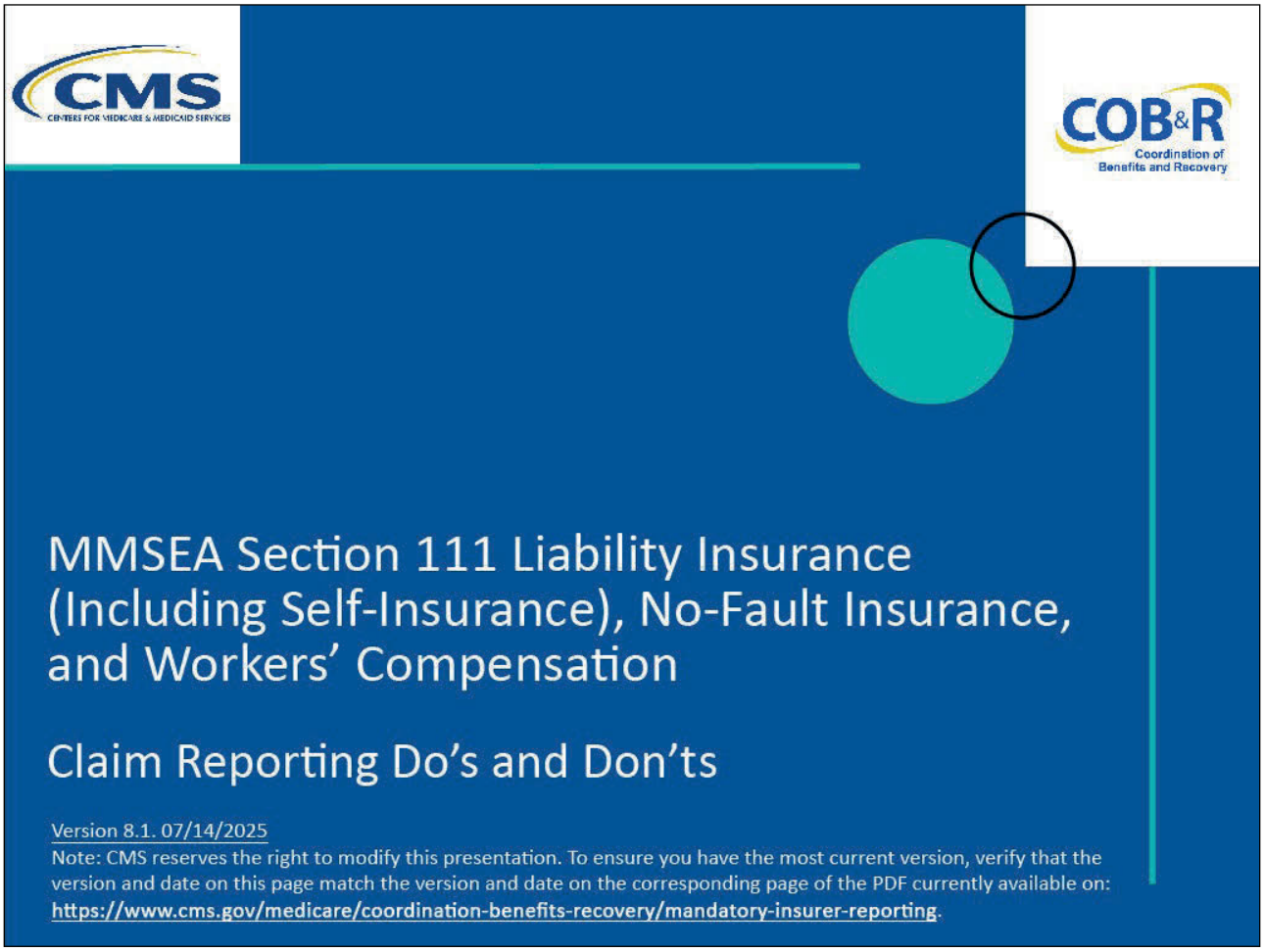
Claim Reporting Do's and Don'ts

Slide 1 of 25 - Claim Reporting Do's and Don'ts

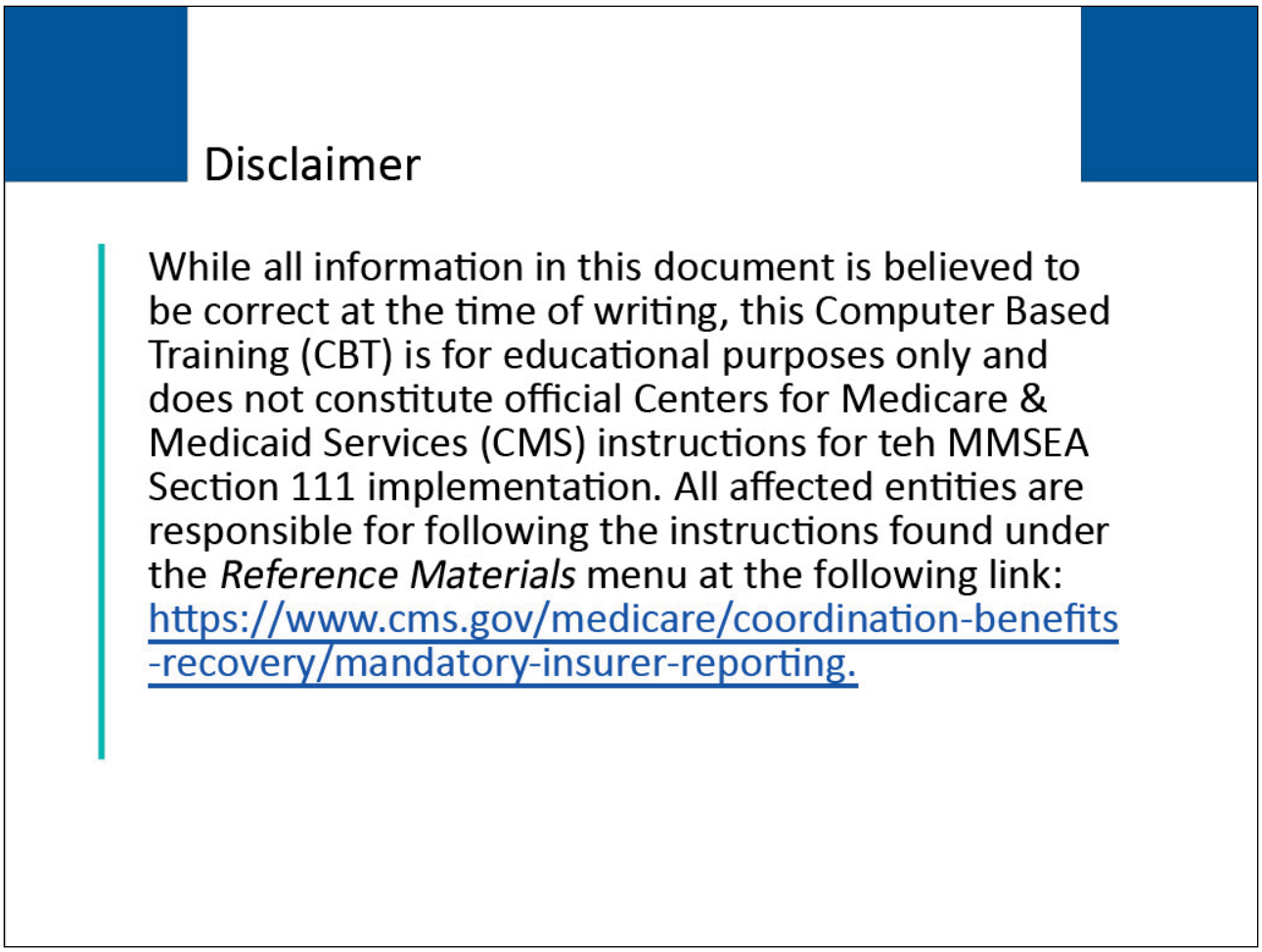


Slide notes

Welcome to the Claim Reporting Do's and Don'ts course.

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

Slide 2 of 25 - Disclaimer

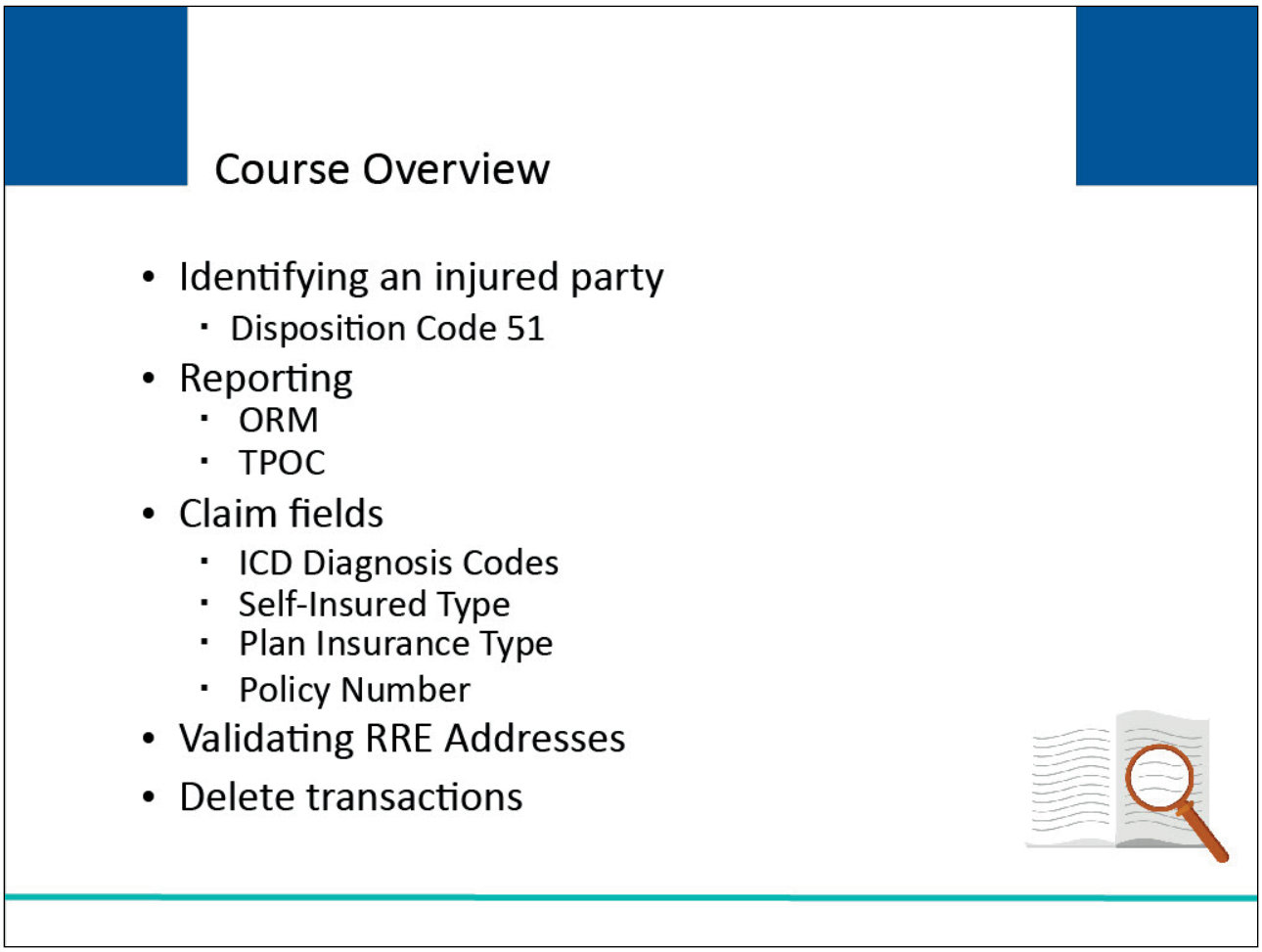


Slide notes

While all information in this document is believed to be correct at the time of writing, this Computer Based Training (CBT) is for educational purposes only and does not constitute official Centers for Medicare & Medicaid Services (CMS) instructions for the MMSEA Section 111 implementation.

All affected entities are responsible for following the instructions found at the following link: Mandatory Insurer Reporting (NGHP) | CMS.

Slide 3 of 25 - Course Overview



Slide notes

This module provides some helpful suggestions for RREs to consider when submitting Claim Input Files or providing claim information via DDE.

It includes information on:

- identifying an injured party and Disposition Code 51;
- reporting ongoing responsibility for medicals (ORM) and Total Payment Obligation to Claimant (TPOC);
- submitting certain claim fields (ICD Diagnosis Codes, Self-Insured Type, Plan Insurance Type, and Policy Number); and
- the importance of validating RRE addresses.

It also reviews when delete transactions should be used.

Note: Liability insurance (including self-insurance), no-fault insurance and workers' compensation are sometimes collectively referred to as "non-group health plan" or "NGHP."

The term NGHP will be used in this CBT for ease of reference.

Slide 4 of 25 - PAID Act

PAID Act

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act also known as the PAID Act requiring that CMS provide Non-Group Health Plans with a Medicare beneficiary's Part C and Part D enrollment information for the past 3 years.

