12 or Fields 9-11 depending on the Relationship code submitted. **Required if Claimant 2 Relationship is 'X', 'Y' or 'Z'. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**
13	Claimant 2 Mailing Address Line 1	50	192	241	Alpha-numeric	First line of the mailing address for Claimant 2 named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. 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. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes						
Field No.						
14	Claimant 2 Mailing Address Line 2	50	242	291	Alpha-numeric	Second line of the mailing address for Claimant 2 named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**
15	Claimant 2 City	30	292	321	Alpha-numeric	Mailing address city for Claimant 2 named above. Field may contain only alphabetic, Space, Comma, & - ' . @ # / ; : characters. No numeric characters allowed. 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. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**

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**
16	Claimant 2 State	2	322	323	Alpha-betic	US Postal abbreviation State Code for Claimant 2 named above. See http://www.usps.com If no US address is available, supply 'FC'. Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses. **Required if Claimant 2 Relationship is not blank. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**
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. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces or all zeroes.**
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). **If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces or all zeroes.**

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. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces or all zeroes.**
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. **If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.**
21	Reserved for Future Use	20	348	367	Alpha-numeric	Fill with spaces.

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 Attorney/Other Representative Information						
This section is only required if Claimant 2 has a representative. ***If not supplying Claimant 2 Representative information (C2 Representative Indicator is a space), default each field in this section* (Fields 22-35) *to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 22-35) with 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 (Fields 22 - 35 must contain default values according to Data Type, or all spaces) If Claimant 2 has more than one representative, provide information for his/her attorney if available. **Required if Claimant 2 has a representative.**
23	C2 Representative Last Name	40	369	408	Alpha-betic	Surname of C2 representative. Embedded hyphens (dashes), apostrophes and spaces accepted. **Either C2 Representative Last Name *and* First Name – or – C2 Representative Firm Name is required if Claimant 2 has a representative. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.**

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**
24	C2 Representative First Name	30	409	438	Alpha-betic	Given or first name of C2 representative. May only contain letters and spaces. **Either C2 Representative Last Name *and* First Name – or – C2 Representative Firm Name is required if Claimant 2 has a representative. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.**
25	C2 Representative Firm Name	70	439	508	Alpha-numeric	Representative's firm name. **Either C2 Representative Last Name *and* First Name – or – C2 Representative Firm Name is required if Claimant 2 has a representative. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.**
26	C2 Representative TIN	9	509	517	Alpha-numeric	C2 Representative's Federal Tax Identification Number (TIN). If C2 representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the C2 representative's Social Security Number (SSN). May contain only spaces and numbers. If no C2 Representative TIN is available, fill with spaces or all zeroes. **If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces or all zeroes.** **Optional.**

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**
27	C2 Representative Mailing Address Line 1	50	518	567	Alpha-numeric	First line of the mailing address for the C2 representative named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 2 has a representative. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.**
28	C2 Representative Mailing Address Line 2	50	568	617	Alpha-numeric	Second line of the mailing address of the C2 representative named above. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.**

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**
29	C2 Representative City	30	618	647	Alpha-numeric	Mailing address city for the C2 representative named above. Field may contain only alphabetic, Space, Comma, & - ' . @ # / ; : characters. No numeric characters allowed. If no US address is available, fill with spaces and supply 'FC' in the corresponding State Code. **Required if Claimant 2 has a representative. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.**
30	C2 Representative State	2	648	649	Alpha-betic	US Postal abbreviation State Code for the C2 representative named above. See http://www.usps.com If no US address is available supply 'FC'. Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses. **Required if Claimant 2 has a representative. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.**

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**
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. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces or all zeroes.**
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). **If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces or all zeroes.**
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. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces or all zeroes.**

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**
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. **If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.**
35	Reserved for Future Use	20	674	693	Alpha-numeric	Fill with spaces.
Claimant 3 Information						
If not supplying Claimant 3 information (Claimant 3 Relationship is a space), default each field in this section (Fields 36-50) *to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 36-50) with 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	Alpha-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	
43	Claimant 3 Mailing Address Line 2	50	825	874	Alpha-numeric	
44	Claimant 3 City	30	875	904	Alpha-numeric	
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	

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**
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 (C3 Representative Indicator is a space), default each field in this section* (Fields 51-64) *to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 51-64) with 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	Alpha-numeric	
56	C3 Representative Mailing Address Line 1	50	1101	1150	Alpha-numeric	
57	C3 Representative Mailing Address Line 2	50	1151	1200	Alpha-numeric	
58	C3 Representative City	30	1201	1230	Alpha-numeric	
59	C3 Representative State	2	1231	1232	Alpha-betic	

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**
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 (Claimant 4 Relationship is a space), default each field in this section (Fields 65-79) *to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 65-79) with 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	Alpha-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	
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-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**
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 (C4 Representative Indicator is a space), default each field in this section* (Fields 80-92) *to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 80-92) with 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	Alpha-numeric	
85	C4 Representative Mailing Address Line 1	50	1684	1733	Alpha-numeric	
86	C4 Representative Mailing Address Line 2	50	1734	1783	Alpha-numeric	
87	C4 Representative City	30	1784	1813	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**
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. Must be non-zero if a non-zero value is submitted in TPOC Amount 2. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 2 is all zeroes.

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. ***Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as "00001000000".*** Must be non-zero if a non-zero value is submitted in TPOC Date 2. Must be all zeroes if TPOC Date 2 is all zeroes.
95	Funding Delayed Beyond TPOC Start Date 2	8	1859	1866	Numeric Date	If funding for the TPOC Amount 2 is delayed, provide actual or estimated date of funding. Also see "Timeliness" of reporting in Section 11.10.2. Format: CCYYMMDD Fill with all zeroes if not applicable.

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**
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. Must be non-zero if a non-zero value is submitted in TPOC Amount 3. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 3 is all zeroes.
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. ***Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as "00001000000".*** Must be non-zero if a non-zero value is submitted in TPOC Date 3. Must be all zeroes if TPOC Date 3 is all zeroes.

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**
98	Funding Delayed Beyond TPOC Start Date 3	8	1886	1893	Numeric Date	If funding for the TPOC Amount 3 is delayed, provide actual or estimated date of funding. Also see "Timeliness" of reporting in Section 11.10.2. Format: CCYYMMDD Fill with all 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. Must be non-zero if a non-zero value is submitted in TPOC Amount 4. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 4 is all zeroes.

