



**MMSEA Section 111
Medicare Secondary Payer Mandatory Reporting**

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

**Chapter I:
INTRODUCTION AND OVERVIEW**

Version 7.1

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Chapter 1: Summary of Version 7.1 Updates

The updates listed below have been made to the Introduction and Overview Chapter Version 7.1 of the NGHP User Guide. As indicated on prior Section 111 NGHP Town Hall teleconferences, the Centers for Medicare & Medicaid Services (CMS) continue to review reporting requirements and will post any applicable updates in the form of revisions to Alerts and the user guide as necessary.

There are no version updates to this chapter.

Chapter 2: Introduction and Important Terms

The Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide has been written for use by all Section 111 liability insurance (including self insurance), no-fault insurance, and workers' compensation Responsible Reporting Entities (RREs). The five chapters of the user guide—referred to collectively as the “Section 111 NGHP User Guide”—provide information and instructions for the Medicare Secondary Payer (MSP) NGHP reporting requirements mandated by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173).

This **Introduction and Overview Chapter** of the MMSEA Section 111 NGHP User Guide provides an overview of Medicare, Medicare Secondary Payer (MSP), Section 111 Mandatory Insurer reporting requirements, the reporting process for Section 111, and training and education resources. The other four chapters of the NGHP User Guide (Registration Procedures, Technical Information, Policy Guidance, and the Appendices) should be referenced for more specific information and guidance on Section 111 NGHP Registration, Policy, or Technical information.

Please note that CMS continues to update and implement the Section 111 requirements. New versions of the Section 111 User Guide will be issued when necessary to document revised requirements and when additional information has been added for clarity. At times, certain information will be released in the form of an Alert document. All recent and archived alerts can be found on the Section 111 web site: <https://go.cms.gov/mirnghp>. 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 guidance 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.

All official instructions pertinent to Section 111 reporting are on the Section 111 Web Site found at: <https://go.cms.gov/mirnghp>. Please check this site often for the latest version of this guide and for other important information, such as new Alerts. In order to be notified via email of updates posted to this web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. 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 <https://www.cob.cms.hhs.gov/Section111/>.

Important Terms Used in Section 111 Reporting

The following terms are frequently referred to throughout this Guide, and are critical to understanding the Section 111 NGHP reporting process.

- Entities responsible for complying with Section 111 are referred to as “Responsible Reporting Entities” or “**RREs.**” The NGHP User Guide Policy Guidance Chapter (Section 6) has a detailed description of who qualifies as an RRE.
- Liability insurance (including self-insurance), no-fault insurance, and workers’ compensation are often collectively referred to as “**Non-Group Health Plan**” or “**NGHP**” insurance.
- **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” (medical care) associated with a claim. Typically, ORM only applies to no-fault and workers’ compensation claims. Please see the NGHP User Guide Policy Guidance Chapter III 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 or apart from ORM. A TPOC generally reflects a “one-time” or “lump sum” settlement, judgment, award, or other payment intended to resolve or partially resolve a claim. It is the dollar amount of the total payment obligation to, or on behalf of, the injured party in connection with the settlement, judgment, award, or other payment.
- CMS defines the **Date of Incident (DOI)** as follows:
 - The date of the accident (for an automobile or other accident);
 - The date of first exposure (for claims involving exposure, including; occupational disease, or any associated cumulative injury);
 - The date of first ingestion (for claims involving ingestion);
 - The date of the implant or date of first implant, if there are multiple implants (for claims involving implant(s); or
 - 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 a medical practitioner (for claims involving cumulative injury).

This CMS definition differs from the definition of that generally used by the insurance industry under specific circumstances. For the DOI used by the insurance and workers’ compensation industry, see Field 13 of the Claim Input File Detail Record in the NGHP User Guide Appendices, Chapter V.

Chapter 3: Medicare Entitlement, Eligibility, and Enrollment

This section provides a general overview of Medicare entitlement, eligibility and enrollment. Please refer to <https://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 (ESRD - 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.

Chapter 4: MSP Overview

Medicare Secondary Payer (MSP) is the term used when the Medicare program does not have primary payment responsibility—that is, when 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 (and subsequent amendments), Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation. An insurer or workers’ compensation plan cannot, by contract or otherwise, supersede federal law, as by alleging its coverage is “supplemental” to Medicare.

The coverage data collected through Section 111 reporting is used by CMS in processing claims billed to Medicare for reimbursement for items and services furnished to Medicare beneficiaries, and for MSP recovery efforts. Medicare beneficiaries, insurers, self-insured entities, recovery agents, and attorneys, are always responsible for understanding when there is coverage primary to Medicare, for notifying Medicare when applicable, and for paying appropriately.

Section 111 reporting is a comprehensive method for obtaining information regarding situations where Medicare is appropriately a secondary payer. It does 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 any conditional payments made by Medicare within 60 days of receipt of such settlement, judgment, award, or other payment. The Section 111 reporting requirements do not eliminate this obligation.)

4.1 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 the NGHP User Guide Appendix Chapter V (Appendix I) is critical.

Additional information can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. The MSP Manual is CMS Publication 100-05. Chapter 1 can be found at <https://www.cms.gov/manuals/downloads/msp105c01.pdf>.

4.2 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."

Entities and individuals engaged in a business, trade, or profession are self-insured if they have not purchased liability insurance coverage. This includes responsibility for deductibles. See the NGHP User Guide Appendices Chapter V for the full CMS definition of "self-insurance."

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" (PIP), 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.

4.3 Workers’ Compensation

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. Workers’ compensation is a law or plan that compensates employees who get sick or injured on the job. Most employees are covered under workers’ compensation plans.

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 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” with regard to workers’ compensation.)

4.4 Role of the BCRC and CRC

The purpose of Medicare’s Coordination of Benefits (COB) process is to identify primary payers to Medicare for the health benefits available to Medicare beneficiaries and to coordinate the payment process to prevent the mistaken or unnecessary payment of Medicare benefits, including conditional payments. The Benefits Coordination & Recovery Center (BCRC) consolidates the activities that support the collection, management, and reporting of other insurance or workers’ compensation coverage for Medicare beneficiaries. The BCRC updates the

CMS systems and databases used in the claims payment and recovery processes. It does not process claims or answer claims-specific inquiries.

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

In situations where Medicare is seeking reimbursement from the beneficiary, the BCRC is also 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.

The Commercial Repayment Center (CRC) is responsible for the recovery of conditional payments where a liability insurer (including a self-insured entity), no-fault insurer, or workers' compensation entity has assumed ORM and is the identified debtor. For more information on NGHP recovery, see the NGHP recovery page: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Non-Group-Health-Plan-Recovery.html>.

Chapter 5: 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, and 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 were 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 the NGHP User Guide Appendices Chapter V. Section 111 authorizes CMS' implementation of the required reporting by program instruction or otherwise. All implementation instructions, including this user guide, are available on (or through a download at) CMS' dedicated web page: <https://go.cms.gov/mirnghp>.

Section 111:

- Adds reporting rules; it does not eliminate any existing statutory provisions or regulations.
- Does not eliminate CMS' existing processes, including CMS' process for self-identifying pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation claims to CMS' Benefits Coordination & Recovery Center (BCRC) or the processes for Non-Group Health Plan MSP recoveries, where appropriate.
- Includes penalties for noncompliance.

Who Must Report:

- An applicable plan.
- 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.
- 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 are 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. See detailed information in the NGHP User Guide Technical Information Chapter IV.