This information will be provided both online and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

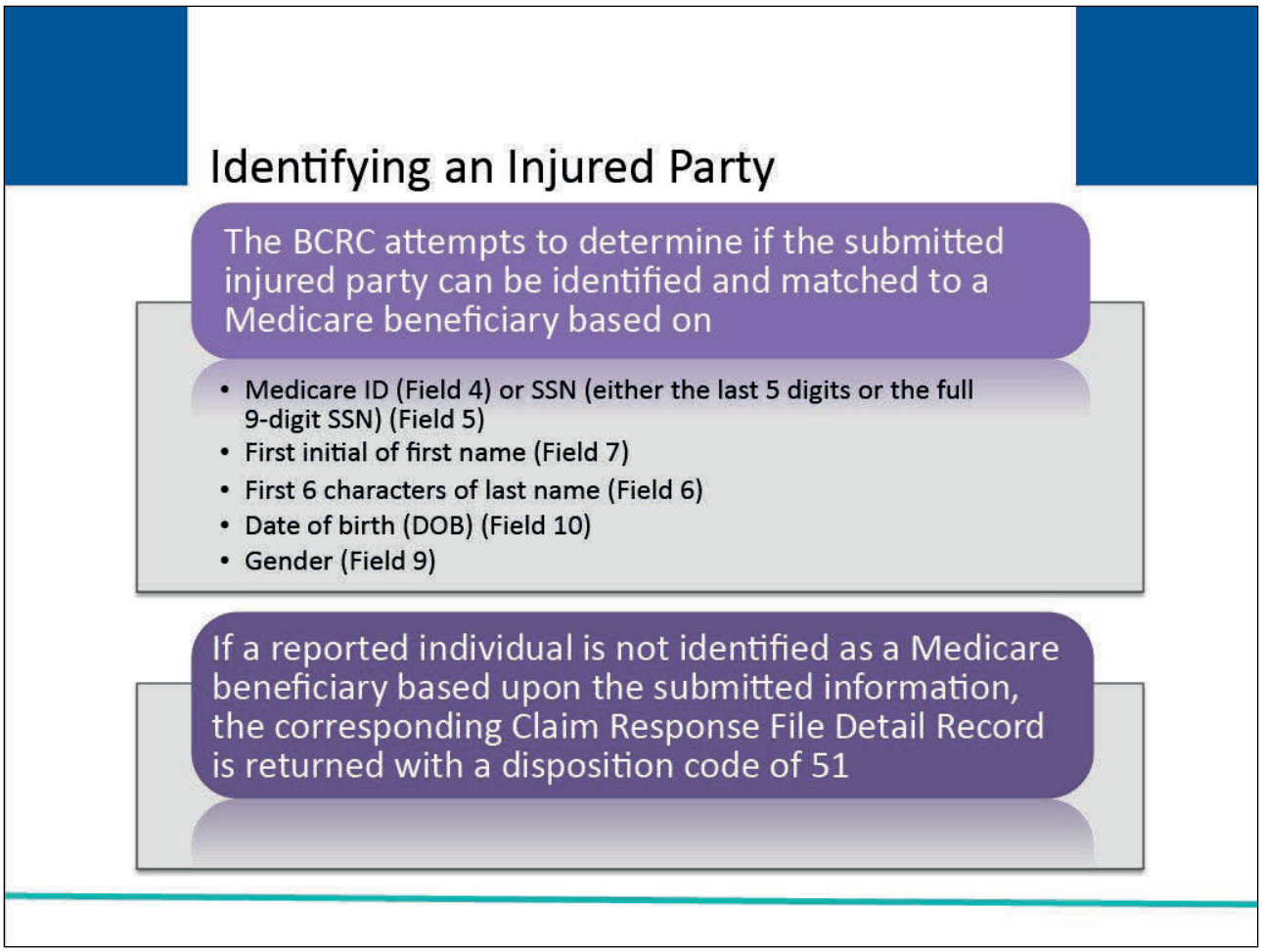
Slide notes

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act also known as the PAID Act requiring that CMS provide Non-Group Health Plans with a Medicare beneficiary's Part C and Part D enrollment information for the past three years.

This information will be provided both online and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

Note: To support the PAID Act, the Query Response File will be updated to include Contract Number, Contract Name, Plan Number, Coordination of Benefits (COB) Address, and Entitlement Dates for the last three years (up to 12 instances) of Part C and Part D coverage. The updates will also include the most recent Part A and Part B entitlement dates.

Slide 5 of 25 - Identifying an Injured Party



Slide notes

When a Claim Input File Detail Record is processed, the Benefits Coordination & Recovery Center (BCRC) attempts to determine if the submitted injured party can be identified and matched to a Medicare beneficiary.

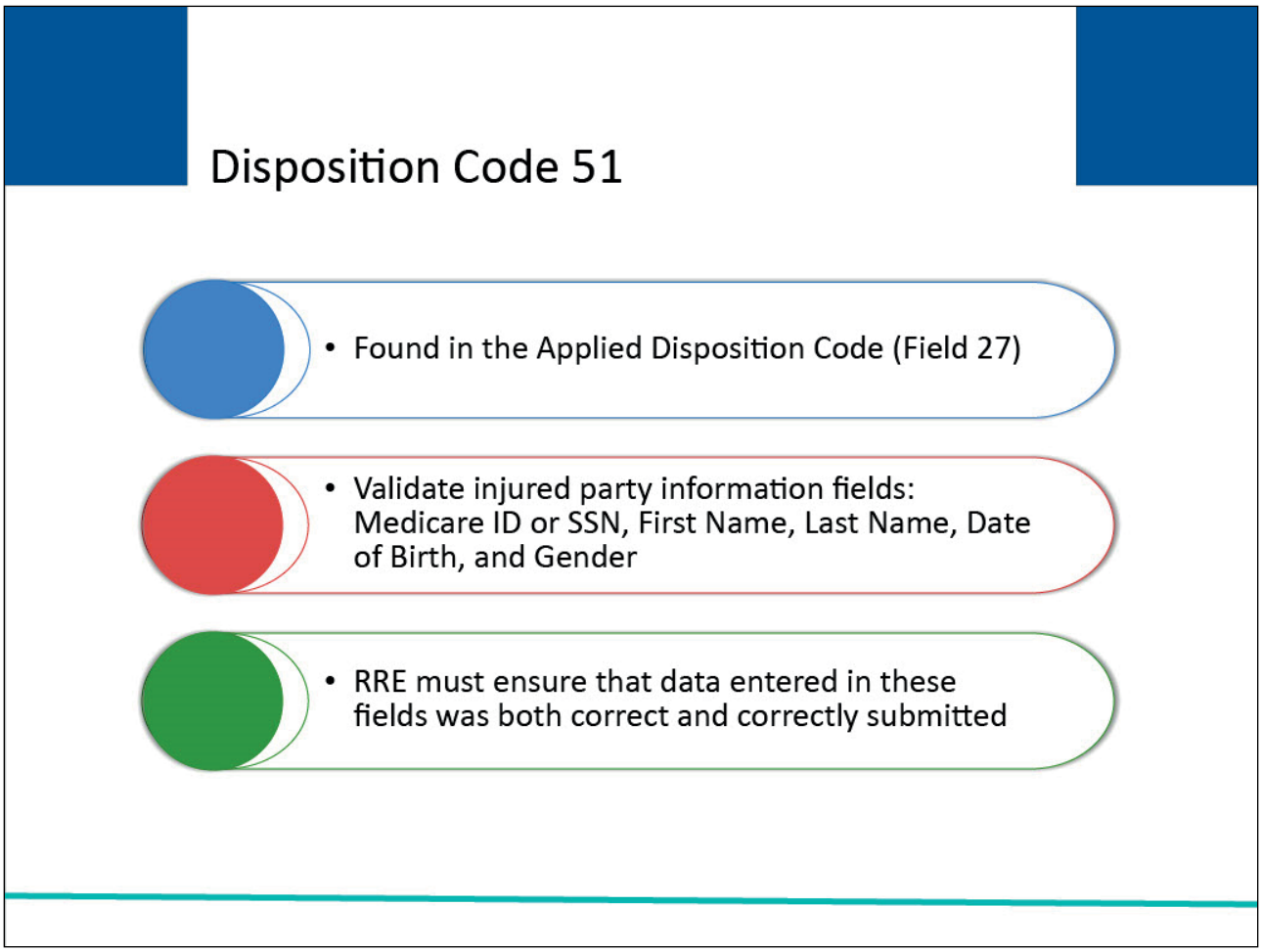
First, the BCRC must find an exact match on the Medicare ID or Social Security Number (SSN) (i.e., the last five digits or full 9 digits of the SSN, whichever is submitted).

Then at least three out of four of the following fields must be matched exactly and all four must match when a partial SSN is used: first initial of the First Name, first 6 characters of the Last Name, Date of Birth (DOB), and Gender.

If a reported individual is not identified as a Medicare beneficiary based on the submitted information, the corresponding Claim Response File Detail Record is returned with a disposition code of 51.

Please note: The matching process depends on the quality of the data submitted.

Slide 6 of 25 - Disposition Code 51



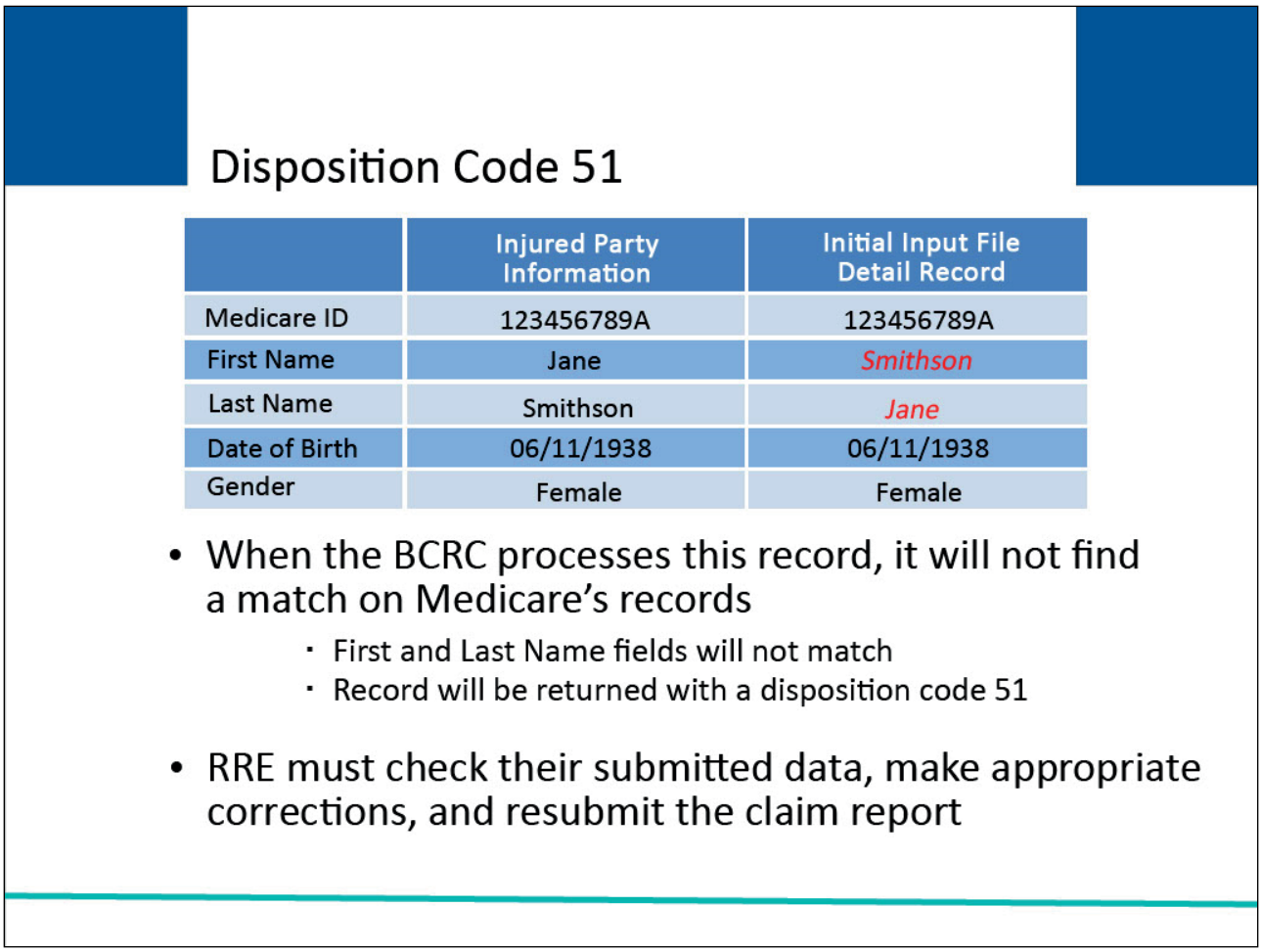
Slide notes

Disposition codes are found in the Applied Disposition Code (Field 27) on the Claim Response File Detail Record.

If a disposition code of 51 is received, the RRE must validate the information submitted in the injured party information fields (Medicare ID or SSN, First Name, Last Name, Date of Birth, and Gender).

The RRE must check to ensure that the data entered in these fields was both correct and correctly submitted.