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**
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. ***Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as "00001000000".*** Must be non-zero if a non-zero value is submitted in TPOC Date 4. Must be all zeroes if TPOC Date 4 is all zeroes.
101	Funding Delayed Beyond TPOC Start Date 4	8	1913	1920	Numeric Date	If funding for the TPOC Amount 4 is delayed, provide actual or estimated date of funding. Also see "Timeliness" of reporting in Section 11.10.2. Format: CCYYMMDD Fill with all zeroes if not applicable.

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**
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. Must be non-zero if a non-zero value is submitted in TPOC Amount 5. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 5 is all zeroes. NOTE: If more than five TPOCs need to be reported for a single claim, then put the most recent TPOC Date in TPOC Date 5.

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**
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. Must be non-zero if a non-zero value is submitted in TPOC Date 5. Must be all zeroes if TPOC Date 5 is all zeroes. ***Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as "00001000000".*** NOTE: If more than five TPOCs need to be reported for a single claim, add the sixth and subsequent TPOC Amounts to the amount reported in TPOC Amount 5.
104	Funding Delayed Beyond TPOC Start Date 5	8	1940	1947	Numeric Date	If funding for the TPOC Amount 5 is delayed, provide actual or estimated date of funding. Also see "Timeliness" of reporting in Section 11.10.2. Format: CCYYMMDD Fill with all 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. Must match the date on the corresponding header record. 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.) Right justify and pad with leading zeroes. A record count of 215 should be submitted as '0000215'. **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. Must match the date on the corresponding trailer record. 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.**

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**
3	TIN	9	14	22	Numeric	RRE's TIN. 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. If RRE ID is associated with a foreign entity with no TIN, fill with a pseudo-TIN formatted as 9999xxxxx where 'xxxxx' is an RRE-assigned number. **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 9-digit number 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. If not used, must be spaces. If used, must be a non-zero 9-digit number, right justified and padded on the left with zeroes. No letters or special characters are accepted.*** 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 if Office Code/Site ID is supplied in Field 73 of the Claim Input File 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**
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. This is the name used for recovery demand notifications, if applicable. The first two characters of this field must be non-blank (filled with characters other than spaces). Limit field to no more than eight separate words in the first 40 characters for best results. **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. Limit field to no more than eight separate words in the first 40 characters for best results. This address line should be used for the primary street address information including suite and/or apartment number if possible. If the RRE has registered as a foreign entity and no US address is available, fill with spaces and supply 'FC' in the TIN/Office Code State (Field 9). **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**
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. Limit field to no more than eight separate words in the first 40 characters for best results. This address line should be used for the secondary street address information such as "ATTN TO", internal mailstops, department name, etc. If the RRE has registered as a foreign entity and no US address is available, fill with spaces and supply 'FC' in the TIN/Office Code State (Field 9).

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. Field may contain only alphabetic, Space, Comma, & - ' . @ # / ; : characters. No numeric characters allowed. If the RRE has registered as a foreign entity and no US address is available, fill with spaces and supply 'FC' in the TIN/Office Code State (Field 9). **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**
9	TIN/Office Code State	2	232	233	Alpha-betic	US Postal state abbreviation of the address associated with the unique TIN/Office Code combination reflected on this record. See http://www.usps.com Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses. This mailing address should reflect where the RRE wishes to have the recoveries and other associated correspondence directed for the TIN/Office Code combination. If the RRE has registered as a foreign entity and no US address is available, supply 'FC' and place the correct international mailing address in Fields 12-15. **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. If the RRE has registered as a foreign entity and no US address is available, fill with zeroes (or all spaces) and supply 'FC' in the TIN/Office Code State (Field 9). **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). If the RRE has registered as a foreign entity and no US address is available, fill with zeroes and supply 'FC' in the TIN/Office Code State (Field 9).
12	Foreign RRE Address Line 1	32	243	274	Alpha-numeric	First line of mailing address of a foreign RRE. Use ***only if*** RRE has no US address. **Required if TIN/Office Code State (Field 9) = 'FC'.**

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**
13	Foreign RRE Address Line 2	32	275	306	Alpha-numeric	Second line of mailing address of a foreign RRE. Use ***only if*** RRE has no US address. **Optional.**
14	Foreign RRE Address Line 3	32	307	338	Alpha-numeric	Third line of mailing address of a foreign RRE. Use ***only if*** RRE has no US address. **Optional.**
15	Foreign RRE Address Line 4	32	339	370	Alpha-numeric	Fourth line of mailing address of a foreign RRE. Use ***only if*** RRE has no US address. **Optional.**
16	Reserved for Future Use	1850	371	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. Must match the date on the corresponding header record. 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.) Right justify and pad with leading zeroes. A record count of 5 should be submitted as '0000005'. **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	Alpha-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. If a value of '0' was submitted, the COBC will change this to a value of '1' for matching purposes.
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.

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**
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.
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

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**
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.
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 – TIN Reference Response File Layout

Effective October 1, 2011

TIN Reference Response File Header Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Header Record – 1000 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value 'NTRH' COBC supplied.
2	Section 111 RRE ID	9	5	13	Numeric	COBC assigned Section 111 RRE ID. As supplied by RRE input record.
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Contains value 'NGHTNRP' COBC supplied.
4	File Date	8	21	28	Numeric Date	Date TIN Reference Response File was transmitted to the RRE. Format: CCYYMMDD COBC supplied.
5	Reserved for Future Use	972	29	1000	Alpha-numeric	Contains all spaces.