Note: To determine if you are an RRE, you must use the applicable statutory language in conjunction with <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Archive/Downloads/SupportingStatement082808.pdf>. Attachment A of the PRA is also available in the NGHP User Guide Appendices, Chapter V. See either of these appendices in order to determine if you are an RRE for purposes of these provisions. The statutory language, the PRA Notice and the PRA Supporting Statement with Attachments are all available as downloads at: <https://go.cms.gov/mirnghp>.

Chapter 6: Process Overview

Purpose: 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. Section 111 reporting helps CMS determine primary versus secondary payer responsibility—that is, which health insurer pays first, which pays second, and so on. A more detailed explanation of Section 111 related legislation, MSP rules, and the structure of the Section 111 reporting process is provided in the NGHP User Guide Policy Guidance Chapter.

Section 111 RREs: Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities, or “RREs.” Section 111 requires RREs to submit information specified by the Secretary of Health and Human Services (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. For Section 111 reporting, RREs are required to 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, or their designated reporting agents, and the CMS Benefits Coordination & Recovery Center (BCRC). The BCRC manages the technical aspects of the Section 111 data submission process for all Section 111 RREs.

Querying for Medicare eligibility: RREs must be able to determine whether an injured party is a Medicare beneficiary, and gather the information required for Section 111 reporting. CMS allows RREs that are file submitters to submit a *query* to the BCRC to determine the Medicare status of the injured party prior to submitting claim information for Section 111 reporting. The query record must contain the injured party’s Social Security Number (SSN) or Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]), name, date of birth and gender. When submitting an SSN, RREs may enter a partial SSN. To do this, enter spaces for the first 4 positions followed by the last 5 digits of the SSN so that the field is populated with the required 9 characters.

On the query response record, the BCRC will provide information on whether the individual has been identified as a Medicare beneficiary based upon the information submitted and if so, provide the Medicare ID (and other updated information for the individual) found on the Medicare Beneficiary Database (MBD). The reason for Medicare entitlement, and the dates of Medicare entitlement and enrollment (coverage under Medicare), are not returned on the query file response.

Note: With DDE, the separate query function is not available. Instead, with the DDE application, the RRE will learn, in real time, whether an injured party is a Medicare beneficiary when the RRE enters the injured party information (i.e., Medicare ID or SSN, first name, last name, date of birth and gender) on-line on the DDE Injured Party Information screen. Note: RREs may enter a partial SSN on the DDE page. To do this, enter the last 5 digits of the SSN. Leading spaces are not required.

What should be submitted?: For purposes of NGHP data submissions, the term “**claim**” has a specific reference. It is used to signify the overall compensation claim for liability insurance (including self-insurance), no-fault insurance or workers’ compensation, rather than a single (or disaggregated) claim for a particular medical service or item. NGHP claim information is to be submitted where the injured party is a Medicare beneficiary and payments for medical care (“medicals”) are claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals.

Website: The BCRC maintains an application on the Section 111 COB Secure Website (the COBSW) for Section 111 processing. Its URL is: <https://www.cob.cms.hhs.gov/Section111/>. Please see Chapter 7 of this guide for a more thorough explanation of this website and instructions on how to obtain the Section 111 COBSW User Guide.

Data Submission Method: RREs may choose to submit claim information through either:

- An electronic file exchange, **OR**
- A manual direct data entry (DDE) process using the Section 111 COBSW (if the RRE has a low volume of claim information to submit).

More information on data exchange options can be found in the NGHP User Guide Technical Information Chapter IV.

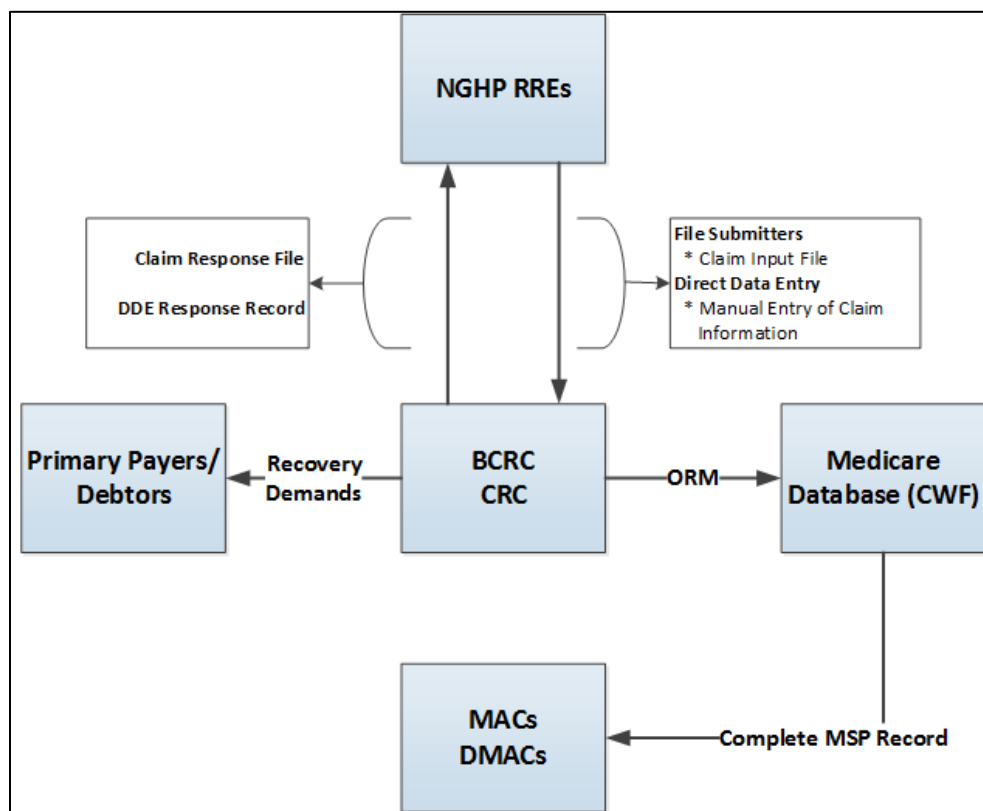
RREs who select an electronic file submission method must first fully test the file exchange process. RREs who select the DDE submission method will not perform testing. More information on the testing process can be found in the NGHP User Guide Technical Information Chapter IV.

When the BCRC has cleared an RRE for “production” input file submissions, the RRE 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 the NGHP User Guide Policy Guidance Chapter III. 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 the NGHP User Guide Policy Guidance Chapter III. 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 *Special Qualified Reporting Exception for ORM...* in the NGHP User Guide Policy Guidance, Chapter III).

Ongoing DDE and quarterly file submissions are to contain only new or changed claim information using add, update and delete transactions. Detailed specifications for the Section 111 reporting process are provided in the NGHP User Guide Technical Information Chapter IV.

Data Exchange Process

Figure 6-1 illustrates the Data Exchange process. A narrative description of this process directly follows the figure.

Figure 6-1: Electronic File/DDE Submission Process

- RREs that are file submitters electronically transmit their Claim Input File to the BCRC. RREs that are using DDE will manually enter and submit their claim information to the BCRC one claim report at a time using an interactive web application on the Section 111 COBSW.
- The BCRC processes the data in the *input file/DDE submission* by editing the incoming data and determining whether or not the submitted information identifies the injured party as a Medicare beneficiary.
- If the submitted claim information passes the BCRC edit process and is applicable to Medicare coverage, insurance information for Medicare beneficiaries derived from the input file is posted to other CMS databases (e.g., the Common Working File).
 - The BCRC and the CRC help protect the Medicare Trust Fund by identifying and recovering Medicare payments that should have been paid by another entity as the primary payer as part of an NGHP claim which includes, but is not limited to, liability insurance (including self-insurance), no-fault insurance, and workers' compensation. The Primary Payers/Debtors receive recovery demands advising them of the amount of money owed to the Medicare program.
 - The Common Working File (CWF) is a Medicare application that maintains all Medicare beneficiary information and claim transactions. The CWF receives information regarding claims reported with ORM so that this information can be used by other Medicare contractors (A/B MACs) and (DME MACs) for claims processing, to ensure Medicare pays secondary when appropriate.