Slide 7 of 25 - Disposition Code 51



Slide notes

Let's say an RRE must submit a claim report for the following injured party:

- Medicare ID: 123456789A,
- First Name: Jane,
- Last Name: Smithson,
- Date of Birth: 06/11/1938,
- Gender: Female.

On the initial Claim Input File Detail Record, the RRE submits the correct data in the Medicare ID, Date of Birth, and Gender fields.

However, the RRE submits the Last Name in the First Name field and submits the First Name in the Last Name field. When this record is processed by the BCRC, a match will not be found on Medicare's records.

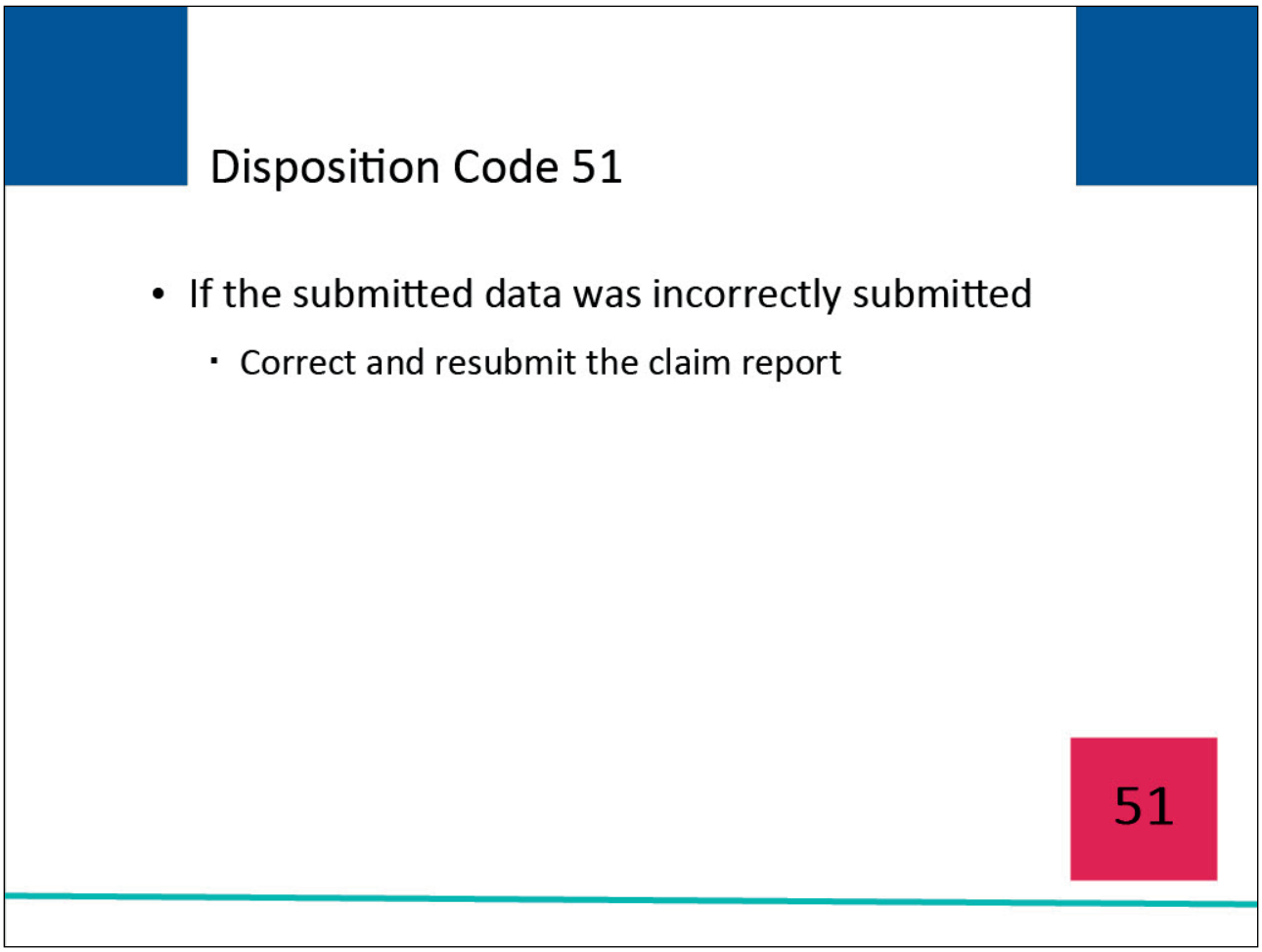
Although the BCRC will find an exact match on the Medicare ID, only two of the remaining four data elements (Date of Birth and Gender) will exactly match Medicare's records.

The First and Last Name Fields will not match Medicare’s records since these fields were entered incorrectly. The response record will be returned with a disposition code 51.

The RRE must then check the data submitted in the injured party fields to ensure that it was both correct and correctly submitted.

Once reviewed, the RRE will see that the first and last names were not entered in the correct fields. The RRE must make the appropriate corrections and resubmit the claim report.

Slide 8 of 25 - Disposition Code 51



Slide notes

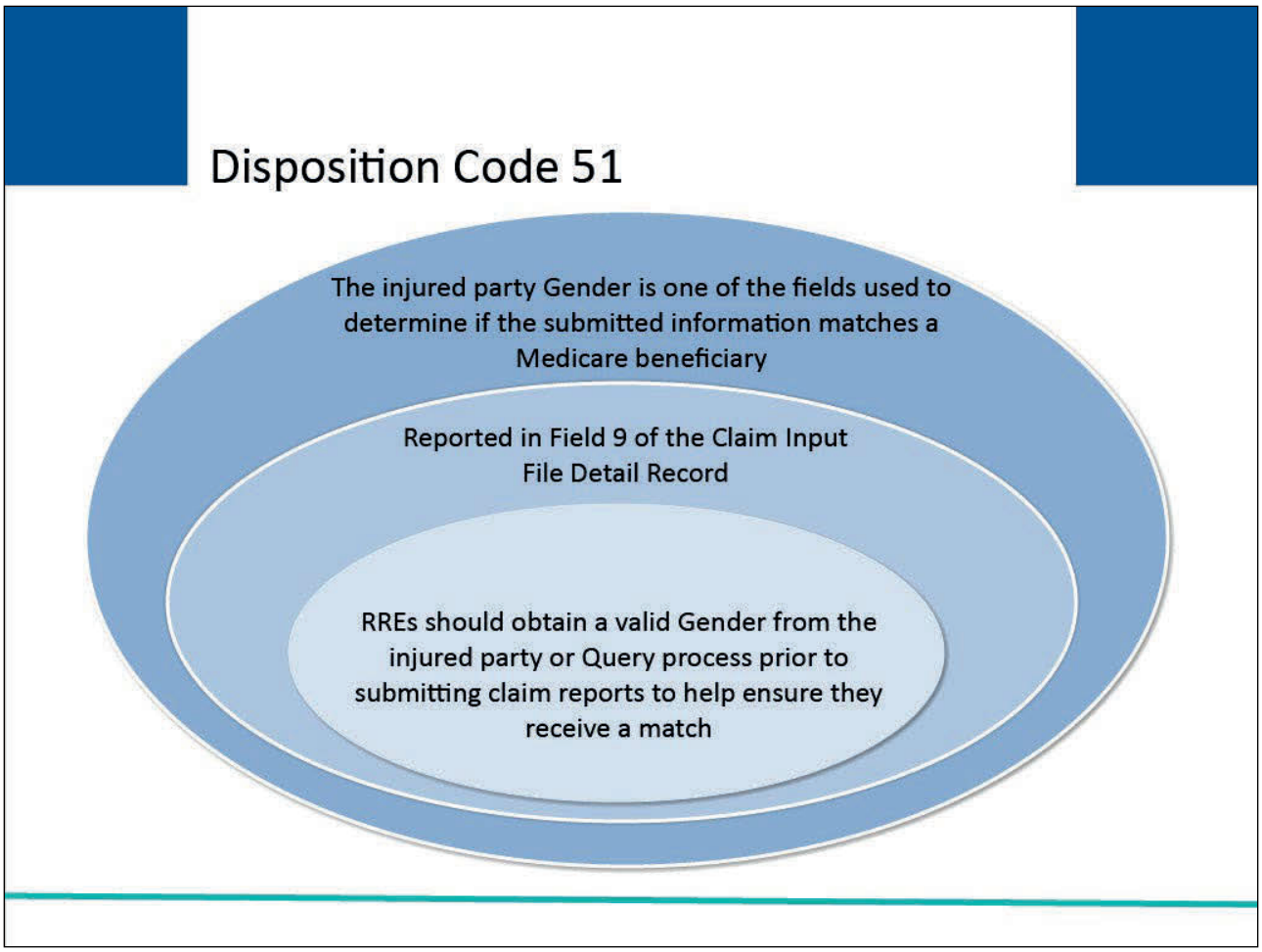
If a claim has received a disposition code of 51 and the RRE has checked the data and the data was incorrectly submitted, the claim report must be corrected and resubmitted.

Note: This disposition code will be returned on the claim and query response files if the RRE submits the SSN (i.e., the last 5 digits or full 9 digits of the SSN) on the input record and the information is not matched to a Medicare beneficiary.

RREs will also receive this disposition code if neither the Medicare ID nor SSN is submitted on the input record or if the SSN entered is not 5 or 9 digits.

In this case, the RRE must obtain a valid Medicare ID or SSN and resubmit the record on the next file submission.

Slide 9 of 25 - Disposition Code 51

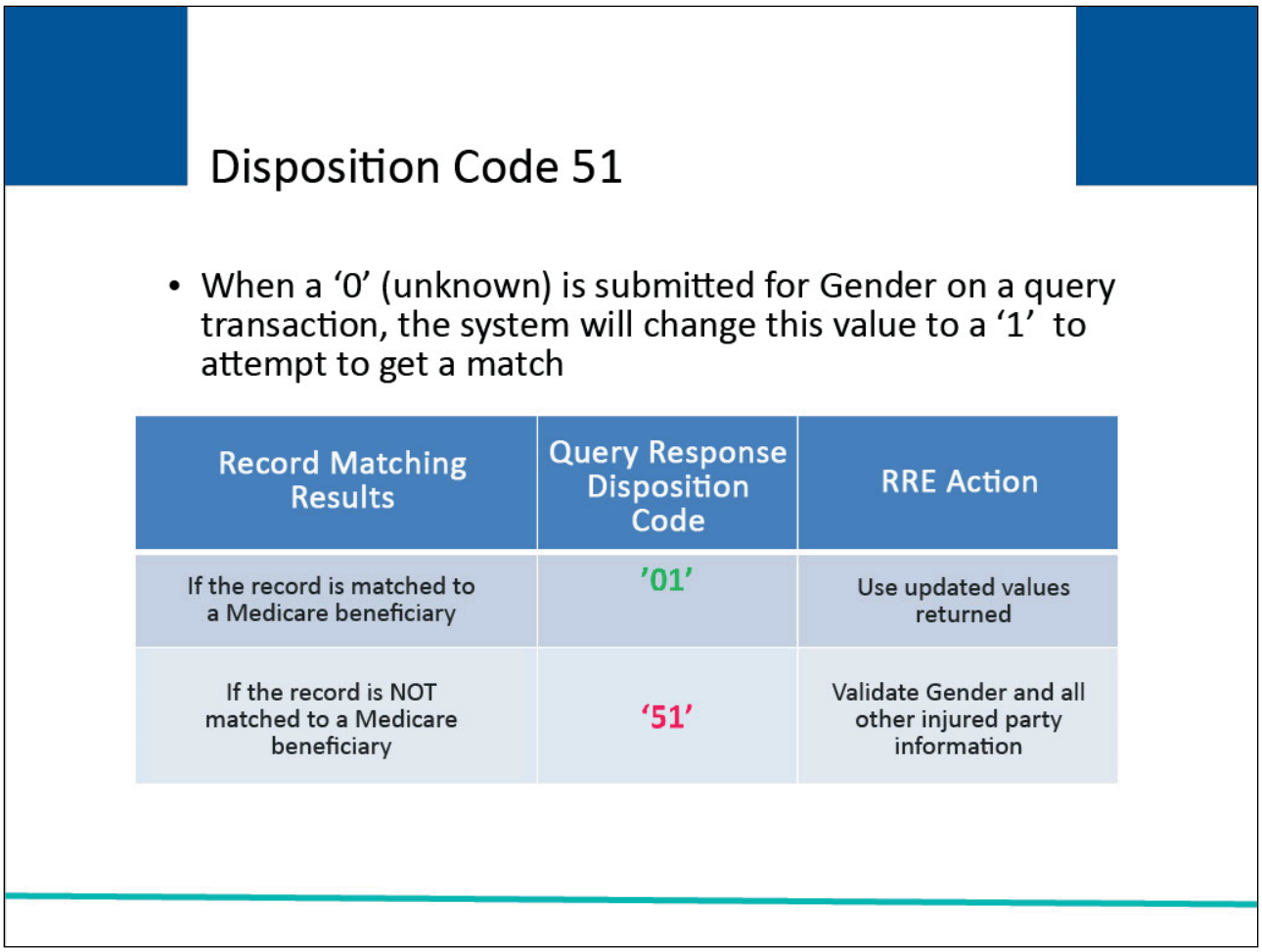


Slide notes

The injured party's Gender is one of the fields used to determine if the submitted information matches a Medicare beneficiary. It is reported in Field 9 of the Claim Input File Detail Record.