TIN Reference Response File Detail Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Detail Record – 1000 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value 'NTRD'
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	Submitted TIN	9	14	22	Numeric	Tax identification number of the entity as provided on the input record.
4	Submitted Office Code/Site ID	9	23	31	Numeric	Office Code/Site ID as provided on the input record.
5	Submitted TIN/Office Code Mailing Name	70	32	101	Alpha-numeric	TIN/Office Code Mailing Name as provided on input record.
6	Submitted TIN/Office Code Mailing Address Line 1	50	102	151	Alpha-numeric	TIN/Office Code Mailing Address Line 1 as provided on input record.
7	Submitted TIN/Office Code Mailing Address Line 2	50	152	201	Alpha-numeric	TIN/Office Code Mailing Address Line 2 as provided on input record.
8	Submitted TIN/Office	30	202	231	Alpha-numeric	TIN/Office Code City as provided on input record.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Detail Record – 1000 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
	code City					
9	Submitted TIN/Office Code State	2	232	233	Alphabetic	TIN/Office Code State as provided on input record.
10	Submitted TIN/Office Code Zip	5	234	238	Alpha-numeric	TIN/Office Code Zip code as provided on input record.
11	Submitted TIN/Office Code Zip+4	4	239	242	Alpha-numeric	TIN/Office Code Zip+4 as provided on input record.
12	Applied TIN/Office Code Mailing Address Line 1	50	243	292	Alpha-numeric	TIN/Office Code Address line 1, after address validation completed, which will be used by Medicare for subsequent processing. TIN/Office Code Address Change Flag (Field 33) will equal Y if the applied address in Fields 12 - 17 is different from the submitted address (Fields 6 - 11) and N if it is the same as the submitted address. Will contain spaces if the TIN record was rejected. The field will also contain spaces if the submitted TIN/Office State code contained 'FC' indicating a foreign RRE address was submitted.
13	Applied TIN/Office Code Mailing Address Line 2	50	293	342	Alpha-numeric	TIN/Office Code Mailing Address Line 2 after address validation completed. See description for Field 12.
14	Applied TIN/Office Code City	30	343	372	Alpha-numeric	TIN/Office Code City after address validation completed. See description for Field 12.
15	Applied TIN/Office Code State	2	373	374	Alphabetic	TIN/Office Code State after address validation completed. See description for Field 12.
16	Applied	5	375	379	Alpha-	TIN/Office Code Zip after

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Detail Record – 1000 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
	TIN/Office Code Zip				numeric	address validation completed. See description for Field 12.
17	Applied TIN/Office Code Zip+4	4	380	383	Alpha-numeric	TIN/Office Code Zip+4 after address validation completed. See description for Field 12.
18	Submitted Foreign RRE Address Line 1	32	384	415	Alpha-numeric	Foreign RRE Address Line 1 as provided on input record.
19	Submitted Foreign RRE Address Line 2	32	416	447	Alpha-numeric	Foreign RRE Address Line 2 as provided on input record.
20	Submitted Foreign RRE Address Line 3	32	448	479	Alpha-numeric	Foreign RRE Address Line 3 as provided on input record.
21	Submitted Foreign RRE Address Line 4	32	480	511	Alpha-numeric	Foreign RRE Address Line 4 as provided on input record.
22	TIN Disp Code	2	512	513	Alpha-numeric	Code to indicate validation processing results of the submitted TIN Reference File Detail Record: '01' – TIN Record accepted 'TN' – TIN Record rejected
23	TIN Error Code 1	4	514	517	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Detail Record – 1000 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
24	TIN Error Code 2	4	518	521	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.
25	TIN Error Code 3	4	522	525	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.
26	TIN Error Code 4	4	526	529	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.
27	TIN Error Code 5	4	530	533	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.
28	TIN Error Code 6	4	534	537	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.
29	TIN Error Code 7	4	538	541	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Detail Record – 1000 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
30	TIN Error Code 8	4	542	545	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.
31	TIN Error Code 9	4	546	549	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.
32	TIN Error Code 10	4	550	553	Alpha-numeric	Code associated with an error found by the COBC in the submitted TIN Reference record. Provided only if disposition code denotes error. See TIN Error Code Table for values.
33	TIN/Office Code Address Change Flag	1	554	554	Alpha-numeric	Code indicating whether Submitted Address (Fields 6 - 11) differs from the Applied Address (Fields 12 - 17). Values: Y – address changed N – address did not change Space – record could not be validated
34	Reserved for Future Use	446	555	1000	Alpha-numeric	Filled with spaces.

TIN Reference Response File Trailer Record

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Trailer Record – 1000 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value 'NTRT' COBC supplied.
2	Section 111 RRE ID	9	5	13	Numeric	COBC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). As supplied by RRE input record.
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Contains value 'NGHTNRP' COBC supplied.
4	File 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 TIN Reference Response File Detail Records contained within file (does not include header or trailer records). COBC supplied.
6	Reserved for Future Use	965	36	1000	Alpha-numeric	Filled with spaces.

Appendix E – HEW 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 ASC X12 270/271. They reflect the flat file input and output for the HEW software. The layouts for Version 2.0.0 (Effective January 1, 2010 – December 31, 2011) and Version 3.0.0 (Effective October 1, 2011) are the same. RREs must implement Version 3.0.0 of the HEW software by January 1, 2012.

Mainframe and Windows PC/Server-based versions of the HEW software are available. You may download the Windows version of the HEW software after logging on to the Section 111 COBSW at www.section111.cms.hhs.gov. You may request a copy of both the mainframe and Windows versions from your EDI Representative or by contacting the COBC EDI Department at 646-458-6740.

If you choose to use your own ANSI X12 translator to create the ANSI X12 270 files for the Section 111 Query Input File and process the X12 271 response, please refer to the NGHP page of www.cms.gov/MandatoryInsRep. Download the companion document for the X12 270/271 mapping required for Section 111 ("270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide for NGHP Entities") or contact your EDI Representative for a copy.

HEW Query Input File Header Record – Versions 2.0.0 and 3.0.0

Section 111 HEW Versions 2.0.0 and 3.0.0 Query Input File Header Record – 200 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	177	24-200	Unused Field. Fill with spaces.

HEW Query Input File Detail Record – Versions 2.0.0 and 3.0.0

Section 111 HEW Versions 2.0.0 and 3.0.0 Query Input File Detail Record – 200 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. Embedded hyphens (dashes), apostrophes and spaces accepted. **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.** *****If a value of '0' is submitted, the

Section 111 HEW Versions 2.0.0 and 3.0.0 Query Input File Detail Record – 200 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
				COBC will change it to ‘1’ for matching purposes.
6	SSN	9	29-37	Social Security Number of the Individual/Injured Party. Alphanumeric. May contain only spaces or numbers. **Required if HICN not provided.**
7	RRE DCN 1	30	38-67	Primary identifier assigned to record by RRE for tracking. Will be returned on the corresponding response record. Optional.
8	RRE DCN 2	30	68-97	Secondary identifier assigned to record by RRE for tracking. Will be returned on the corresponding response record. Optional.
9	Filler	103	98-200	Unused. Fill with spaces.