When the data processing by the BCRC is completed, or the prescribed time limit for sending a response has been reached, the BCRC electronically transmits a response file to RREs using the file submission process, or a response on the DDE Claims Listing page for RREs using DDE. The response will include information on any errors found, disposition codes that indicate the results of processing, and MSP information as prescribed by the response format.

RREs must take the appropriate action, if any, based on the response(s) received.

Detailed specifications for the Section 111 reporting process are provided in the NGHP User Guide Technical Information Chapter IV.

Chapter 7: Section 111 COB Secure Website (COBSW)

The BCRC maintains an application on the Section 111 COB Secure Website (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 <https://www.cob.cms.hhs.gov/Section111/>.

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. Obtain login IDs and assign users for Section 111 RRE ID COBSW accounts.
- Exchange files via HTTPS or SFTP directly with the BCRC. 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.
- Opt in to receive a monthly Unsolicited Alerts Response File when submitted ORM records are updated by others (as of July, 2023).
- 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 the NGHP User Guide Registration Procedures Chapter II.

Sources of Help Related to Using the Section 111 COBSW

To access the Section 111 COBSW, go to <https://www.cob.cms.hhs.gov/Section111/> using your Internet browser. Once you click on the **I Accept** link and accept the terms of the Login Warning, the home page will display.

- Information on the New Registration, Account Setup, and other processes can be found under the *How To* menu at the top of the home page. A login ID is not needed to access this menu option. Click on the drop-down menu a 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 home page. 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 user guide. The following are additional documents that are only available to NGHP RREs after login:
 - Test Beneficiary Data
 - Excluded ICD-9 Diagnosis Code Data
 - Excluded ICD-10 Diagnosis Code Data
 - Error Code Data
 - HEW Software Download
- **Computer-Based Training (CBT) modules** for the Section 111 application on the COBSW are available free of charge to RREs and their agents. These courses are all available on the Mandatory Insurer Reporting (NGHP) [Training Material](#) page on the CMS web site. Contact your assigned EDI Representative for additional help and assistance using the COBSW. See Section 8.1 for more information.

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 SFTP (See the NGHP User Guide Technical Information Chapter IV). 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 the NGHP User Guide Registration Procedures Chapter II).

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 the NGHP User Guide Registration Procedures Chapter II 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 they add you as an Account Designee. You will receive an email 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 the NGHP User Guide Registration Procedures Chapter II, 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 BCRC 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 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 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 Section 111 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 Section 111 COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use 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 personal information.
- Can remove themselves from the RRE ID.
- 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.

COBSW Maintenance

Routine maintenance on the COBSW and Section 111 SFTP server is typically performed during the third weekend of each month as needed. However, bulletins will be posted to the COBSW Login screen to notify RREs of any changes to scheduled maintenance. 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).

Best Practices

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 log in to CMS resources.

System-Generated Emails

The emails shown in the following table are generated by the system to the Authorized Representative and/or Account Manager for the RRE ID. Emails will be sent from cobva@section111.cms.hhs.gov. Please do not reply to this email address as replies are not monitored by the BCRC. If additional information or action is needed, please contact your EDI Representative directly.

Table 7-1: Email Notification Table

Email Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	<p>Sent within 10 business days upon completion of the Account Setup step on the Section 111 COBSW. Includes attachment with profile report. The RRE's Authorized Representative must review, sign and return the profile report to the BCRC within 30 days. If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status.</p> <p>Note: It is recommended that RREs return their signed profile report via email to: their assigned EDI Representative. Do not return signed profile reports to the COBVA email address from which it had initially been received. When returning this via email, ensure that the profile report is a scanned copy of the document with a wet signature (i.e., an original signature is included on the profile report).</p>
Non-Receipt of Signed Profile Report	Authorized Representative, Account Manager	Generated 30 days after the profile report email if a signed copy of the profile report has not been received at the BCRC. The Authorized Representative for the RRE ID must sign and return the profile report. If another copy is needed, contact your EDI Representative.
Successful File Receipt	Account Manager	Sent after an input file has been successfully received but not yet processed at the BCRC. Informational only. No action required. Subsequent emails 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 email may be ignored if you have nothing to report for the quarter.
Threshold Error	Account Manager	Sent after the Successful File Receipt email when an input file has been suspended for a threshold error. Contact your EDI Representative to resolve.

Email Notification	Recipient	Purpose
Severe Error	Account Manager	Sent after the Successful File Receipt email 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 BCRC. 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 BCRC has completed processing on an input file and the response file is available.
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 email will contain a 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.

Chapter 8: Customer Service and Reporting Assistance for Section 111

Please be sure to visit the Section 111 page on the CMS web site at <https://go.cms.gov/mirnghp> frequently for updated information on Section 111 reporting requirements including updates to this guide. In order to be notified via email of updates to this web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the *Related Links* section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP *What's New* page.

The Section 111 Resource Mailbox, at PL110-173SEC111-comments@cms.hhs.gov, is a vehicle that Responsible Reporting Entities (RREs) may use to send CMS policy-related questions regarding the Medicare Secondary Payer (MSP) reporting requirements included in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. RREs are requested to send only policy-related questions to the Section 111 Resource Mailbox. If an RRE has a technical question, and if you are unable to contact your Electronic Data Interchange (EDI) Representative, for any reason, call the EDI Hotline at (646) 458-6740. If you have not registered to become an RRE, please directly contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627.

Please note that emails from CMS or the BCRC 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 email addresses.

8.1 Electronic Data Interchange (EDI) Representative

After you register for Section 111 reporting, you will be assigned an 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 the COBSW screens after completion of the New Registration portion of the registration process and will also be included within your profile report which is generated upon completion of the Account Setup step of the registration process. Your profile report is sent to the RRE's Authorized Representative and Account Manager via email after the account set up has been completed.

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

8.2 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 BCRC.** 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 EDI Department number at 646-458-6740 for assistance.

Escalation Process

The CMS and the BCRC 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 BCRC Management can address and prioritize issues appropriately.

1. Contact your EDI Representative at the BCRC. If you have not yet been assigned an EDI Representative, please call the EDI Department number at 646-458-6740 for assistance.
2. If your Section 111 EDI Representative does not respond to your inquiry or issue within **two business days**, you may contact the EDI Director, Angel Pagan, at 646-458-2121. Mr. Pagan's email is apagan@ehmedicare.com.
3. If the EDI Director does not respond to your inquiry or issue within **one business day**, you may contact the BCRC Project Director, Jim Brady, who has overall responsibility for the EDI Department and technical aspects of the Section 111 reporting process. Mr. Brady can be reached at 646-458-6682. His email address is JBrady@ehmedicare.com. Please contact Mr. Brady only after attempting to resolve your issue following the escalation protocol provided above.