RREs are advised to obtain a valid Gender from the injured party or the query process prior to submitting claim reports to help ensure they receive a match.

Slide 10 of 25 - Disposition Code 51



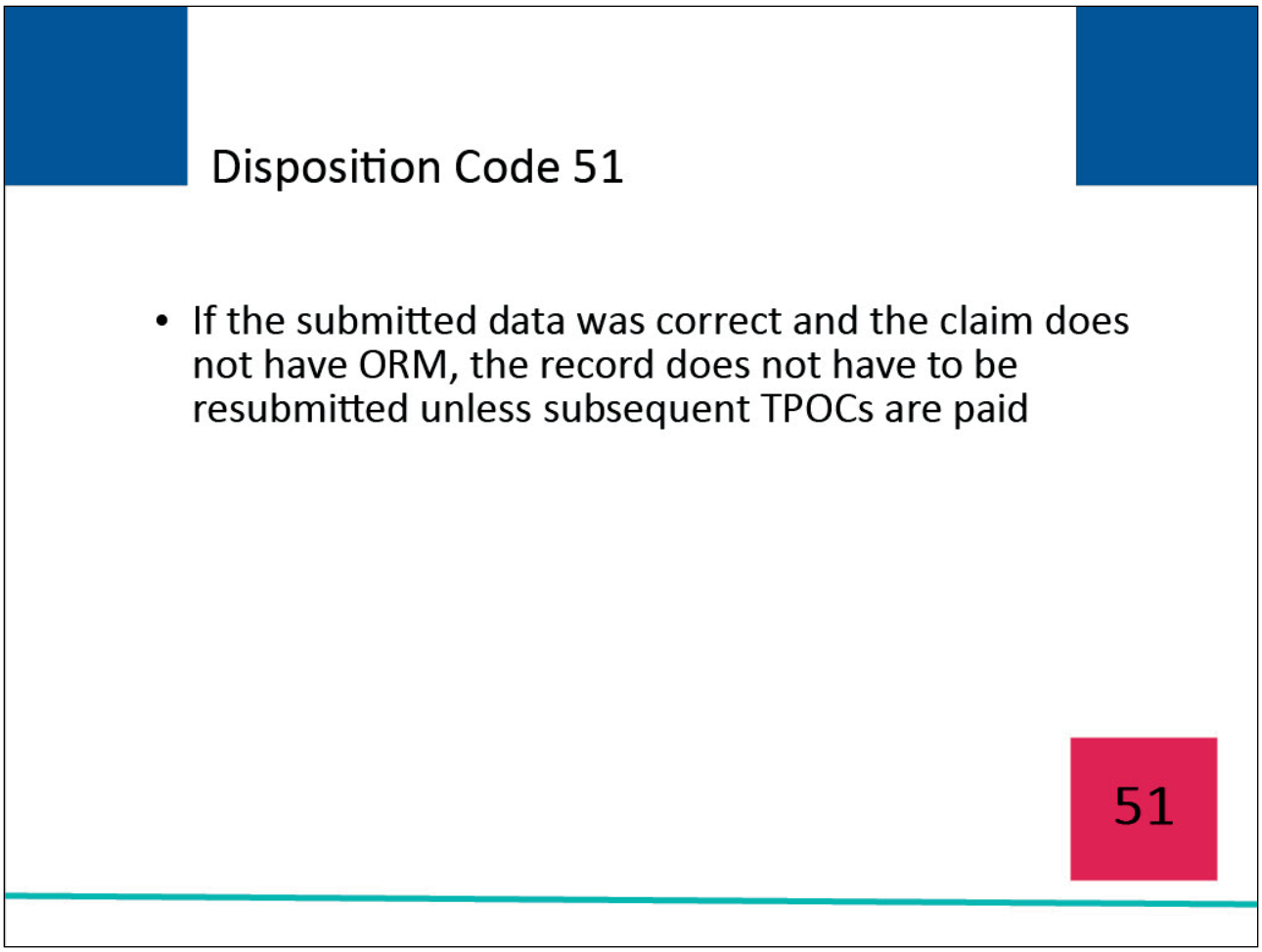
Slide notes

When using the query process, please be aware that when an RRE submits a query transaction with a '0' (unknown) in the Gender field, the system will change this value to '1' to attempt to get a match.

If the record is matched to a Medicare beneficiary, the Query Response File Record is returned with a '01' disposition code. In this case, the RRE should use the updated values returned in the Medicare ID, Name fields, DOB, and Gender when the corresponding Claim Input File Detail Record is submitted. However, if this record is not matched to a Medicare beneficiary, the Query Response File Record is returned with a disposition code of '51' and the converted '1' in the Gender field. The RRE should NOT use the Gender value returned in this case.

The RRE must validate the correct Gender and all other injured party information prior to submitting the Claim Input File Detail Record.

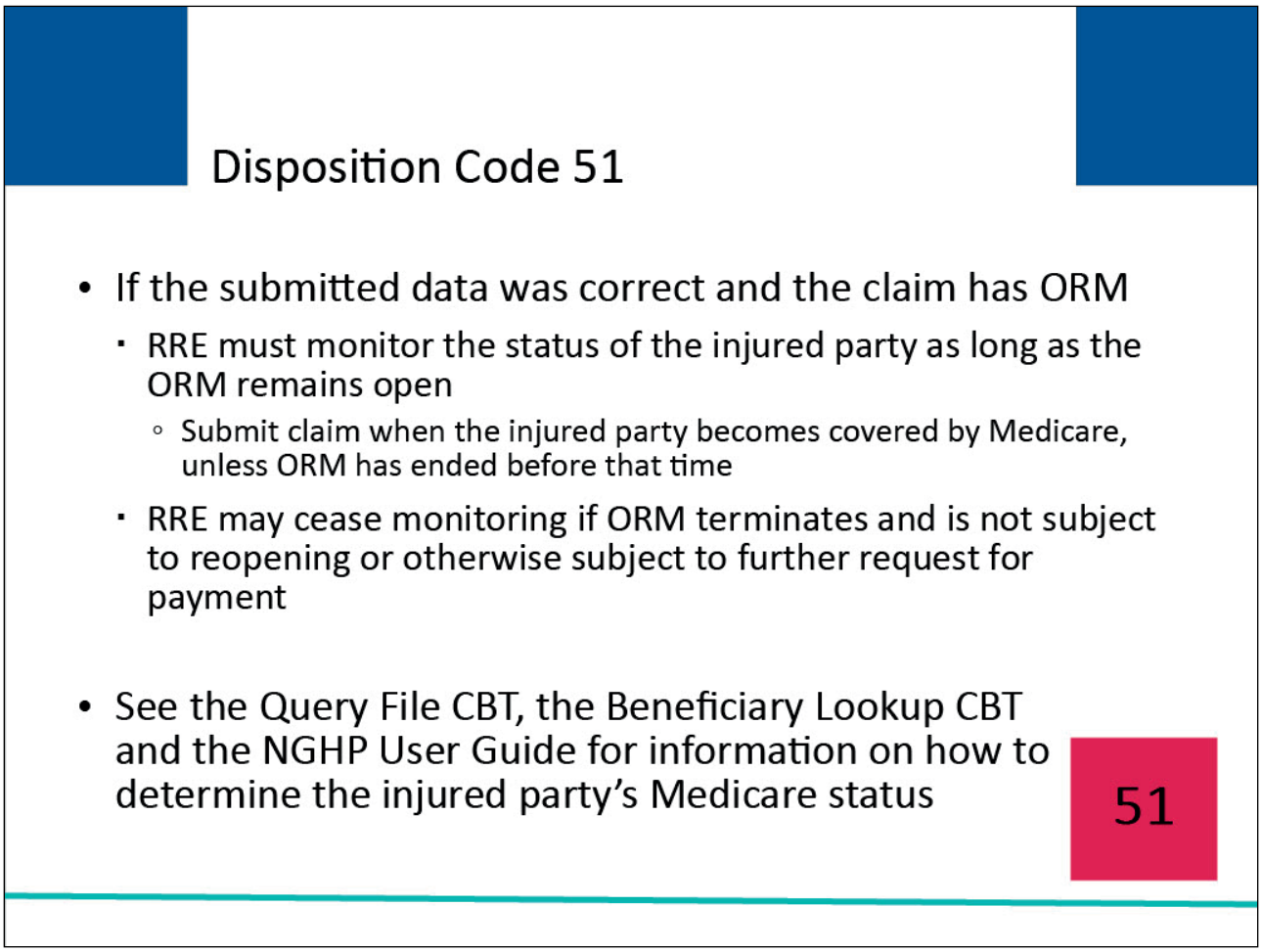
Slide 11 of 25 - Disposition Code 51



Slide notes

If the RRE has ensured that the data was submitted correctly and the claim does not have ORM, the record does not have to be resubmitted, unless subsequent TPOC payments are made.

Slide 12 of 25 - Disposition Code 51



Slide notes

If the RRE has ensured that the data was submitted correctly, and the claim has ORM, the RRE must monitor the status of the injured party in order to determine if/when the injured party becomes covered by Medicare.

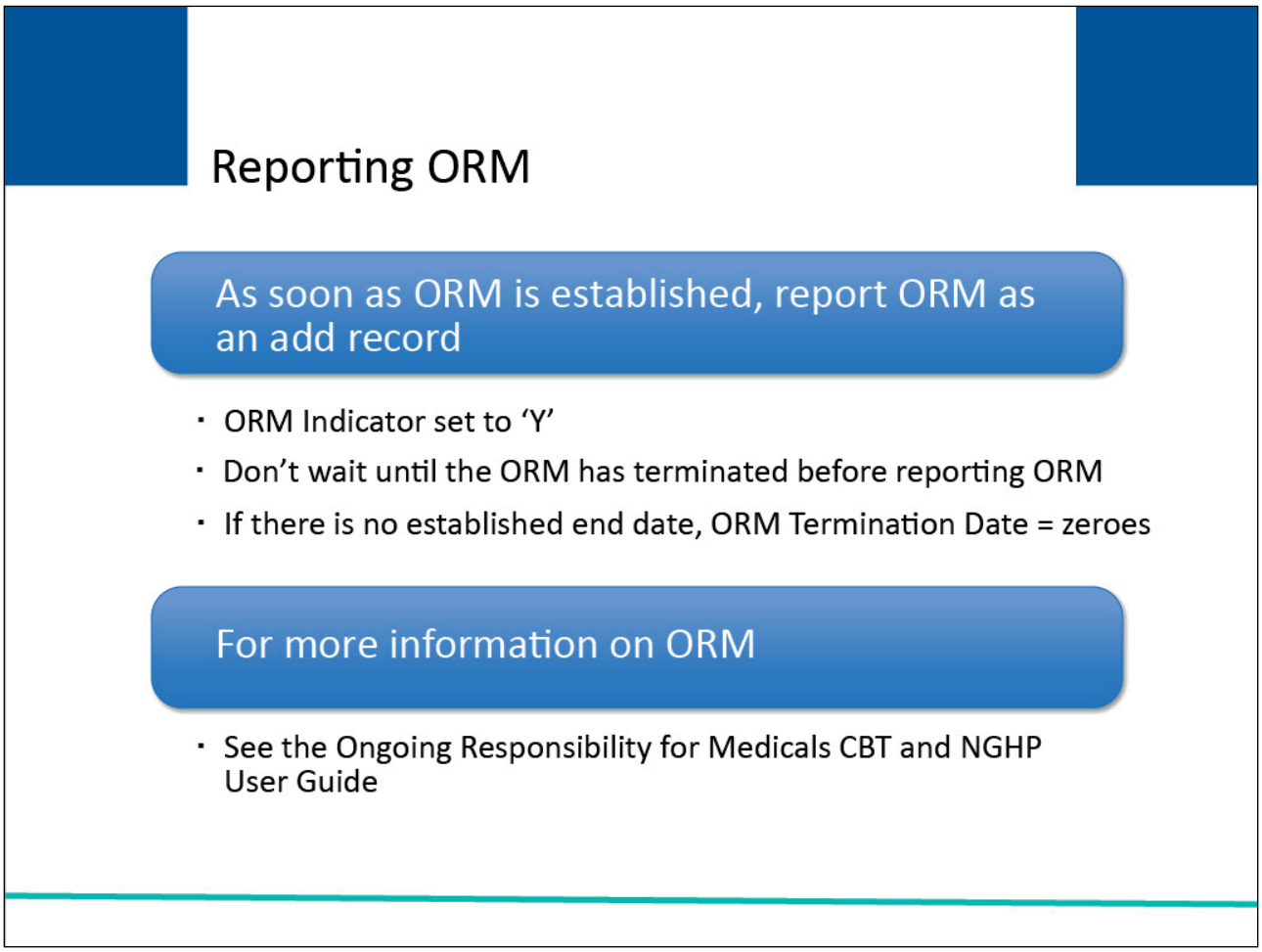
Monitoring the injured party must continue as long as the ORM remains open. When the individual becomes covered by Medicare, the RRE must submit a Claim Detail Record.

If the ORM terminates and is not subject to reopening or otherwise subject to further request for payment, monitoring of such individuals may cease.