HEW Query Input File Trailer Record – Versions 2.0.0 and 3.0.0

Section 111 HEW Versions 2.0.0 and 3.0.0 Query Input File Trailer Record – 200 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. Right justify and pad with leading zeroes. A record count of 215 should be formatted as '000000215'. **Required.**
6	Filler	168	33-200	Unused Field. Fill with spaces.

HEW Query Response File Record – Versions 2.0.0 and 3.0.0

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

Section 111 HEW Versions 2.0.0 and 3.0.0 Query Response File Record – 300 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.

Section 111 HEW Versions 2.0.0 and 3.0.0 Query Response File Record – 300 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
5	Sex Code	1	28-28	Covered Individual's Gender: 1 = Male* 2 = Female **Updated with Medicare information** if the individual is identified as a Medicare beneficiary based upon the information submitted. *If '0' was submitted on the input record then the COBC will change this value to '1' prior to matching.
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 CMS matches on the HICN, and takes no action to validate or match on 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.
10	RRE DCN 1	30	117-146	Primary identifier assigned to record by RRE for tracking as submitted on the input record.

Section 111 HEW Versions 2.0.0 and 3.0.0 Query Response File Record – 300 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
11	RRE DCN 2	30	147-176	Secondary identifier assigned to record by RRE for tracking as submitted on the input record.
12	Filler	124	177-300	Future Use

Appendix F – Disposition, Error and Compliance Flag Codes

Response File Disposition Codes

Disposition Codes	Description
01	Claim Response File: Record accepted by the COBC as an “Add”, “Delete” or “Update” record. RRE has indicated ongoing responsibility for medicals. TIN Reference Response File: TIN Record accepted. HEW Query Response File: For queries, the individual was identified as a Medicare beneficiary based upon the information submitted.
02	Claim Response File: Record accepted by the COBC as an “Add”, “Delete” or “Update” record. RRE has indicated **no** ongoing responsibility for medicals.

Disposition Codes	Description
03	Claim Response File: Record was found to be error-free and the injured party was matched to a Medicare beneficiary, but the period of time reflected on the claim report did not overlap the beneficiary's Medicare coverage dates. 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 Amounts 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.
SP	Claim Response File: 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, unless otherwise specified in the error description, or as instructed by your EDI Representative.***
50	Claim Response File: 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.

Disposition Codes	Description
51	Individual was not identified as a Medicare Beneficiary. Claim Response File: 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. HEW Query Response File: For queries, the individual was **not** identified as a Medicare beneficiary based upon the information submitted. 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.
TN	TIN Reference File: Detail Record rejected due to errors. Only returned on TIN Reference Response File (effective 10/1/2011). TIN Record returned with at least one TN edit (specific TIN Reference Response File error codes are described below). Record must be corrected and resubmitted on the next file submission or as directed by your EDI Representative.

Claim Response File Compliance Flag Codes

Note: Codes 02 and 04 – 09 in the following table will only be used through September 30, 2011. As of October 1, 2011, changes will be implemented to return a TIN Reference Response File with error codes associated to specific TIN errors.

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.
04	Invalid TIN/Office Code Mailing Address Line 1 on the associated TIN Reference File Detail Record and TIN/Office Code State is not equal to 'FC'. TIN/Office Code Mailing Address Line 1 field is missing or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.
05	Invalid TIN/Office Code Mailing Address Line 2 on the associated TIN Reference File Detail Record and TIN/Office Code State is not equal to 'FC'. If supplied, TIN/Office Code Mailing Address Line 2 must not contain any characters other than alpha, numeric and special characters, A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.
06	Invalid TIN/Office Code City on the associated TIN Reference File Detail Record and TIN/Office Code State is not equal to 'FC'. TIN/Office Code City is missing or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.

07	Invalid TIN/Office Code State on the associated TIN Reference File Detail Record. TIN/Office Code State is missing or contained a value other than a valid US postal state code or ‘FC’.
08	Invalid TIN/Office Code Zip on the associated TIN Reference File Detail Record and TIN/Office Code State is not equal to ‘FC’. TIN/Office Code Zip must contain 5 numeric digits. If State is equal to ‘FC’, must contain all zeroes or all spaces.
09	Invalid Foreign RRE Address Line 1-4 on the associated TIN Reference File Detail Record. The TIN/Office Code State supplied was ‘FC’ but the Foreign RRE Address Line 1-4 fields contained all spaces or non-alphanumeric characters; or the TIN/Office Code State supplied was not ‘FC’ and the Foreign RRE Address Line 1-4 fields were not equal to all spaces.

Claim Response File Error Codes

Excel and text files containing the error codes, fields and corresponding descriptions are available at www.section111.cms.hhs.gov. After accepting the Login Warning, the Section 111 COBSW Login page will display. Click on the Reference Materials menu option to view the reference files available for download including the error table below.

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 may only contain spaces, valid numeric and alphabetic characters. No dashes, hyphens or other special characters allowed.
CB05	Injured Party SSN	Field must contain all spaces or a numeric value. No dashes, hyphens or special characters 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

Error Code	Field	Description
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.
CI02	Industry Date of Incident	Optional. 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). First position must be 'E'. Field must contain a valid ICD-9-CM 'E' Code. Must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not include decimal point. See Section 11.2.5.
CI04	State of Venue	Required. Must be a valid US Postal state abbreviation, 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). Must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI06	ICD-9 Diagnosis Code 2	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI07	ICD-9 Diagnosis Code 3	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI08	ICD-9 Diagnosis Code 4	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.

Error Code	Field	Description
CI09	ICD-9 Diagnosis Code 5	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI10	ICD-9 Diagnosis Code 6	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI11	ICD-9 Diagnosis Code 7	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI12	ICD-9 Diagnosis Code 8	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI13	ICD-9 Diagnosis Code 9	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI14	ICD-9 Diagnosis Code 10	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI15	ICD-9 Diagnosis Code 11	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI16	ICD-9 Diagnosis Code 12	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.