Chapter 9: Training and Education

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

- CMS Publications—The Section 111 CMS web page (<https://go.cms.gov/mirnghp>) has 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 email of updates to this web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP *What's New* page.
- Section 111 Teleconferences—CMS conducts Town Hall Teleconferences to provide information and answer questions 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 What's New tab at <https://go.cms.gov/mirnghp>.
- Free Computer Based Training (CBT) Courses—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, DDE and general MSP topics. These courses are all available on the Mandatory Insurer Reporting (NGHP) [Training Material](#) page on the CMS web site.
- All updated Section 111 policy guidance published in the form of an Alert can be found on the CMS web page (<https://go.cms.gov/mirnghp>). Any Alert posted after the date of the currently published user guide supersedes the applicable language in the user guide. All Alerts 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.

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 their 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:

- [Medicare Secondary Payer](#) website
- [Workers' Compensation Medicare Set Aside Arrangements](#) website
- [Internet-Only Manuals \(IOMs\)](#) website (MSP Manual is CMS Publication 100-05)

Chapter 10: Checklist—Summary of Steps to Register, Test and Submit Production Files

The following summarizes the steps needed to participate in the reporting process for Section 111. Reference the Registration Procedures, Technical Information, and Policy Guidance sections for more detailed instruction.

Before you begin, determine the following:

- Individuals who will be the RRE's Authorized Representative, Account Manager and Account Designees.
- Whether reporting agents will be used.
- 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.
- 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 BCRC via the CMS Extranet and CMSNet, and create transmission jobs and datasets.

Register and set up your account:

- 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 email (within 10 business days after registration is complete) indicating your registration and account setup were accepted by the BCRC.

Once you successfully register:

- The RRE's Authorized Representative must approve the account setup, by physically signing the profile report, which includes the Data Use Agreement, and returning it to the BCRC within 30 days.

If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status. Note: It is recommended that RREs return their signed profile via email to their assigned EDI Representative. Do not return signed profile reports to the COBVA email address from which it had initially been received. When returning this via email, ensure that the profile report is a scanned copy of the document with a wet signature (i.e., an original signature is included on the profile report).

- 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 BCRC.

- 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).
- Confirm via email that the information on the annual profile report is correct. Failure to confirm this information may result in deactivation of the RRE ID.

Submit your quarterly Claim Input File during your assigned submission periods (ongoing):

- 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. The system requires you to change your password every 60 days.
- Monitor automated emails generated by the system regarding file processing status. These emails are sent to the Account Manager for the RRE ID who should forward these emails 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.



**MMSEA Section 111
Medicare Secondary Payer Mandatory
Reporting**

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

**Chapter II:
REGISTRATION PROCEDURES**

Version 7.1

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Chapter 1: Summary of Version 7.1 Updates

The update listed below has been made to the Registration Procedures Chapter Version 7.1 of the NGHP User Guide. As indicated on prior Section 111 NGHP Town Hall teleconferences, the Centers for Medicare & Medicaid Services (CMS) continue to review reporting requirements and will post any applicable updates in the form of revisions to Alerts and the user guide as necessary.

There are no version updates to this chapter.

Chapter 2: Introduction

The Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide has been written for use by all Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation Responsible Reporting Entities (RREs). The five chapters of the user guide—referred to collectively as the “Section 111 NGHP User Guide”—provides information and instructions for the MSP NGHP reporting requirements mandated by Section 111.

This **Registration Procedures Chapter** of the MMSEA Section 111 NGHP User Guide provides detailed information on the Section 111 registration process including the purpose of registering, the registration and account setup requirements, registration timeframes, the five steps of the Section 111 registration and account set up, and information on the steps Responsible Reporting Entities (RREs) must take if changes occur after their initial Section 111 registration is completed. The other four chapters of the NGHP User Guide: Introduction and Overview, Policy Guidance, Technical Information, and Appendices should be referenced as needed, for applicable guidance.

Please note that CMS continues to update and implement the Section 111 requirements. New versions of the Section 111 User Guide will be issued when necessary to document revised requirements and when additional information has been added for clarity. At times, certain information will be released in the form of an Alert document. All recent and archived alerts can be found on the Section 111 web site: <https://go.cms.gov/mirnghp> 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 guidance 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.

All official instructions pertinent to Section 111 reporting are on the Section 111 web site found at: <https://go.cms.gov/mirnghp>. Please check this site often for the latest version of this guide and for other important information, such as new Alerts. In order to be notified via email of updates posted to this web page, click the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. Additional information related to Section 111 can be found on the login page at <https://www.cob.cms.hhs.gov/Section111/> of the Section 111 Coordination of Benefits Secure Web Site (COBSW).

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

Chapter 3: Process Overview

Purpose: 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. Section 111 reporting helps CMS determine primary versus secondary payer responsibility—that is, which health insurer pays first, which pays second, and so on. A more detailed explanation of Section 111-related legislation, MSP rules, and the structure of the Section 111 reporting process is provided in the NGHP User Guide Chapter III, Policy Guidance.

Section 111 RREs: Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities, or “RREs”. Section 111 requires RREs to submit information specified by the Secretary of Health and Human Services (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. For Section 111 reporting, RREs are required to 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, or their designated reporting agents, and the CMS Benefits Coordination & Recovery Center (BCRC). The BCRC manages the technical aspects of the Section 111 data submission process for all Section 111 RREs.

Querying for Medicare eligibility: RREs must be able to determine whether an injured party is a Medicare beneficiary, and gather the information required for Section 111 reporting. CMS allows RREs that are file submitters to submit a *query* to the BCRC to determine the Medicare status of the injured party prior to submitting claim information for Section 111 reporting. The query record must contain the injured party’s Social Security Number (SSN) or Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier (MBI), name, date of birth and gender. When submitting an SSN, RREs may report a partial SSN. To do this, enter spaces for the first 4 positions followed by the last 5 digits of the SSN so that the field is populated with the required 9 characters.

On the query response record, the BCRC will provide information on whether the individual has been identified as a Medicare beneficiary based upon the information submitted and if so, provide the Medicare ID (and other updated information for the individual) found on the Medicare Beneficiary Database (MBD). Beneficiary Part C (Medicare Advantage Plan) and Part D (Medicare prescription drug coverage) enrollment information will be provided for the past 3 years (up to 12 instances), as well as the most recent Part A and Part B entitlement dates.

Note: DDE reporters can use the Beneficiary Lookup function on the Section 111 COBSW. They will also learn, in real time, whether an injured party is a Medicare beneficiary during the reporting process.

What should be submitted?: For purposes of NGHP data submissions, the term “**claim**” has a specific reference. It is used to signify the overall compensation claim for liability insurance (including self-insurance), no-fault insurance or workers’ compensation, rather than to a single

(or disaggregated) claim for a particular medical service or item. NGHP claim information is to be submitted where the injured party is (or was) a Medicare beneficiary and payments for medical care (“medicals”) are claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals.

Note: Records will be accepted up to 3 months before the MSP effective date.

Website: The BCRC maintains an application for Section 111 processing at <https://www.cob.cms.hhs.gov/Section111/> on the Section 111 COB Secure Website (the COBSW).

Please see Chapter 6 of this guide for a more thorough explanation of this website and instructions on how to obtain the Section 111 COBSW User Guide.

Data Submission Method: RREs may choose to submit claim information through either:

- An electronic file exchange, **OR**
- A manual direct data entry (DDE) process using the Section 111 COBSW (if the RRE has a low volume of claim information to submit).

More information on data exchange options can be found in the NGHP User Guide Technical Information Chapter IV.

RREs who select an electronic file submission method must first fully test the file exchange process. RREs who select the DDE submission method will not perform testing. More information on the testing process can be found in the NGHP User Guide Technical Information Chapter IV.