One final query or claim report should be submitted after an ORM Termination Date has been reached, to ensure the RRE obtains the most up-to-date information on the individual before they stop checking.

Please refer to the Query File CBT, the Beneficiary Lookup CBT, and the NGHP User Guide for a description of how an RRE can determine the injured party's Medicare status prior to submitting claim information.

Slide 13 of 25 - Reporting ORM

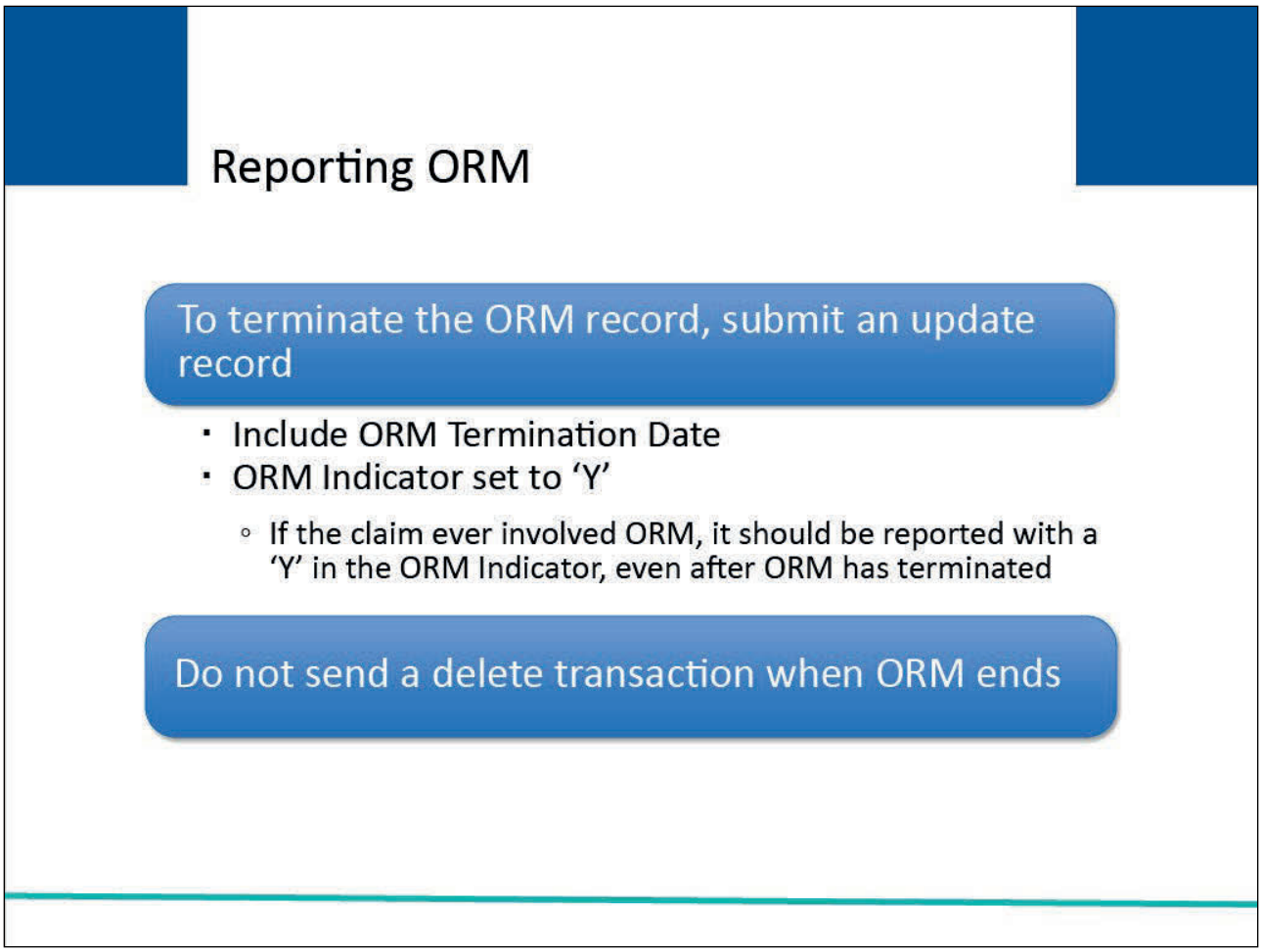


Slide notes

As soon as ongoing responsibility for medicals (ORM) is established, report the ORM as an add record (ORM Indicator set to 'Y'). Do not wait until the ORM has terminated before reporting the existence of ORM.

If there is no established end date, a value of all zeroes must be entered in the ORM Termination Date. For more information on ORM, please see the Ongoing Responsibility for Medicals CBT and the NGHP User Guide.

Slide 14 of 25 - Reporting ORM

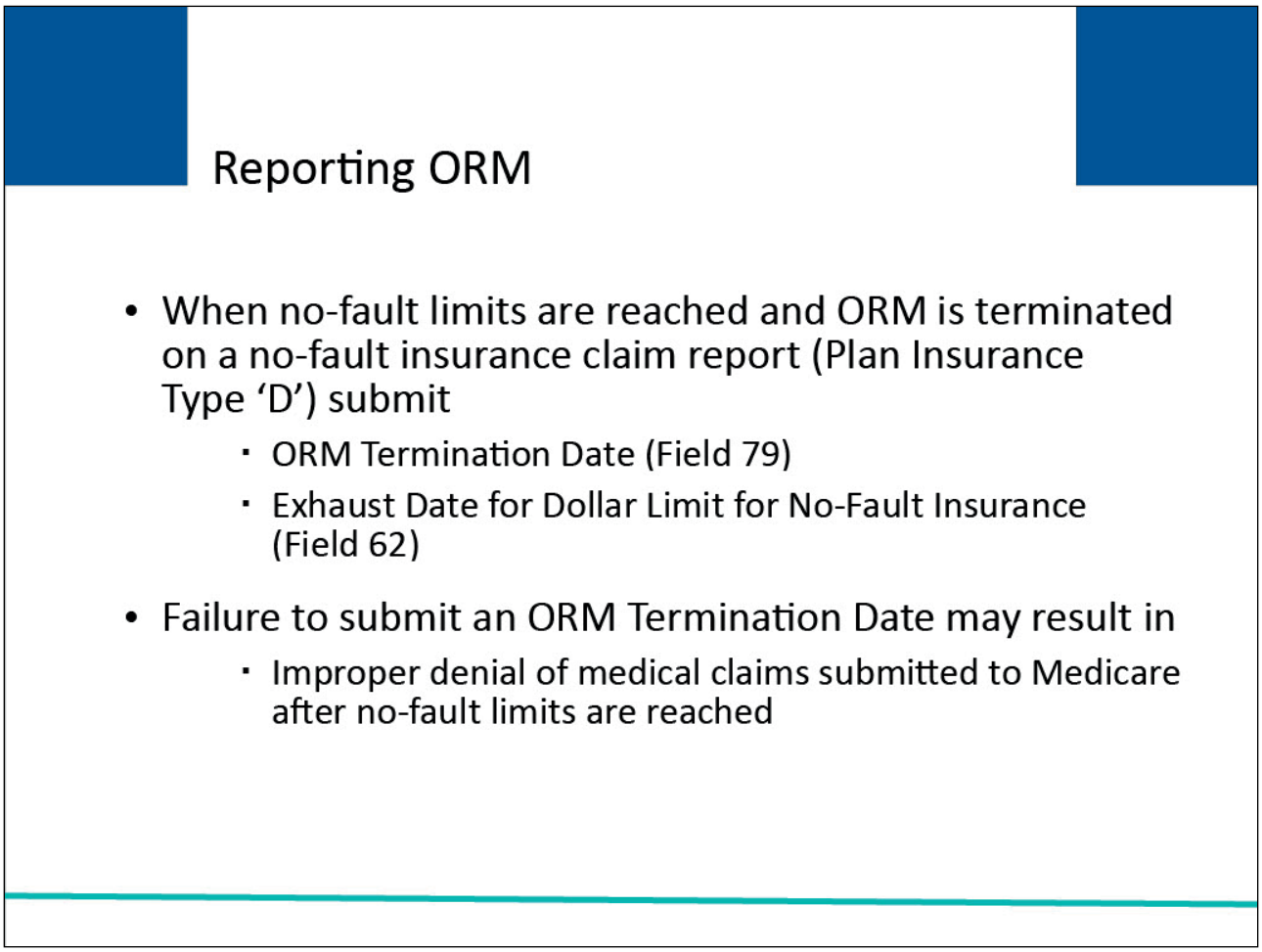


Slide notes

To terminate the ORM record, submit an updated record with the ORM Termination Date and a 'Y' in the ORM Indicator field.

Remember, if the claim ever involved ORM, it should be reported with a 'Y' in the ORM Indicator, even after ORM has terminated. Do not send a delete transaction when the RRE's ORM ends.

Slide 15 of 25 - Reporting ORM

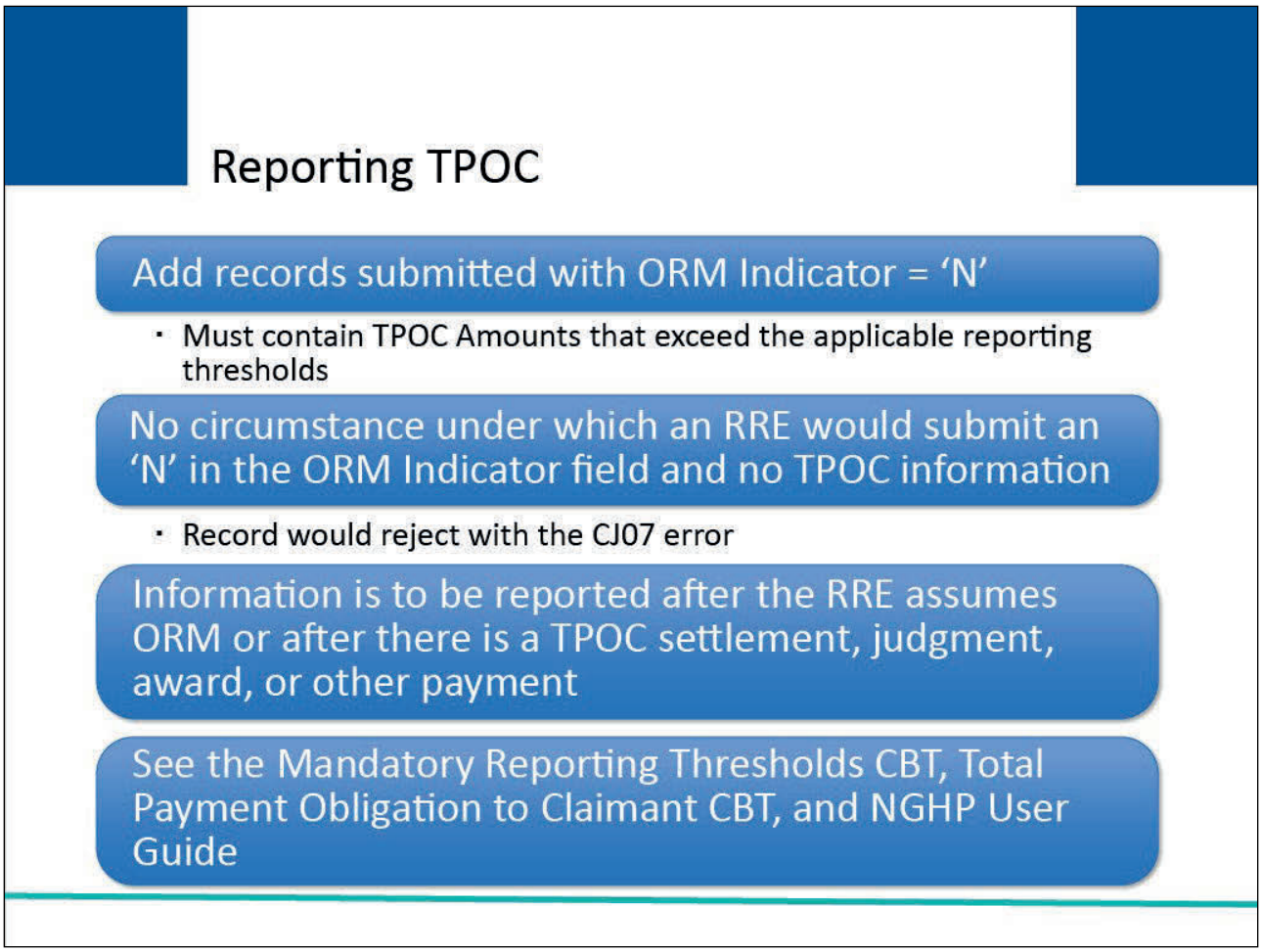


Slide notes

When no-fault limits are reached and ORM is terminated on a no-fault insurance claim report (Plan Insurance Type 'D'), be sure to submit an ORM Termination Date (Field 79) in addition to the Exhaust Date for Dollar Limit for No-Fault Insurance (Field 62).

Failure to submit an ORM Termination Date may result in improper denial of medical claims submitted to Medicare after no-fault limits are reached.