Error Code	Field	Description
CI17	ICD-9 Diagnosis Code 13	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI18	ICD-9 Diagnosis Code 14	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI19	ICD-9 Diagnosis Code 15	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI20	ICD-9 Diagnosis Code 16	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI21	ICD-9 Diagnosis Code 17	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI22	ICD-9 Diagnosis Code 18	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI23	ICD-9 Diagnosis Code 19	Optional. Must contain spaces or must exactly match a value in the first 5 bytes of a record on the list under Reference Materials at www.section111.cms.hhs.gov. Must **not** be on the list of "Excluded Codes" in Appendix I. Must not begin with 'E'. Must not begin with 'V'. Must not include decimal point. See Section 11.2.5.
CI25	ICD-9 Diagnosis and Alleged Cause of Injury	Both a valid ICD-9 Diagnosis Code 1 and a valid Alleged Cause of Injury must be provided. This error will also be returned if the NOINJ default code is not used properly (See Section 11.2.5.1).

Error Code	Field	Description
CI26	Product Liability Indicator	Not used.
CI27	Product Generic Name	Not used.
CI28	Product Brand Name	Not used.
CI29	Product Manufacturer	Not used.
CI30	Product Alleged Harm	Not used.
CS01	Self Insured Indicator	Required if Plan Insurance Type equal to 'E' or 'L' and must be equal to 'Y' or 'N'. If Plan Insurance Type equals 'D' must equal space or 'N'.
CS02	Self Insured Type	Required. If Self Insured Indicator equals 'Y' Self Insured Type must equal to 'I' or 'O'. If Self Insured Indicator not equal 'Y' Self Insured Type 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	DBA Name 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.
CS06	Legal Name	Legal Name 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 or foreign RRE pseudo-TIN. Must be numeric. Include leading zeroes. Do not include hyphens.

Error Code	Field	Description
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. Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided.
CP11	No-Fault Insurance Limit	Must contain a numeric value or all zeroes. Required for Plan Insurance Type ‘D’ (No-Fault). If Plan Insurance Type is equal to ‘D’ and there is no No-Fault Insurance Limit, fill with all zeroes or all 9’s. If Plan Insurance Type is ‘E’ or ‘L’, must be filled with all zeroes.
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.
CP13	TIN/Office Code Mailing Name	Required. Field must contain at least 2 alphanumeric characters. The first 2 characters of this field may not be blank, they must be filled. 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	N/A	Not Used.
CP15	N/A	Not Used.
CP16	N/A	Not Used.

Error Code	Field	Description
CP17	N/A	Not Used.
CP18	N/A	Not Used.
CP19	N/A	Not Used.
CP20	N/A	Not Used.
CP21	N/A	Not Used.
CP22	N/A	Not Used.
CP23	N/A	Not Used.
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. If greater than spaces, 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. If greater than spaces, 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, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR05	Representative TIN	If Representative Indicator equal to space, field must be equal to all spaces or all zeroes. May contain a 9-digit number, all zeroes or all spaces.
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 space, field must be equal to spaces. If Representative State = 'FC', field must be equal to all spaces.

Error Code	Field	Description
CR07	Representative 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, & - ' . @ # / : ; . If Representative Indicator is equal to space, field must be equal to spaces. If Representative State = 'FC', field must be equal to all spaces.
CR08	Representative City	Required if Representative Indicator is not equal to space. If required, cannot be equal to all spaces. Field may contain only alphabetic, Space, Comma, & - ' . @ # / ; : characters. No numeric characters allowed. If Representative Indicator is equal to space, 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 space, 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 space, field must be equal to zeroes or all spaces. If Representative State = 'FC', field must be equal to all zeroes or all spaces.
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 space, field must be equal to zeroes or all spaces. 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 space, field must be equal to zeroes or all spaces. If Representative State = 'FC', field must be equal to all zeroes.
CR13	Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Representative Indicator equal to space, field must be equal to spaces.
CR14	Representative Name/Firm Name	Either Representative Last Name *and* Representative First Name – or – Representative Firm Name is required, if Representative Indicator is not equal to space.
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). Required if a non-zero TPOC Amount 1 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 1 is all zeroes.
CJ04	TPOC Amount 1	Must contain a numeric value or all zeroes. Required if a non-zero TPOC Date 1 is supplied. Must be all zeroes if TPOC Date 1 is zero.
CJ05	Funding Delayed Beyond TPOC Start Date 1	Must contain a valid date or all zeroes.
CJ06	DOI/ORM Termination Date	ORM Termination Date cannot be more than 6 months greater than the file submission date.
CJ07	TPOC Threshold	Total of TPOC Amounts reported on Add record (Action Type = 0) with ORM Indicator = 'N' does not exceed interim reporting threshold. See Section 11.4. Information is to be reported ***when*** the RRE assumes ORM or ***when*** there is a TPOC settlement, judgment, award or other payment. Records submitted with neither ORM nor TPOC information will be rejected with this error.
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 space, field must contain a non-zero 9-digit numeric value. Must not match other Claimant TINs. If Claimant 1 Relationship is equal to a space, field must contain all zeroes or all spaces.
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.

Error Code	Field	Description
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. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 1 Relationship is equal to space, field must be equal to spaces. If Claimant 1 State = 'FC', field must be equal to all spaces.
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 only alphabetic, space, comma, & - ' . @ # / ; : characters. No numeric characters allowed. If Claimant 1 Relationship is equal to space, 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 space, 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 space, field must contain a valid 5-digit numeric US Zip Code. If Claimant 1 Relationship equal to space, field must be equal to zeroes or all spaces. 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 space, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 1 Relationship equal to space, field must be equal to zeroes or all spaces. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC12	Claimant 1 Phone	If Claimant 1 Relationship is not equal to space, field must contain a non-zero 10-digit numeric value. If Claimant 1 Relationship equal to space, field must be equal to zeroes. If Claimant 1 State = 'FC', field must be equal to all zeroes.
CC13	Claimant 1 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 1 Relationship equal to space, field must be equal to spaces.

Error Code	Field	Description
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 space, field must contain a non-zero 9-digit numeric value. Must not match other Claimant SSNs. If Claimant 2 Relationship is equal to a space, field must contain all zeroes or all spaces.
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 space, 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. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 2 Relationship is equal to space, field must be equal to spaces. If Claimant 2 State = 'FC', field must be equal to all spaces.