When the BCRC has cleared an RRE for “production” input file submissions, the RRE 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 the NGHP User Guide Policy Guidance Chapter (Section 6.4). 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 the NGHP User Guide Policy Guidance Chapter III. 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 *Special Qualified Reporting Exception for ORM...* in the NGHP User Guide Policy Guidance Chapter III).

Ongoing DDE and quarterly file submissions are to contain only new or changed claim information using add, update and delete transactions. Detailed specifications for the Section 111 reporting process are provided in the NGHP User Guide Technical Information Chapter IV.

Chapter 4: Registration and Account Setup

4.1 Overview

In order to comply with the requirements of Section 111 of the MMSEA, Responsible Reporting Entities (RREs) are required to provide notification to the Benefits Coordination & Recovery Center (BCRC) of their intent to report data by registering on the Section 111 COBSW. Each applicable RRE must complete the registration process regardless of whether an agent will be submitting files on that entity's behalf. An agent cannot complete the initial registration; however the agent can complete the RRE's account setup and may also be the Account Manager. Registration and account setup must be completed on the Section 111 COBSW (<https://www.cob.cms.hhs.gov/Section111/>).

Registration **by the RRE** is required and must be completed before testing between the RRE (or its agent) and the BCRC can begin or before reporting via DDE may commence. Through the registration process, the BCRC will obtain the information needed to the following:

- Validate information provided by the RRE registrant.
- Identify the method (file submission or DDE) an RRE will use to submit claim information.
- Assign a Section 111 Responsible Reporting Entity Identification Number (RRE ID).
- 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 file transfer mechanisms.
- Assign an Electronic Data Interchange (EDI) Representative to each entity to assist with ongoing communication, use of the Section 111 COBSW and data exchange.
- Assign login IDs to individual users associated with each RRE ID account.

Registration Timeframes

- Potential Section 111 RREs are not required to register if they will have nothing to report for purposes of the Section 111 liability insurance (including self-insurance), no-fault insurance, or workers' compensation.
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.
- Section 111 RREs must register in time for a full quarter of testing if they have future situations where they have a reasonable expectation of having to report (including those who do not register initially because they have no expectation of having claims to report).
- The registration process will remain available indefinitely for existing and new RREs:
 - To alter your reporting structure if needed

- To request additional RRE IDs in the future if changes in your business operations require changes in your data reporting requirements.

Note: If you have registered for an RRE ID that you later determine you will not need or no longer use, contact your EDI Representative to have it deactivated.

For those RREs that will be submitting claim information via a file (File Submitters):

- Must complete registration before testing may begin.
- Once testing is complete and the RRE ID is set to a production status, the RRE: Must submit a Claim Input File once per quarter during the assigned file submission timeframe for each RRE ID (if there is new or changed information to report). May, but are not required to, submit an empty quarterly Claim Input File if there is no new information to report.

For those RREs that will be submitting claim information via direct data entry (DDE Submitters):

- Must complete registration before reporting may begin.
- Will not perform testing.
- Must submit claim information via the Section 111 COBSW. Although DDE submitters will not have an assigned window for reporting claim reports, claim information must still be submitted within 45 calendar days of the Total Payment Obligation to Claimant (TPOC) or assumption/termination of ongoing responsibility for medicals (ORM).

Accessing Additional Tools

For additional information on New Registration, Account Setup, and other process:

1. Go to the COBSW URL: <https://www.cob.cms.hhs.gov/Section111/>.
2. Click the **I Accept** link and accept the terms of the *Login Warning*. The home page will display.
3. The following *Help* pages can be found under the *How To* menu option at the top of the page, whether before or after clicking the “I Accept” link and proceeding to the login page. Click the *How To* drop-down menu to display the list, then click the item you want to access. A login ID is not needed to access this menu option.
 - How to Get Started
 - How to Request Your Login ID
 - How to Request Your Password
 - How to Change Your Password
 - How to Reset Your PIN
 - How to Change Your Authorized Representative
 - How to Change Your Account Manager
 - How to Invite Designees
 - How to Change Your File Transmission Method

In particular, please read the documents found under **How to Get Started** and **How to Invite Account Designees**.

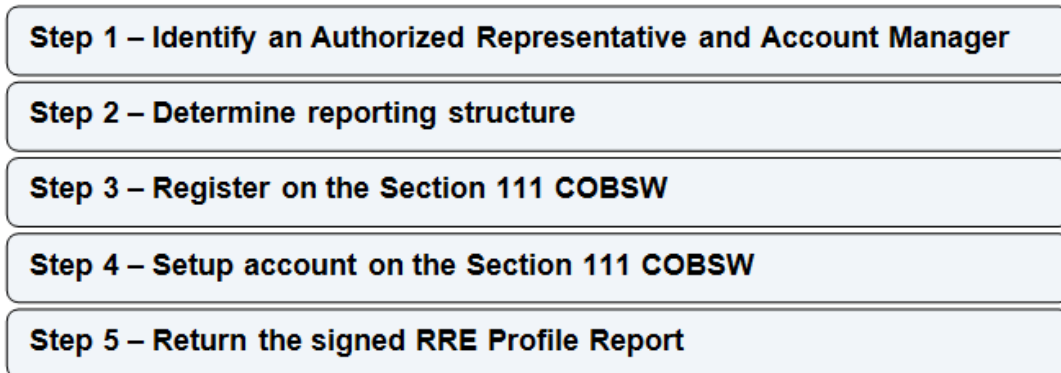
Once you have begun the registration process on the Section 111 COBSW, you will have access to *Help* information on each page displayed. By clicking on the link for the Help page, a new window will open with instructions and information needed to complete the page you are working on.

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.

4.2 Process

The following illustrates the five steps in the Section 111 registration and account setup process. A thorough description of each step follows.

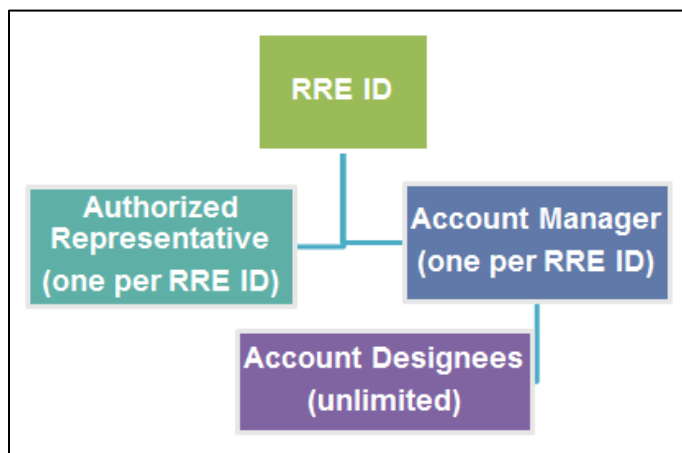
Figure 4-1: Section 111 Registration and Account Setup Process



4.2.1 Step 1: Identify an Authorized Representative and Account Manager

The first step in the registration and account setup process is to identify an Authorized Representative and an Account Manager. Each RRE ID can have only one designated Authorized Representative and one Account Manager. The Account Manager can then register other Section 111 COBSW users, known as Account Designees, who are associated with the RRE's account (Figure 4-2).

Figure 4-2: RRE ID Role Structure Example



Authorized Representative

The Authorized Representative is the individual in the RRE organization who has the legal authority to bind the organization to 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. The person named as the Authorized Representative cannot be a user of the Section 111 COBSW for any RRE ID nor can they be an agent for the RRE.