Slide 16 of 25- Reporting TPOC



Slide notes

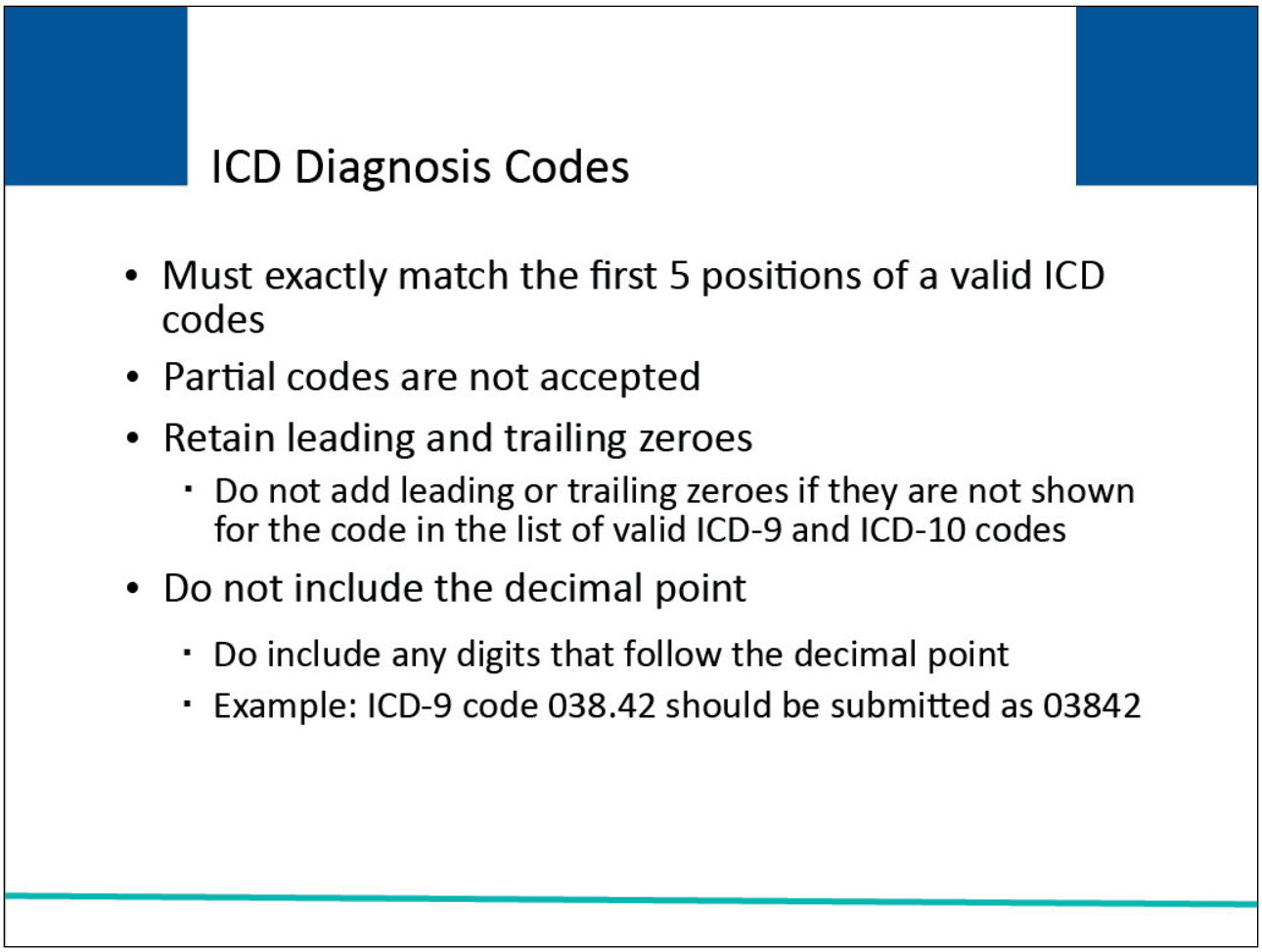
Add records submitted with 'N' in the ORM Indicator (Field 78) must contain TPOC Amounts that exceed the applicable reporting thresholds.

There is no TPOC threshold applied to no-fault claims. There is no circumstance under which an RRE would submit 'N' in the ORM Indicator and not include TPOC information.

This would result in rejection of the record with the CJ07 error. Claim information is to be reported after the RRE assumes ORM or after there is a TPOC settlement, judgment, award, or other payment.

Please see the Mandatory Reporting Thresholds CBT, the Total Payment Obligation to Claimant CBT and the NGHP User Guide for more information on these topics.

Slide 17 of 25 - ICD Diagnosis Codes



Slide notes

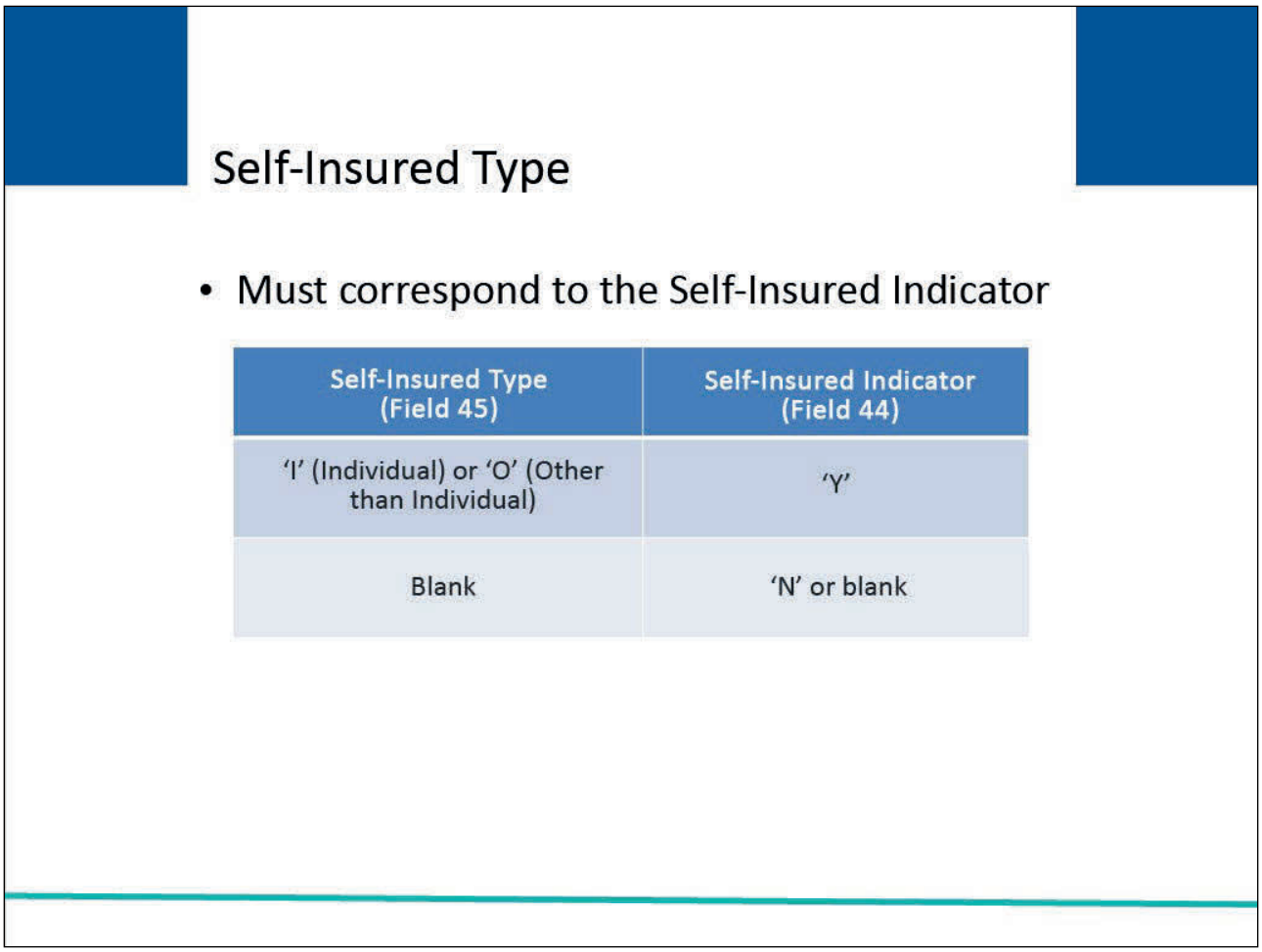
Be sure to submit ICD Diagnosis Codes (starting in Field 18) that exactly match the first 5 positions of a code on the list of valid ICD codes (See Section 6.2.5 (ICD-9 and ICD-10 Codes) in the NGHP User Guide Technical Information Chapter for more information). Partial codes are not accepted. Retain 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-9 and ICD-10 codes.

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

The excluded and no-fault excluded ICD-10 diagnosis codes have been updated, Diagnosis Code describing the alleged injury/illness. These codes are special defaults for liability reporting.

Note: Excel spreadsheets of the ICD-9/ICD-10 excluded and valid codes for FY 2023 are now available for download on CMS.gov at ICD-9/ICD-10 Excluded and Valid Codes for FY 2023 Spreadsheet (Appendix A, Appendix F, and Appendix I).

Slide 18 of 25 - Self-Insured Type



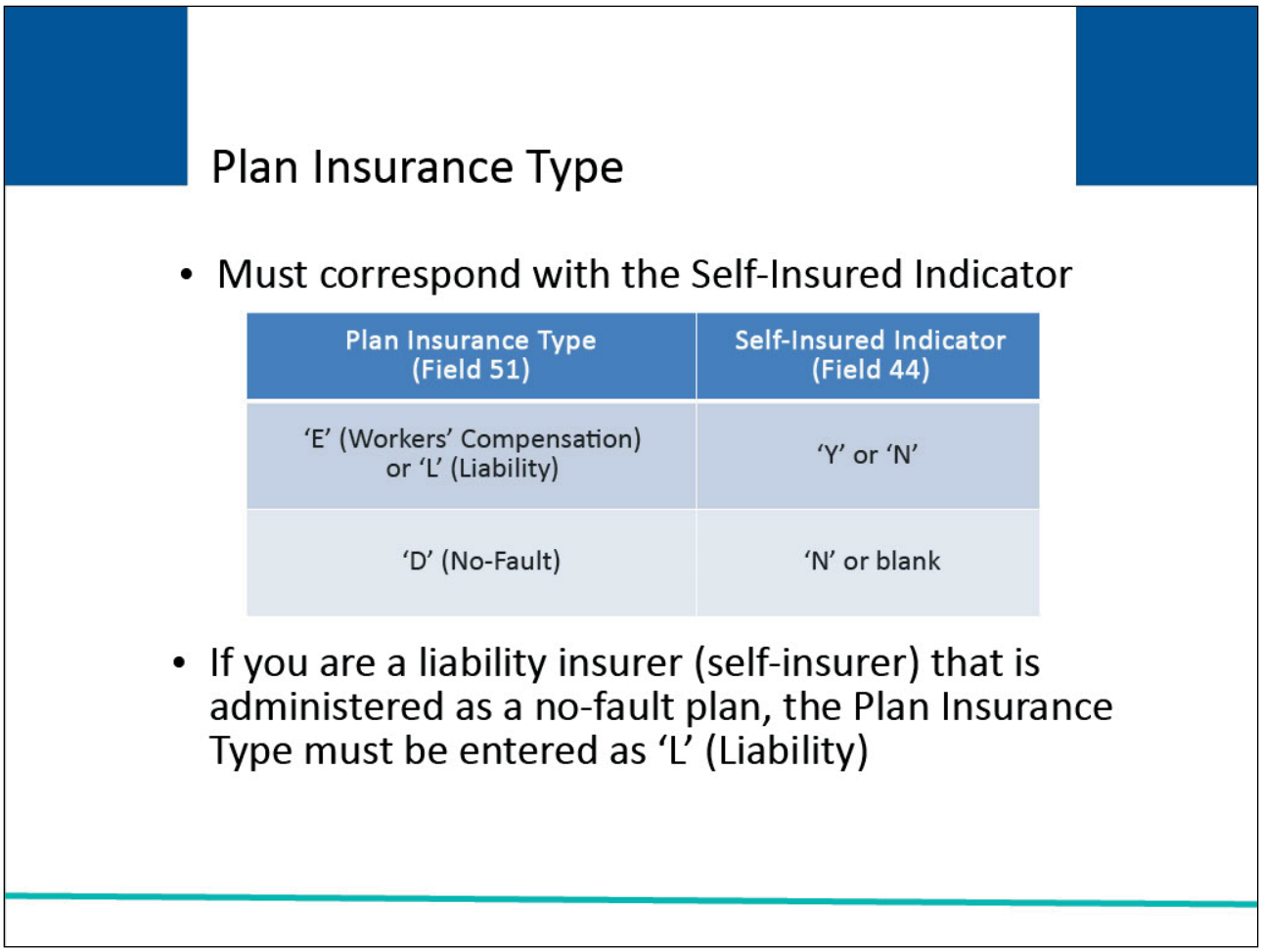
Slide notes

The value in the Self-Insured Type (Field 45) must correspond to the value in the Self-Insured Indicator (Field 44).

The Self-Insured Type must be 'I' (Individual) or 'O' (Other than Individual) if the Self-Insured Indicator is 'Y' (Yes). The Self-Insured Type must be blank if the Self-Insured Indicator is 'N' (No) or blank.