Error Code	Field	Description
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 only alphabetic, space, comma, & - ' . @ # / ; : characters. No numeric characters allowed. If Claimant 2 Relationship is equal to space, 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 space, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 2 Relationship equal to space, field must be equal to spaces.
CC30	Claimant 2 Zip	If Claimant 2 Relationship is not equal to space, field must contain a valid 5-digit numeric US Zip Code. If Claimant 2 Relationship equal to space, field must be equal to zeroes or all spaces. 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 space, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 2 Relationship equal to space, field must be equal to zeroes or all spaces. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC32	Claimant 2 Phone	If Claimant 2 Relationship is not equal to space, field must contain a non-zero 10-digit numeric value. If Claimant 2 Relationship equal to space, field must be equal to zeroes or all spaces. If Claimant 2 State = 'FC', field must be equal to all zeroes.
CC33	Claimant 2 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 2 Relationship equal to space, 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.

Error Code	Field	Description
CC42	Claimant 3 TIN	If Claimant 3 Relationship is not equal to space, field must contain a non-zero 9-digit numeric value. Must not match other Claimant TINs. If Claimant 3 Relationship is equal to a space, field must contain all zeroes or all spaces.
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 space, 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. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 3 Relationship is equal to space, field must be equal to spaces. If Claimant 3 State = 'FC', field must be equal to all spaces.
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 only alphabetic, space, comma, & - ' . @ # / ; : characters. No numeric characters allowed. If Claimant 3 Relationship is equal to space, 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 space, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 3 Relationship equal to space, field must be equal to spaces.
CC50	Claimant 3 Zip	If Claimant 3 Relationship is not equal to space, field must contain a valid 5-digit numeric US Zip Code. If Claimant 3 Relationship equal to space, field must be equal to zeroes or all spaces. If Claimant 3 State = 'FC', field must be equal to all zeroes.

Error Code	Field	Description
CC51	Claimant 3 Zip+4	If Claimant 3 Relationship is not equal to space, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 3 Relationship equal to space, field must be equal to zeroes or all spaces. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC52	Claimant 3 Phone	If Claimant 3 Relationship is not equal to space, field must contain a non-zero 10-digit numeric value. If Claimant 3 Relationship equal to space, field must be equal to zeroes or all spaces. If Claimant 3 State = 'FC', field must be equal to all zeroes.
CC53	Claimant 3 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 3 Relationship equal to space, 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 space, field must contain a non-zero 9-digit numeric value. Must not match other Claimant TINs. If Claimant 4 Relationship is equal to a space, field must contain all zeroes or all spaces.
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.

Error Code	Field	Description
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 space, 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. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If Claimant 4 Relationship is equal to space, field must be equal to spaces. If Claimant 4 State = 'FC', field must be equal to all spaces.
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 only alphabetic, space, comma, & - ' . @ # / ; : characters. No numeric characters allowed. If Claimant 4 Relationship is equal to space, 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 space, field must contain US Postal Abbreviation Code or 'FC'. If Claimant 4 Relationship equal to space, field must be equal to spaces.
CC70	Claimant 4 Zip	If Claimant 4 Relationship is not equal to space, field must contain a valid 5-digit numeric US Zip Code. If Claimant 4 Relationship equal to space, field must be equal to zeroes or all spaces. 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 space, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes. If Claimant 4 Relationship equal to space, field must be equal to zeroes or all spaces. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC72	Claimant 4 Phone	If Claimant 4 Relationship is not equal to space, field must contain a non-zero 10-digit numeric value. If Claimant 4 Relationship equal to space, field must be equal to zeroes or all spaces. If Claimant 4 State = 'FC', field must be equal to all zeroes.
CC73	Claimant 4 Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If Claimant 4 Relationship equal to space, field must be equal to spaces.

Error Code	Field	Description
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. If greater than spaces, 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. If greater than spaces, 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, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR25	Claimant 1 Representative TIN	May contain a 9-digit number, all zeroes or all spaces. If C1 Representative Indicator equal to space, field must be equal to all zeroes or all spaces.
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 space, 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. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C1 Representative Indicator is equal to space, field must be equal to spaces. If C1 Representative State = 'FC', field must be equal to all spaces.

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 only alphabetic, space, comma, & - ' . @ # / ; : characters. No numeric characters allowed. If C1 Representative Indicator is equal to space, 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 space, field must contain US Postal Abbreviation Code or 'FC'. If C1 Representative Indicator equal to space, field must be equal to spaces.
CR30	Claimant 1 Representative Zip	If C1 Representative Indicator is not equal to space, field must contain a valid 5-digit numeric US Zip Code. If C1 Representative Indicator equal to space, field must be equal to zeroes or spaces. 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 space, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C1 Representative Indicator equal to space, field must be equal to zeroes or spaces. 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 space, field must contain a non-zero 10-digit numeric value. If C1 Representative Indicator equal to space, field must be equal to zeroes or spaces. If C1 Representative State = 'FC', field must be equal to all zeroes.
CR33	Claimant 1 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C1 Representative Indicator equal to space, field must be equal to spaces.
CR34	Claimant 1 Representative Name/Firm Name	Either C1 Representative Last Name *and* C1 Representative First Name – or – C1 Representative Firm Name is required if C1 Representative Indicator is not equal to space.
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.

Error Code	Field	Description
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.
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, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR45	Claimant 2 Representative TIN	May contain a 9-digit number, all zeroes or all spaces. If C2 Representative Indicator equal to space, field must be equal to all zeroes or all spaces.
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 space, 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. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C2 Representative Indicator is equal to space, field must be equal to spaces. If C2 Representative State = 'FC', field must be equal to all spaces.
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 only alphabetic, space, comma, & - ' . @ # / ; : characters. No numeric characters allowed. If C2 Representative Indicator is equal to space, 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 space, field must contain US Postal Abbreviation Code or 'FC'. If C2 Representative Indicator equal to space, field must be equal to spaces.
CR50	Claimant 2 Representative Zip	If C2 Representative Indicator is not equal to space, field must contain a valid 5-digit numeric US Zip Code. If C2 Representative Indicator equal to space, field must be equal to zeroes or all spaces. If C2 Representative State = 'FC', field must be equal to all zeroes.