If you need to change your Authorized Representative after completing the New Registration step, you must contact your assigned EDI Representative. Please refer to the Data Use Agreement in Chapter 5 to make sure the person you name as your Authorized Representative has the authority to sign this agreement.

The Authorized Representative Responsibilities are listed in Table 4-1.

Table 4-1: Account Representative Responsibilities

Type	Description
Preliminary	<ul style="list-style-type: none"> • 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 return it to the BCRC.
Ongoing	<ul style="list-style-type: none"> • Overall accountability for Section 111 reporting. • Recipient of BCRC notifications related to non-compliance with Section 111 reporting requirements. • Approve changes to the account.

To register an Authorized Representative:

1. Go to the web site URL: <https://www.cob.cms.hhs.gov/Section111/>.
2. Click the **I Accept** link and accept the terms of the *Login Warning*. The home page will display.
3. Click **Step 1-New Registration**.
4. Click **Continue** to enter the RRE and corporate structure information. Authorized Representative information is required for registration.

Account Manager

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. Account Managers reporting for multiple RRE IDs must test and submit files by RRE ID. However, each individual will only need one login ID and can access multiple RRE ID accounts after being invited by the respective Authorized Representative.

The Account Manager Responsibilities, Abilities, and Restrictions are illustrated in Table 4-2.

Table 4-2: Account Manager Responsibilities, Abilities, and Restrictions

Type	Description
Responsibilities	<ul style="list-style-type: none"> • Register on the COBSW, obtain a login ID and complete the account setup tasks. • Personally agree to the terms of the User Agreement.

Type	Description
Abilities	<ul style="list-style-type: none"> • Invite other users to register on the COBSW and function as Account Designees. • Remove an Account Designee’s association to an RRE ID account. • Be an Account Manager associated with another RRE ID if they receive the authorized PIN from the BCRC 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 a recovery agent as its Account Manager. • Manage the RRE’s profile including selection of a data submission method. • Upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method. • Use their login ID and password to transmit files if the RRE has specified SFTP as the file transfer method. • Submit and view claim information if the RRE has specified the DDE option. • Review file transmission history. • Review file processing status and file statistics. • Change account contact information (e.g., address, phone, etc.). • Change personal information.
Restrictions	<ul style="list-style-type: none"> • Cannot be an Authorized Representative for any RRE ID or an Account Designee for the same RRE ID.

To register an Account Manager:

1. Click **Step 1-New Registration** (required).

The BCRC will then send a letter to the named Authorized Representative with a personal identification number (PIN) and the BCRC-assigned RRE ID (Section 111 Reporter ID) associated with the registration. The Authorized Representative must give this PIN and RRE ID to their Account Manager.

2. Ask the Account Manager to go to the Section 111 COBSW and click **Step 2-Account Setup**.

During the account setup process the Account Manager will create a login ID and password.

Account Designees

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 Responsibilities and Abilities are illustrated in Table 4-3.

Table 4-3: Account Designee Responsibilities, Abilities, and Restrictions

Type	Description
Responsibilities	<ul style="list-style-type: none"> • Register on the Section 111 COBSW, obtain a login ID and complete the account setup tasks.

Type	Description
Abilities	<ul style="list-style-type: none"> • Can be associated with multiple RRE accounts, but only by an Account Manager invitation for each RRE ID. • Upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method. • Use login ID and password to transmit files if the RRE has specified SFTP as the file transfer method. • Submit and view claim information if the RRE has specified the DDE option. • Review file transmission history. • Review file-processing statuses and file statistics. • Change personal information. • Can remove himself/herself from the RRE ID.
Restrictions	<ul style="list-style-type: none"> • 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.

Agent

RREs may use agents to submit data on their behalf. An agent is a data services company, consulting company, or the like, that can create and submit Section 111 files to the BCRC on behalf of the RRE. Information on the use of agents is required as part of the Section 111 registration process.

To supply agent company information:

1. Click **Step 1-New Registration** (required).
2. If you have gone through the initial registration process and have received your mailing containing your RRE ID and PIN from the BCRC, your Account Manager can click **Step 2-Account Set Up**.
3. Agent information is collected as part of this process. An individual associated with an RRE's agent can be the Account Manager or an Account Designee associated with the RRE ID.

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.

Examples on designating and assigning Section 111 COBSW User Roles

CMS allows RREs multiple ways to designate and assign their Section 111 COBSW user roles for their RRE ID(s). The following examples help to illustrate this.

Figure 4-3 illustrates the following example: Insurer A has determined that they want one RRE ID. They have assigned an Authorized Representative and an Account Manager, but have decided not to use Account Designees.

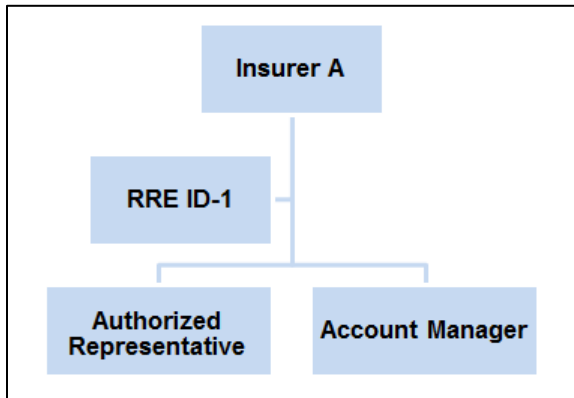
Figure 4-3: One Insurer One RRE ID (Example 1)

Figure 4-4 illustrates the following example: Insurer B has determined that they want one RRE ID. They have assigned an Authorized Representative and an Account Manager as well as an Account Designee to assist the Account Manager with the reporting process.

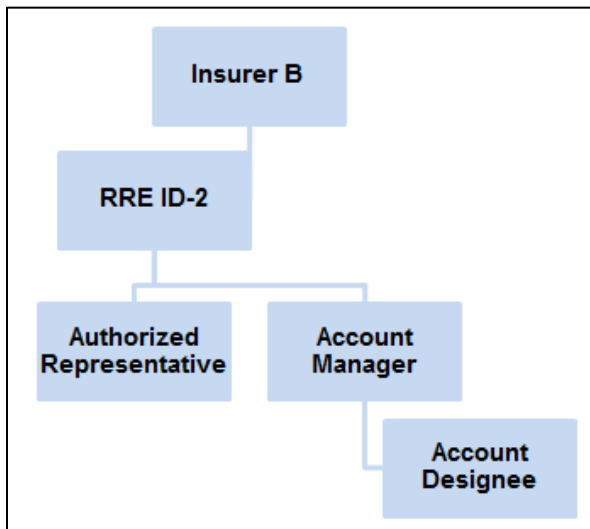
Figure 4-4: One Insurer, One RRE ID (Example 2)

Figure 4-5 illustrates the following example: Insurer C has determined that they want one RRE ID. They have assigned an Authorized Representative, an Account Manager and two Account Designees. One of the Account Designees is Insurer C's agent who will be transferring files for Insurer C.