Records submitted incorrectly will be rejected with CS02 error.

Slide 19 of 25 - Plan Insurance Type

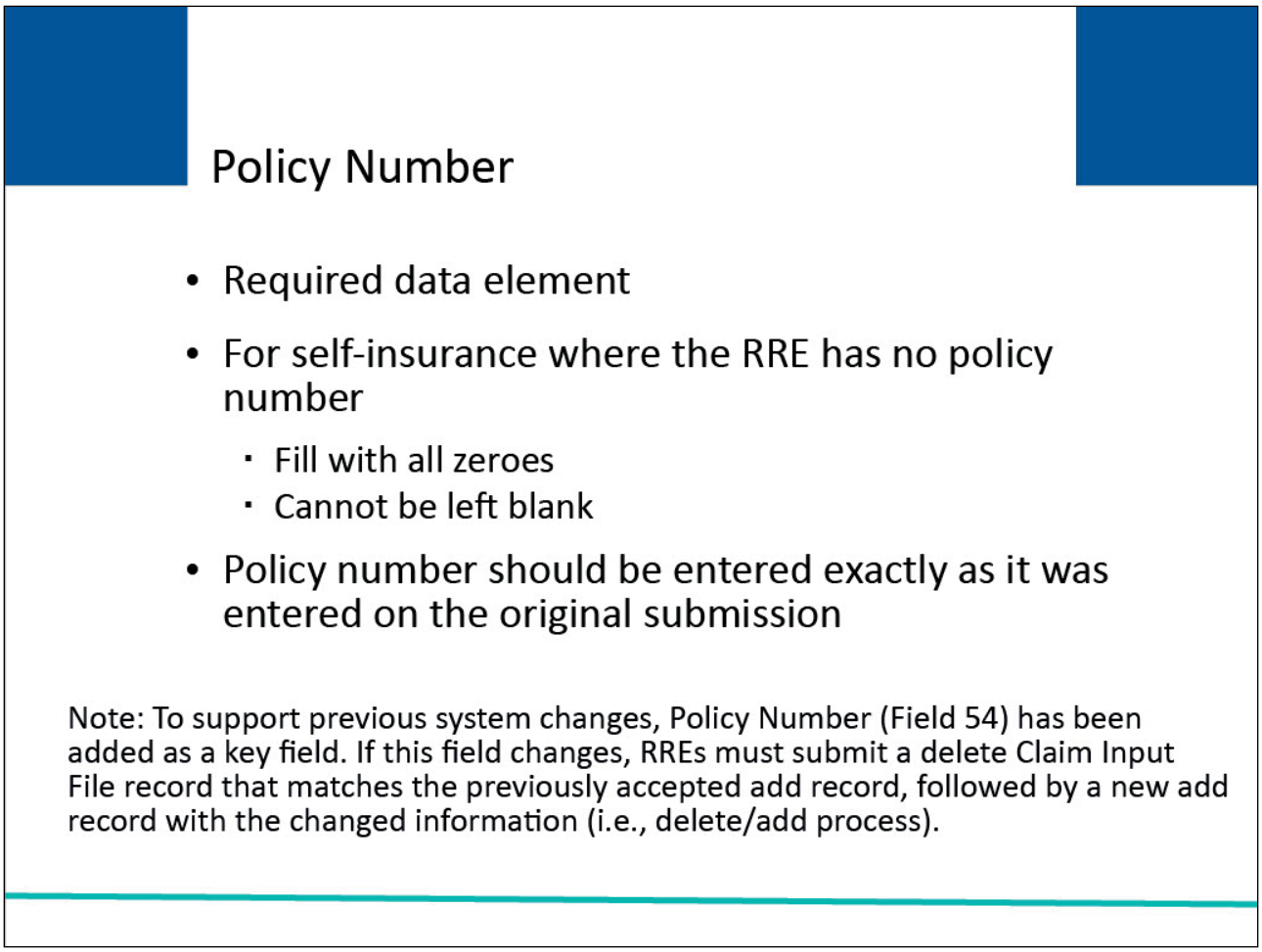


Slide notes

Values in the Plan Insurance Type (Field 51) must correspond with the Self-Insured Indicator (Field 44).

If the Plan Insurance Type is 'E' (Workers' Compensation) or 'L' (Liability), the Self-Insured Indicator must equal 'Y' (Yes) or 'N' (No). If the Plan Insurance Type is 'D' (No-Fault), the Self-Insured Indicator must equal 'N' or blank. Please note: If you are a liability insurer (self-insurer) that is administered as a no-fault plan, the Plan Insurance Type must be entered as 'L' (Liability).

Slide 20 of 25 - Policy Number



Slide notes

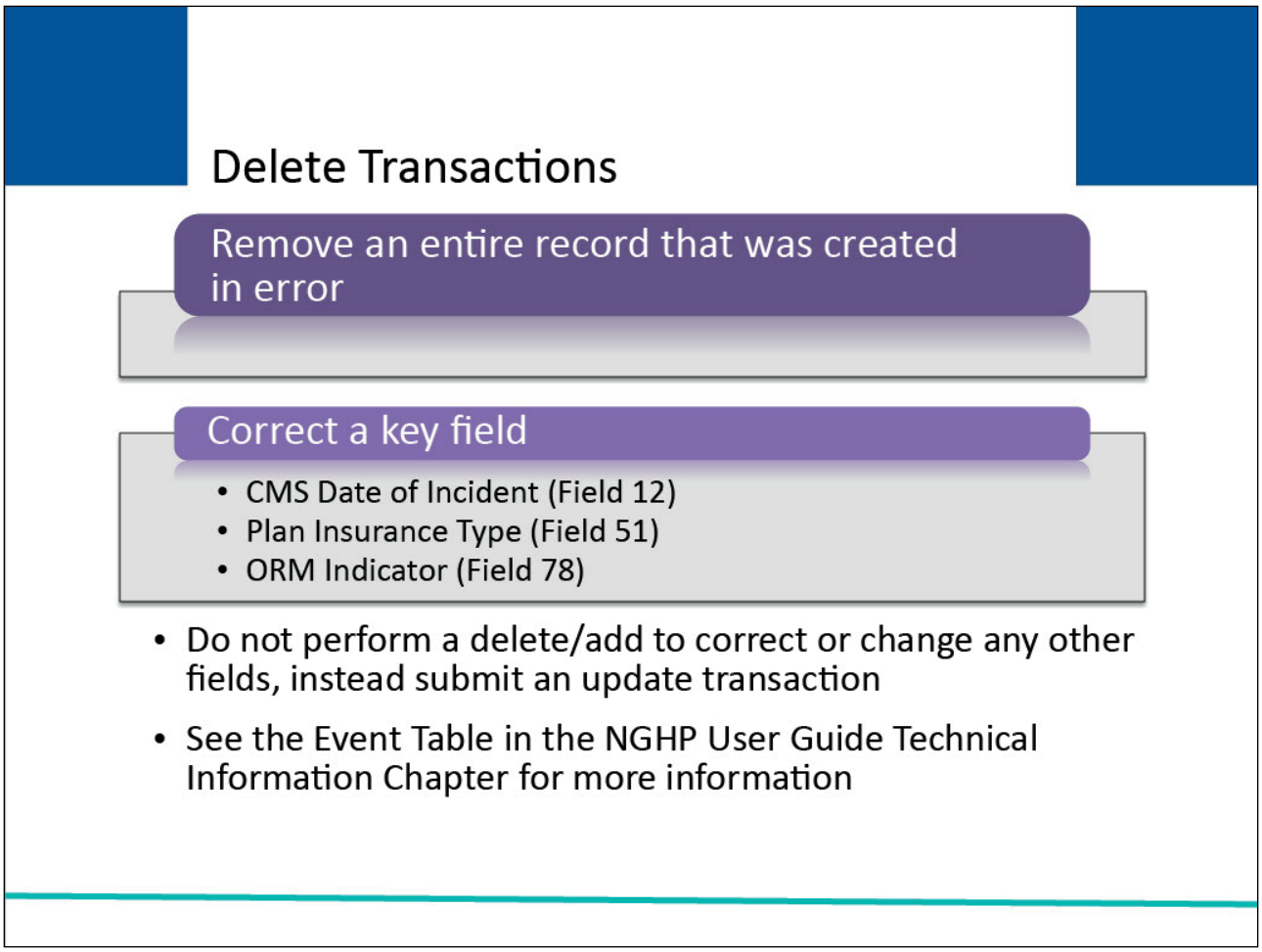
The Policy Number (Field 54) is a required data element. In the case of self-insurance where the RRE has no policy number associated with the claim, this field must be filled with all zeroes, not left blank.

Records submitted with all blanks in the Policy Number field will be rejected with the error CP04.

The policy number should be submitted with a consistent format. When sending updates, enter the policy number exactly as it was entered on the original submission, whether zeros or a full policy number.

Note: To support previous system changes, Policy Number (Field 54) has been added as a key field. If this field changes, RREs must submit a delete Claim Input File record that matches the previously accepted add record, followed by a new add record with the changed information (i.e., delete/add process).

Slide 21 of 25 - Delete Transactions

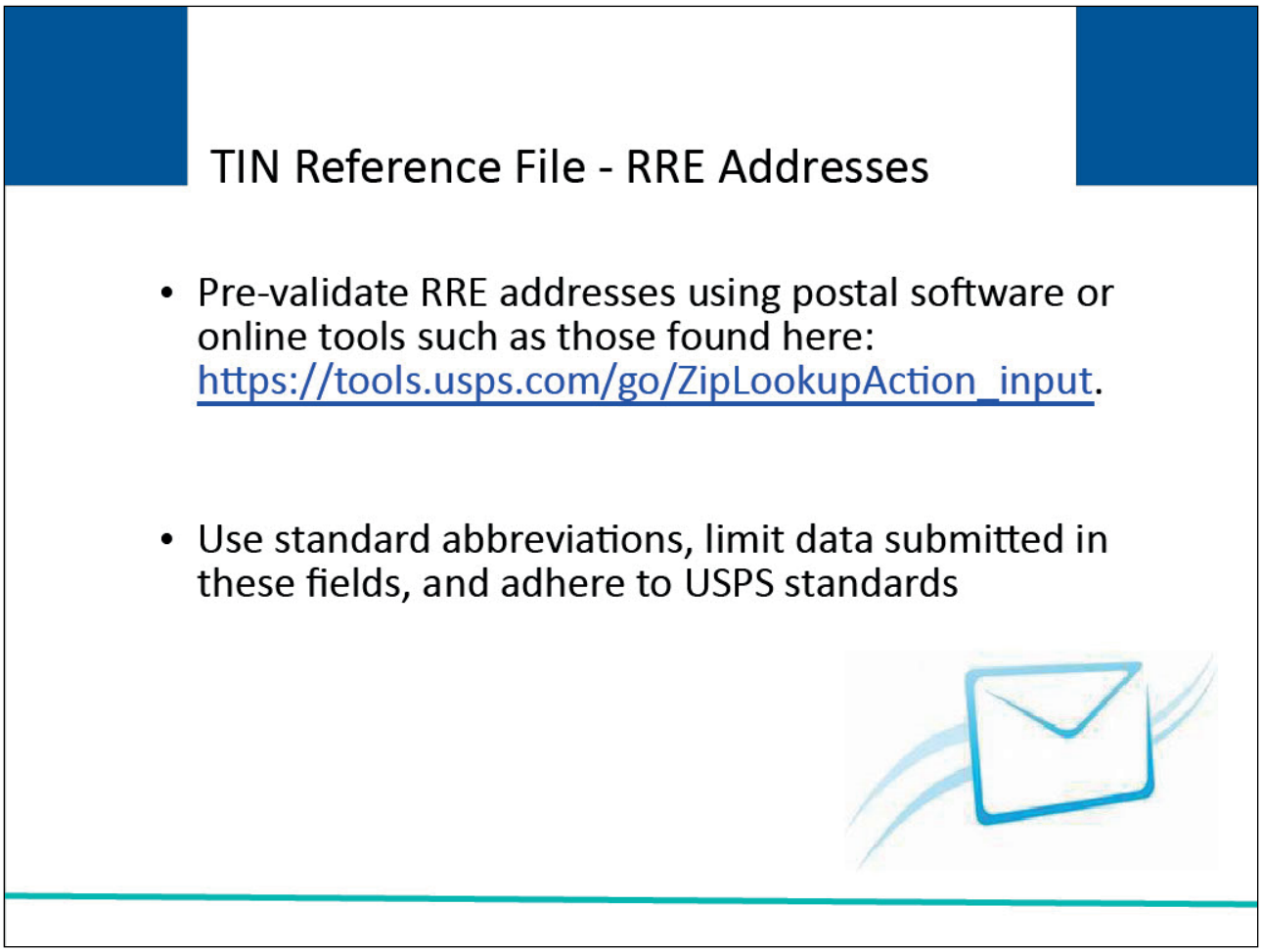


Slide notes

Delete transactions should only be submitted to remove an entire record that was created in error or to correct a key field (i.e., CMS Date of Incident (Field 12), Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51), ORM Indicator (Field 78)). Do not perform a delete/add to correct or change any other fields.

Simply submit an update transaction to correct non-key fields. For more information on this topic see the Event Table in the NGHP User Guide Technical Information Chapter.