Error Code	Field	Description
CR51	Claimant 2 Representative Zip+4	If C2 Representative Indicator is not equal to space, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C2 Representative Indicator equal to space, field must be equal to zeroes or all spaces. 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 space, field must contain a non-zero 10-digit numeric value. If C2 Representative Indicator equal to space, field must be equal to zeroes or all spaces. If C2 Representative State = 'FC', field must be equal to all zeroes.
CR53	Claimant 2 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C2 Representative Indicator equal to space, 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 space.
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. If greater than spaces, 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. If greater than spaces, 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, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR65	Claimant 3 Representative TIN	May contain a 9-digit number, all zeroes or all spaces. If C3 Representative Indicator equal to space, field must be equal to all zeroes or all spaces.
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 space, field must be equal to spaces. If C3 Representative State = 'FC', field must be equal to all spaces.

Error Code	Field	Description
CR67	Claimant 3 Representative 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, & - ' . @ # / : ; . If C3 Representative Indicator is equal to space, field must be equal to spaces. If C3 Representative State = 'FC', field must be equal to all spaces.
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 only alphabetic, space, comma, & - ' . @ # / ; : characters. No numeric characters allowed. If C3 Representative Indicator is equal to space, 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 space, field must contain US Postal Abbreviation Code or 'FC'. If C3 Representative Indicator equal to space, field must be equal to spaces.
CR70	Claimant 3 Representative Zip	If C3 Representative Indicator is not equal to space, field must contain a valid 5-digit numeric US Zip Code. If C3 Representative Indicator equal to space, field must be equal to zeroes or all spaces. 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 space, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C3 Representative Indicator equal to space, field must be equal to zeroes or all spaces. 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 space, field must contain a non-zero 10-digit numeric value. If C3 Representative Indicator equal to space, field must be equal to zeroes or all spaces. If C3 Representative State = 'FC', field must be equal to all zeroes.
CR73	Claimant 3 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C3 Representative Indicator equal to space, field must be equal to spaces.
CR74	Claimant 3 Representative Name/Firm Name	Either C3 Representative Last Name *and* C3 Representative First Name – or – C3 Representative Firm Name is required if C3 Representative Indicator is not equal to spaces.

Error Code	Field	Description
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. If greater than spaces, 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. If greater than spaces, first position must be an alphabetic character. Other positions must contain letters or spaces.
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, & - ' . @ # / : ; . If supplied, must contain at least 2 alphanumeric characters.
CR85	Claimant 4 Representative TIN	May contain a 9-digit number, all zeroes or all spaces. If C4 Representative Indicator equal to space, field must be equal to all zeroes or all spaces.
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 space, 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. Field may contain alpha and/or numeric characters plus the following special characters commas, & - ' . @ # / : ; . If C4 Representative Indicator is equal to space, field must be equal to spaces. If C4 Representative State = 'FC', field must be equal to all spaces.
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 only alphabetic, space, comma, & - ' . @ # / ; : characters. No numeric characters allowed. If C4 Representative Indicator is equal to space, 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 space, field must contain US Postal Abbreviation Code or 'FC'. If C4 Representative Indicator equal to space, field must be equal to spaces.

Error Code	Field	Description
CR90	Claimant 4 Representative Zip	If C4 Representative Indicator is not equal to space, field must contain a valid 5-digit numeric US Zip Code. If C4 Representative Indicator equal to space, field must be equal to zeroes or all spaces. 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 space, field must contain a valid 4-digit numeric US Zip+4 Code or all zeroes If C4 Representative Indicator equal to space, field must be equal to zeroes or all spaces. 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 space, field must contain a non-zero 10-digit numeric value. If C4 Representative Indicator equal to space, field must be equal to zeroes or all spaces. If C4 Representative State = 'FC', field must be equal to all zeroes.
CR93	Claimant 4 Representative Phone Extension	Phone extensions must be left-justified and unused bytes filled with spaces. Must contain all spaces if not provided. If C4 Representative Indicator equal to space, field must be equal to spaces.
CR94	Claimant 4 Representative Name/Firm Name	Either C4 Representative Last Name *and* C4 Representative First Name – or – C4 Representative Firm Name is required if C4 Representative Indicator is not 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). Required if a non-zero TPOC Amount 2 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 2 is all zeroes.
CT02	TPOC Amount 2	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 2 is supplied. Must be all zeroes if TPOC Date 2 is all zeroes.
CT03	Funding Delayed Beyond TPOC Start Date 2	Must contain a valid date or all 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). Required if a non-zero TPOC Amount 3 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 3 is all zeroes.
CT12	TPOC Amount 3	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 3 is supplied. Must be all zeroes if TPOC Date 3 is all zeroes.

Error Code	Field	Description
CT13	Funding Delayed Beyond TPOC Start Date 3	Must contain a valid date or all 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). Required if a non-zero TPOC Amount 4 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 4 is all zeroes.
CT22	TPOC Amount 4	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 4 is supplied. Must be all zeroes if TPOC Date 4 is all zeroes.
CT23	Funding Delayed Beyond TPOC Start Date 4	Must contain a valid date or all 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). Required if a non-zero TPOC Amount 5 is supplied. Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record). Must be all zeroes if TPOC Amount 5 is all zeroes.
CT32	TPOC Amount 5	Must contain a numeric value or zeroes. Required if a non-zero TPOC Date 5 is supplied. Must be all zeroes if TPOC Date 5 is all zeroes.
CT33	Funding Delayed Beyond TPOC Start Date 5	Must contain a valid date or all zeroes.
SP31	Action Type	Record submitted prior to effective date of Medicare entitlement. Injured Party matched to a Medicare beneficiary. No correction necessary by RRE. Resubmit record in next quarterly file submission.
SP47	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP48	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP49	Action Type	No previously accepted record can be matched to submitted delete. Delete failed.
SP50	Action Type	Transaction attempted to add/update/delete an ORM record locked by the COBC. No changes are accepted via Section 111 reporting. Do **NOT** attempt to resubmit this record. See Section 12.2.
TN99	TIN/Office Code	No matching, valid TIN Reference File Detail Record was found for the TIN/Office Code combination on the Claim Input File Detail Record. Refer to errors returned on the TIN Reference Response File. Resubmit corrected TIN Reference File record and/or Claim Input File record.