Figure 4-5: One Insurer, One RRE ID (Example 3)

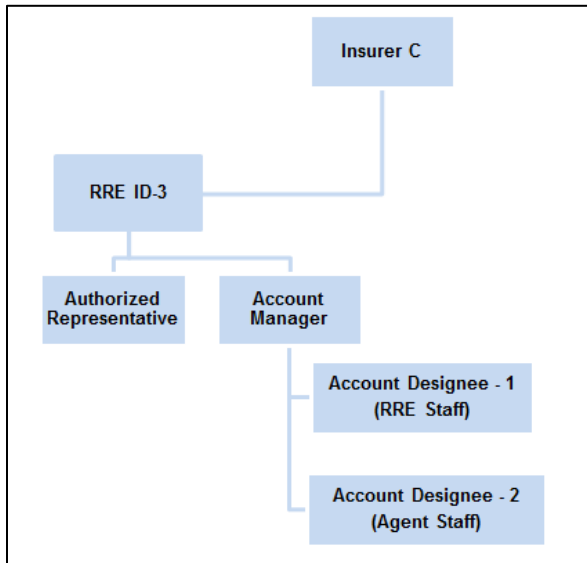


Figure 4-6 illustrates the following example: Insurer D has two claims systems and determines that they want to use 2 RRE IDs. Insurer D decides to use the same Authorized Representative and Account Manager for each RRE ID. Insurer D decides not to use any Account Designees.

Figure 4-6: One Insurer, Two RRE IDs (Example 1)

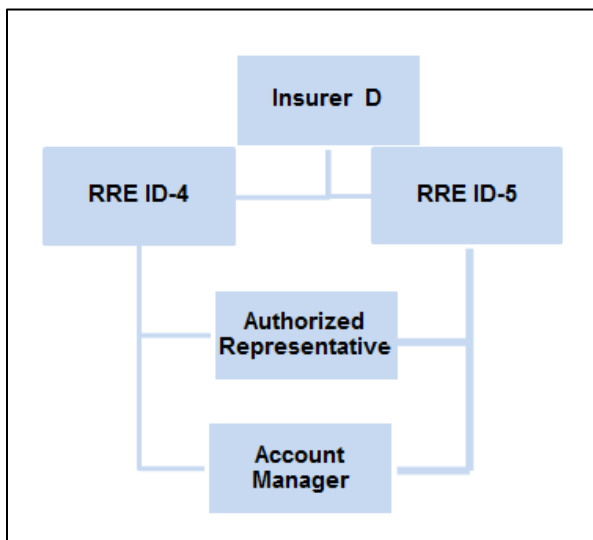
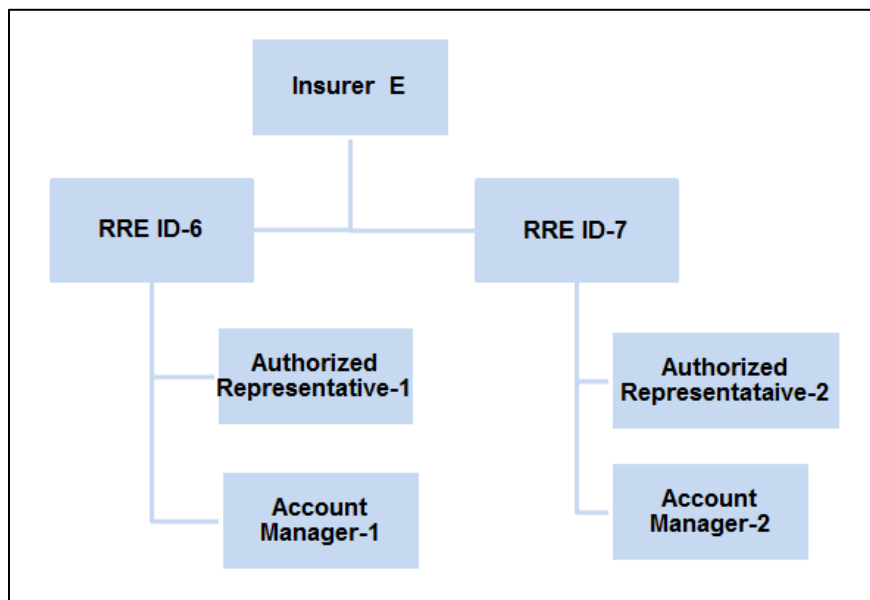


Figure 4-7 illustrates the following example: Insurer E has two claims systems and determines that they want to use two RRE IDs. However, they have determined that they will assign a separate Authorized Representative and Account Manager for each RRE ID. Insurer E decides not to use any Account Designees.

Figure 4-7: One Insurer, Two RRE IDs (Example 2)

4.2.2 Step 2: Determine Reporting Structure

The second step in the registration and account setup process is to determine the reporting structure. Before beginning the registration process, an RRE must determine how to submit Section 111 claim information to the BCRC (i.e., data transmission method) and how many Section 111 Responsible Reporting Entity Identification Numbers (RRE IDs) will be needed.

Data Transmission Method Selection

There are four separate methods of data transmission that Section 111 Responsible Reporting Entities may utilize:

- CMS Electronic File Transfer (CMS EFT) (via a Network Data Mover [NDM])
- Secure File Transfer Protocol (SFTP)
- Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)
- Direct Data Entry (DDE)

For more specific instruction on the data transmission methods, refer to the NGHP User Guide Technical Information Chapter.

Determining the number of RRE IDs needed

The number of RRE IDs needed depends on the number of Claim Input Files an RRE will transmit to the BCRC each quarter.. RREs should submit one Claim Input file per quarter. Please see Chapter IV: Technical Information for more information. Most DDE submitters will only need one RRE ID since multiple users can have access to the same RRE ID account.

Due to corporate organization, claim system structures, data processing systems, data centers and agents that may be used for data submission, an RRE may want to submit more than one Claim Input File to the BCRC on a quarterly basis and therefore will need more than one RRE ID in order to do so. For example, if an RRE will use one agent to submit workers' compensation

claims in one file and another agent to submit liability and no-fault claims in another file, the RRE must register on the Section 111 COBSW twice to obtain two RRE IDs that will be used by each agent respectively. Alternatively, you may use one agent to report Claim Input Files and another agent to submit 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. Note: agents reporting for multiple RRE IDs that are submitting files, must test and submit files by RRE ID.

You are not required to register and obtain an RRE ID by line of business, but file submitters must do so if separate input files will be submitted for each. For example, under the same RRE ID you may submit one Claim Input File with a mix of liability, no-fault and workers' compensation claims. Or, using separate RRE IDs, you may submit separate files for each or any combination by line of business that suits your reporting structure.

Likewise, if a file submitter has two or more subsidiary companies that process workers' compensation claims using different claims systems and it will not combine the claim files for Section 111 reporting, the RRE must register for each claim file submission to obtain separate RRE IDs in order to submit multiple claim files in one quarter. 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 they submit just one file a quarter..

File submitters **may not** set up a separate RRE ID for submission of the Query Input File only. RREs **must** submit Claim Input Files, or provide claim information using the DDE option, for every RRE ID established.

Note: If a file submitter has nothing to report according to the requirements specified in the NGHP User Guide Policy Guidance Chapter, the RRE may, but is not required to, submit an "empty" file for the RRE ID with a header record, no detail records, and a trailer record with a record count of zero.

You must complete the *New Registration* and *Account Setup* steps for **each** RRE ID you establish, so careful consideration must be given to the number of RRE IDs requested.

Once logged into the Section 111 COBSW, most functions are performed by RRE ID. Your Account Manager must invite and identify Account Designees that will need access to multiple accounts by RRE ID. However, each individual Account Designee will only need one login ID and can access multiple RRE ID accounts after being invited by the respective Account Manager(s).

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.

If you register for multiple RRE IDs:

- You can use the same Federal Tax Identification Number (TIN) for each RRE ID or different TINs for each RRE ID. No matching is done between the TINs supplied at registration and the TINs supplied on your input files/claim submission.

The RRE TIN supplied during registration is used by the BCRC to authenticate the RRE prior to establishing the reporting account. The RRE TINs supplied on Claim Input Files/DDE submissions 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.