Slide 22 of 25 - TIN Reference File - RRE Addresses



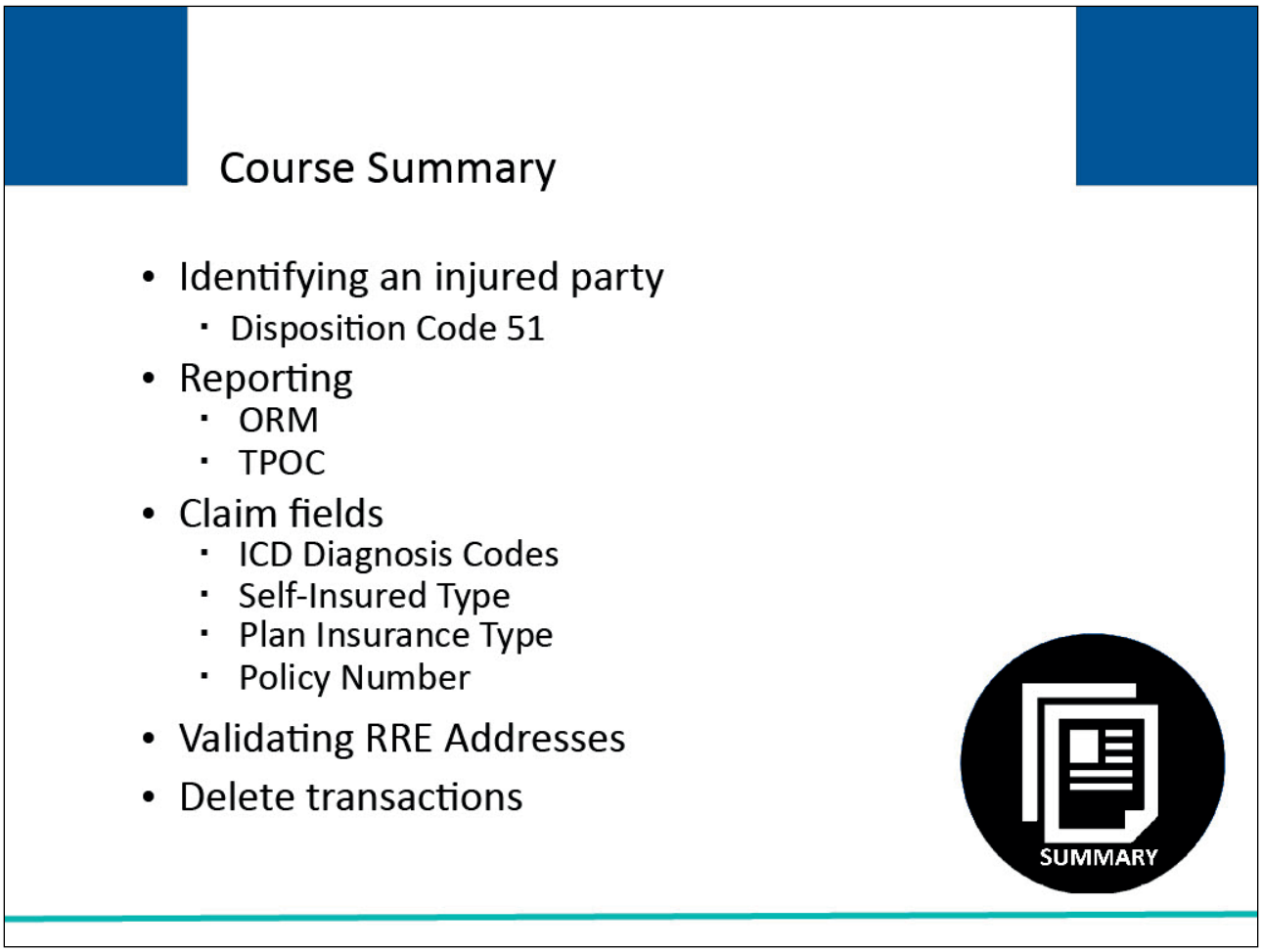
Slide notes

RREs are encouraged to pre-validate RRE addresses using postal software or online tools available on the United States Postal Service (USPS) Web site pages such as the link shown here: USPS Lookup Tool.

RREs should try to use standard abbreviations and attempt to limit data submitted in these fields and adhere to USPS standards.

The address validation enhancements in place will “scrub” addresses submitted on the TIN Reference File using USPS standards, and we recommend that RREs also attempt to meet these standards, to improve results. Although NGHP DDE reporters do not submit TIN Reference Files, they do submit the same TIN information online. It is recommended that DDE reporters also pre-validate RRE addresses.

Slide 23 of 25 - Course Summary



Slide notes

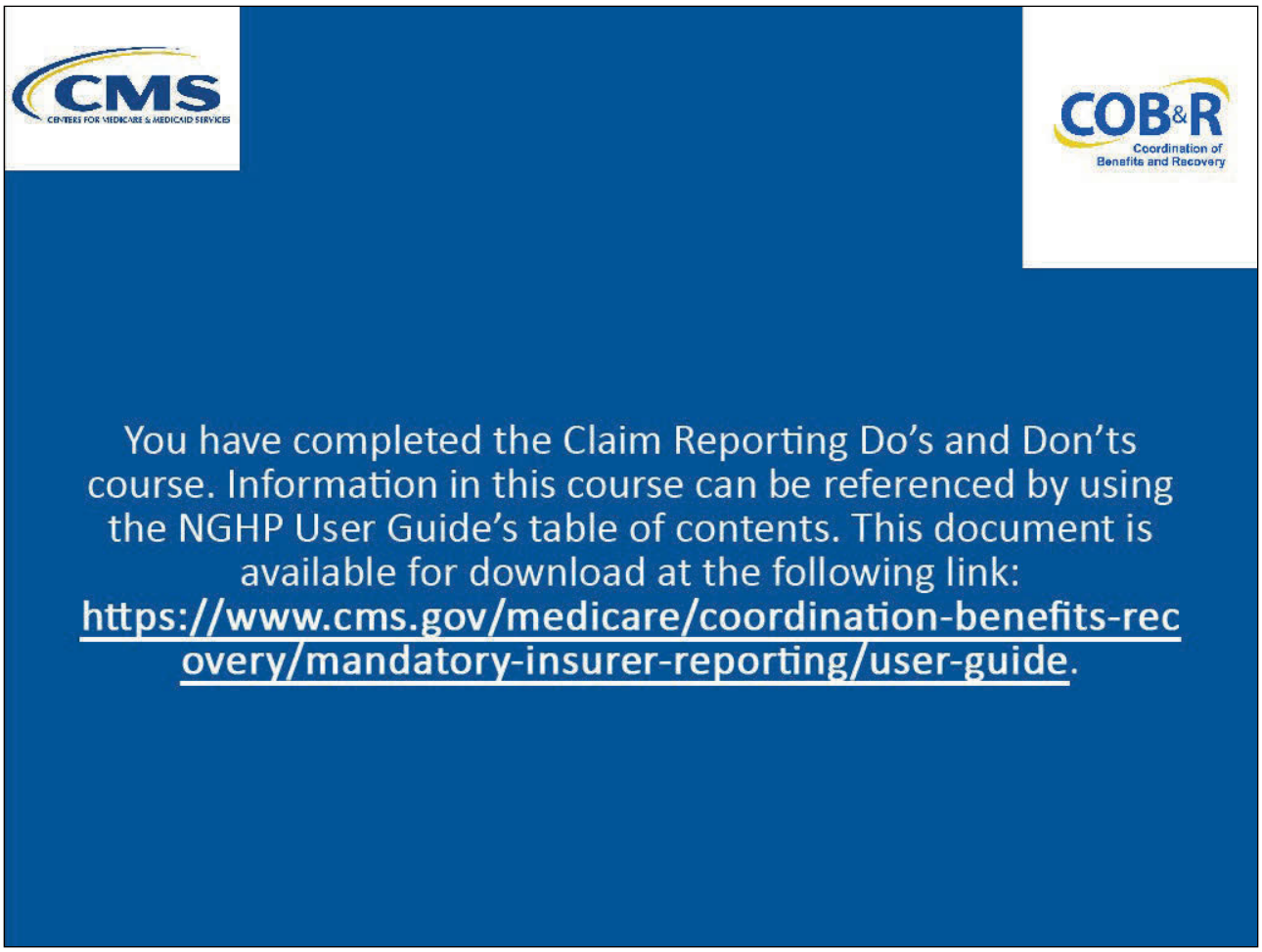
This module provides some helpful suggestions for RREs to consider when submitting Claim Input Files or providing claim information via DDE.

It includes information on:

- Identifying an injured party and Disposition Code 51
- Reporting ongoing responsibility for
  - Medicals (ORM)
  - Total Payment Obligation to Claimant (TPOC)
- Submitting certain claim fields
  - (ICD Diagnosis Codes
  - Self-Insured Type
  - Plan Insurance Type
  - Policy Number)
- The importance of validating RRE addresses

It also reviews when delete transactions should be used.

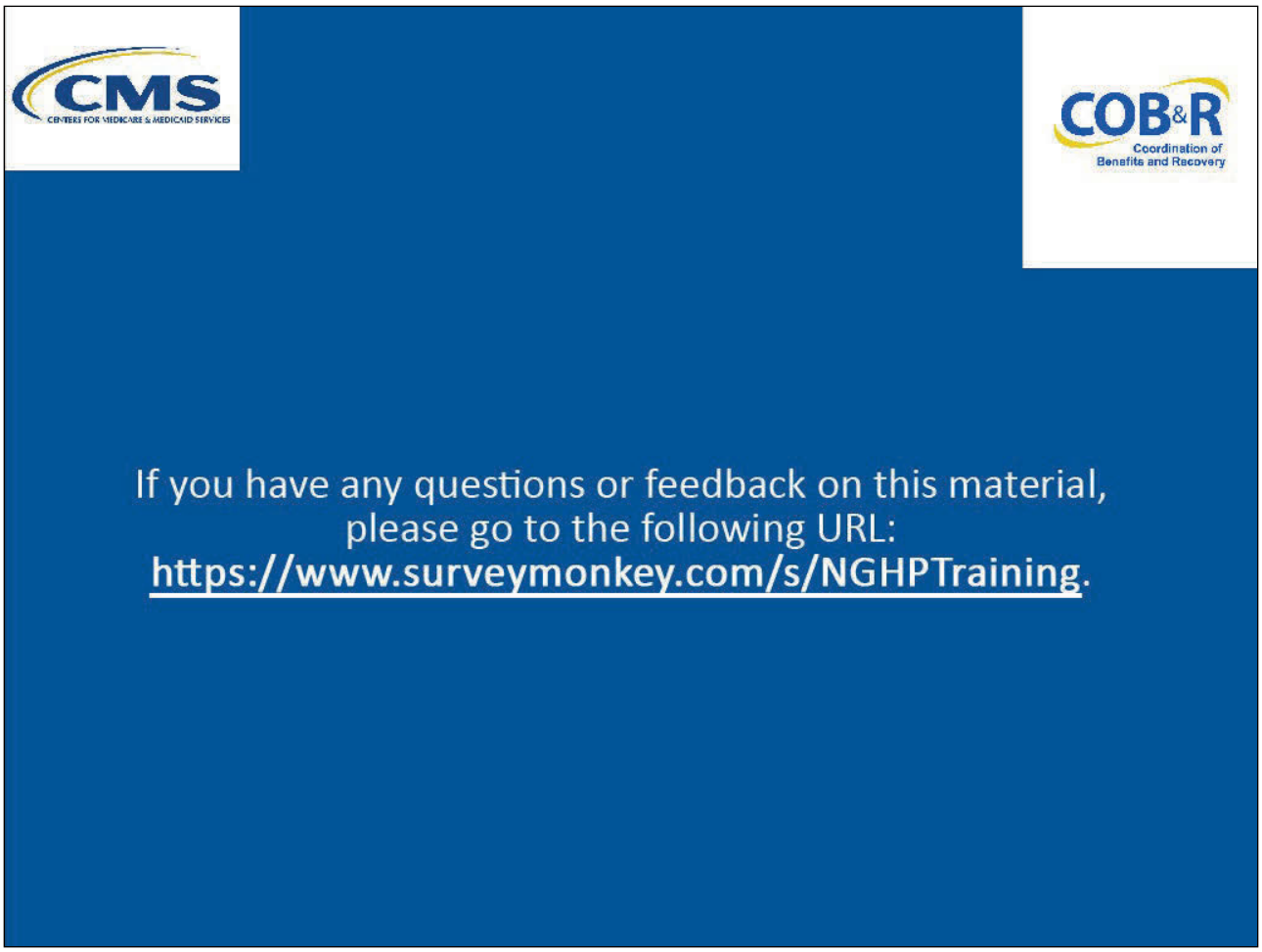
Slide 24 of 25 - Conclusion



Slide notes

You have completed the Claim Reporting Do's and Don'ts course. Information on this course can be referenced by using the NGHP User Guide's table of contents. This document is available for download at the following link: Mandatory Insurer Reporting (NGHP) | CMS.

Slide 25 of 25 - NGHP Training Survey



Slide notes

If you have any questions or feedback on this material, please go to the following URL: NGHP Training Survey.