TIN Reference Response File Error Codes

(Effective October 1, 2011)

TIN Reference Response File Errors		
Error Code	**Field**	**Description**
TN01	TIN – Field 3	Invalid RRE TIN. TIN cannot be validated by the COBC. Must be a 9-digit numeric code. If RRE ID is associated with a foreign entity with no TIN, must be formatted as 9999xxxxx where 'xxxxx' is an RRE-defined number. Otherwise, must be a valid, IRS-assigned TIN. Cannot be blank. If you believe the TIN to be valid, contact your EDI Representative to supply supporting evidence. Your EDI Representative will update the system to mark the TIN as valid and then you may resend the record.
TN02	Office Code/Site ID – Field 4	Invalid Office Code/Site ID. Must be equal to spaces or must be a 9-digit numeric code.
TN03	TIN/Office Code Mailing Name – Field 5	Invalid TIN/Office Code Name. Field cannot be blank. It must contain at least 2 characters. The first 2 characters may not be blank. Cannot contain only the following word(s): SUPPLEMENTAL, SUPPLEMENT, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, MISC, NA, NO, BC, BX, BS, BCBX, BLUE CROSS, BLUE SHEILD, or MEDICARE. Special characters other than , &, - ' . @ # / : ; are not allowed.
TN04	TIN/Office Code Mailing Address Line 1 – Field 6	Invalid TIN/Office Code Mailing Address Line 1. TIN/Office Code Mailing Address Line 1 field is missing or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote. Must be equal to all spaces if TIN/Office Code State is equal to 'FC'.
TN05	TIN/Office Code Mailing Address Line 2 - Field 7	Invalid TIN/Office Code Mailing Address Line 2. If supplied, TIN/Office Code Mailing Address Line 2 must not contain any characters other than alpha, numeric and special characters, A-Z, 0-9, space, &,

TIN Reference Response File Errors		
Error Code	**Field**	**Description**
		dash, @, #, /, comma, semicolon, colon, period, quote. Must be equal to all spaces if TIN/Office Code State is equal to 'FC'.
TN06	TIN/Office Code City - Field 8	Invalid TIN/Office Code City. TIN/Office Code City is missing or contains characters other than alpha and special characters A-Z, space, &, dash, @, #, /, comma, semicolon, colon, period, quote. No numeric characters allowed. Must be equal to all spaces if TIN/Office Code State is equal to 'FC'.
TN07	TIN/Office Code State – Field 9	Invalid TIN/Office Code State. TIN/Office Code State is missing or contained a value other than a valid US postal state code or the value 'FC'.
TN08	TIN/Office Code Zip – Field 10	Invalid TIN/Office Code Zip. TIN/Office Code Zip must contain 5 numeric digits. Must be equal to all spaces or all zeroes if TIN/Office Code State is equal to 'FC'.
TN09	TIN/Office Code Zip+4 – Field 11	Invalid TIN/Office Code Zip+4. TIN/Office Code Zip+4 must contain 4 numeric digits, all zeroes or all spaces. Must be equal to all spaces or all zeroes if TIN/Office Code State is equal to 'FC'.
TN10 – TN16	N/A	Not used.
TN17	Foreign RRE Address Line 1-4 – Fields 12, 13, 14, 15	Invalid Foreign RRE Address Line 1-4. The TIN/Office Code State supplied was 'FC' but the Foreign RRE Address Line 1-4 fields contained all spaces or non-alphanumeric characters; or the TIN/Office Code State supplied was not 'FC' and the Foreign RRE Address Line 1-4 fields were not equal to all spaces.
TN18	Fields 6 - 11	Invalid TIN/Office Code address. The address supplied was insufficient or missing components needed to determine a unique match to the postal database.
TN19	Fields 6 - 11	Invalid TIN/Office Code address. The address matches one to which mail is undeliverable, such as a vacant lot.
TN20	Fields 6 - 11	Invalid TIN/Office Code address. The apartment number was not found in the postal database or was not supplied for an address that requires apartment number.

TIN Reference Response File Errors		
Error Code	**Field**	**Description**
TN21	Fields 6 - 11	Invalid TIN/Office Code address. The house number or box number was not found on the street.
TN22	Fields 6 - 11	Invalid TIN/Office Code address. The street name was not found in the ZIP Code.
TN23	Fields 6 - 11	Invalid TIN/Office Code address. The ZIP Code was not found in the postal database.

Appendix G – 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 H – 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.

Where an entity engages in a business, trade, or profession, deductible amounts are self-insurance for MSP purposes. **However,** where the self-insurance in question is a deductible, and the insurer is responsible for Section 111 reporting with respect to the policy, it is responsible for reporting both the deductible and any amount in excess of the deductible.

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.

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 I – Excluded ICD-9 Diagnosis Codes

This list contains ICD-9 diagnosis codes that are considered invalid by CMS for Section 111 reporting and are to be excluded from all claim report records. 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 or the ICD-9 Diagnosis Code 1-19 (Fields 19-55) on the Claim Input File Detail Record. Field 15 must be a code starting with the letter 'E' **not** on this list. The ICD-9 Diagnosis Codes 1-19 cannot start with the letter 'E', cannot start with the letter 'V', and cannot be a code on this list.

All ICD-9 Diagnosis Codes beginning with the letter 'V' are considered invalid for Section 111 reporting and should be excluded. Therefore, no specific "V Code" appears on this list.

As of January 1, 2011, on add and update record submissions, ICD-9 Diagnosis Codes submitted in Fields 19-55 must be valid, begin with a number (not an E code and not a V code) ICD-9 diagnosis codes that are ***not*** on this list.

Excel and text files containing this list of Excluded ICD-9 Diagnosis Codes may be downloaded from the Section 111 COBSW at www.section111.cms.hhs.gov by clicking on the link found under the Reference Materials menu option of the Login page.

Excluded 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.
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

Excluded ICD-9 Codes	Description
E8496	Place of Occurrence Public Building
E8497	Place of Occurrence Residential Institution
E8498	Place of Occurrence Other Specified Places
E8499	Place of Occurrence Unspecified Place

Appendix J – 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
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
DDE	Direct Data Entry
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 Spending 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 Arrangement
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
IRS	Internal Revenue Service
LGHPs	Large Group Health Plans

Acronym	Description
MBD	Medicare Beneficiary Database
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