- 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.

4.2.3 Step 3: Register on the Section 111 COBSW

The third step in the registration and account setup process is the RRE Registration on the Section 111 COBSW (Figure 4-8). The COBSW application will require you to submit the following information so have this information available when you register:

- 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 email address.
- National Association of Insurance Commissioners (NAIC) company codes, if applicable. If your 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.
- Optional Subsidiary company information to be included in the file submission.
TINs supplied for subsidiaries must be unique and not match the RRE TIN or TINs supplied for other subsidiaries in this step.

Figure 4-8: RRE ID Profile Information Page

RRE ID Profile Information

Complete the information below for the RRE ID you are requesting.

*** Required**

Company EIN/TIN:*

Company Name:*

Company Address

Street Line 1:*

Street Line 2:

City, State, Zip:* , -

NAIC Number:

Company Telephone:* () -

Company Fax: () -

Reporter Type:* GHP Liability/ No Fault/ Workers' Compensation

Registration Steps for the Section 111 COBSW

1. If you are the individual assigned by the RRE, go to the Section 111 COBSW URL (<https://www.cob.cms.hhs.gov/Section111/>) and click the **New Registration** button.
2. Complete and submit the registration for the RRE.

The New Registration step is for the RRE, and the RRE's 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 their choosing. The *New Registration* step on the Section 111 COBSW must be performed for each RRE ID needed for Section 111 reporting.

It is critical that you provide contact information (including email address) 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 BCRC. Once this is completed, the BCRC will send a letter via the US Postal Service to the named Authorized Representative with a personal identification number (PIN) and the BCRC-assigned RRE ID associated with the registration. PIN letters will be sent to the Authorized Representative within 10 business days.

3. 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. During registration you do **not** have to provide all of the TINs that you might later use on your Claim Input File and TIN Reference File submissions.

If you do 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 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 4.2.6 for information on how foreign entities may register on the COBSW.

4.2.4 Step 4: Setup Account on the Section 111 COBSW

The fourth step in the registration and account setup process is when the RRE's Account Manager sets up the RRE's account on the Section 111 COBSW. The individual who completes the Account Setup **must** be the Account Manager for the RRE, so plan for this step accordingly.

To perform the RRE account setup tasks, the RRE's Account Manager must go to the Section 111 COBSW URL (<https://www.cob.cms.hhs.gov/Section111/>) with the PIN and RRE ID and click the **Account Setup** button.

The Account Manager will:

1. Enter the RRE ID and associated PIN.
2. Enter personal information including name, job title, address, phone and email address.
3. Create a login ID for the COBSW.
4. 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).
5. Enter applicable reporting agent name, address, contact email 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.
6. Select a data transmission method (file or DDE).

There are four separate methods of data transmission that RREs may utilize. Three involve the submission of electronic files:

- Connect:Direct [formerly known as Network Data Mover (NDM)] via the CMS Electronic File Transfer protocol (EFT), which then connects to the CMS Extranet Network and CMS' private CMSNet network hosted by Verizon Business Network Services,
- Secure File Transfer Protocol (SFTP) over the Internet to the Section 111 SFTP Server, and
- Hypertext Transfer Protocol over Secure Socket Layer (HTTPS) file upload and download over the Internet using the Section 111 Coordination of Benefits Secure Web Site (COBSW).
- The fourth method is a manual direct data entry (DDE) process on the Section 111 COBSW. Your choice of data transmission methods is dependent on your current capabilities and the volume of data to be exchanged.
- 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.
- If you expect to be transmitting files with less than 24,000 records in one file submission on a regular basis, you may select HTTPS.
- If you expect to submit 500 or fewer NGHP claim reports per year, you may select DDE. Provide file transmission information needed if the Connect:Direct transmission method is selected. Refer to the NGHP User Guide Technical Information Chapter IV 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 Section 111 COBSW login ID, they may log into the application and invite Account Designees to register for login IDs. In addition, after completing Account Setup for their 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.

Things to remember

- The Account Setup step must be completed by your Account Manager. In this step, the Account Manager will obtain a login ID.
- The Account Manager must personally agree to the terms of the User Agreement.
- The Account Manager may be changed after completing this step. If you need to change your Account Manager, contact your assigned EDI Representative.
- Account setup must be repeated for each RRE ID.

Note: If you have been invited to be an Account Designee for an RRE ID previously, you must complete the Account Designee registration process and obtain a login ID before you may complete the *Account Setup* step for another RRE ID as the Account Manager. In other words, if you have an Account Designee invitation pending, you must complete the *Account Designee* registration process and obtain a login ID before you may proceed with setting yourself up as an

Account Manager for other RRE IDs. We strongly encourage users to register as soon as possible after receiving an invitation email to avoid problems completing the Account Setup step for other RRE IDs.

4.2.5 Step 5: Return Signed RRE Profile Report

The last step in the registration and account setup process is when the Authorized Representative returns the signed RRE profile report. Once account setup has been completed by the Account Manager on the Section 111 COBSW and processed by the BCRC, a profile report will be sent to the RRE's Authorized Representative and Account Manager via email. Profile report emails 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 BCRC.
- Your quarterly file submission timeframe for the Claim Input File.
- Contact information for your EDI Representative who will support you through testing, implementation and subsequent production reporting.

Figure 4-9: Sample Profile Report

Reporter ID: 000123456	Date: 04/11/2009
Profile Changed: 04/10/2009	
COBC EDI Representative: Jane Smith	
Email: JaneSmith@ghi.com	
Phone: (555)666-7777	
<hr/>	
Company Information:	
<hr/>	
TIN: 9876534321	
NAIC: 12345	
Name: Insurer USA	
Phone: (555)111-1212	
Address: 207 Smith Lane	
Fax: (555)111-2222	
	NY 10036-5412
Line of Business: <input checked="" type="checkbox"/> No-Fault <input checked="" type="checkbox"/> Workers' Compensation <input checked="" type="checkbox"/> Liability	
<hr/>	
Authorized Representative:	
<hr/>	
Name: James Jones	Phone: (555)232-7878
Title: Vice President	
Fax: (555)232-1212	
Address: 400 Main Street	
	NY 10036-5412
Email: JohnSmith1@InsurerUSA.com	
<hr/>	

The RRE's Authorized Representative must review, sign and return the profile report to the BCRC within 30 days. If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status.

Once your profile report has been marked as received by the BCRC, you may begin testing your Section 111 files. The BCRC will send an email to your Account Manager indicating that testing can begin.

Note: The RRE's profile report will be emailed to the Authorized Representative and Account Manager annually, based upon the receipt date of the last signed profile report. The Authorized Representative will be asked to respond to their EDI Representative via email within 10 days of receipt of the profile report. If all information contained within the profile report is still accurate, simply email your EDI Representative and inform them as such. If changes to the profile information are required, the Authorized Representative must inform the BCRC about the revisions needed. The BCRC will then make the appropriate updates and generate an updated profile report. The Authorized Representative must return a signed copy of the report. If the Authorized Representative has not responded to the annual profile report email within 30 days of receipt, they shall receive a non-receipt email. The Account Manager will be copied on this email. Failure to confirm this information may result in deactivation of the RRE ID. If your RRE ID is deactivated, contact your EDI Representative. Once you provide your EDI Representative with the previously requested information, the RRE ID will be reactivated immediately.

The status of your RRE ID will be updated by the system as each step of the registration process is completed. Once the BCRC receives your signed profile report, your RRE ID will be placed in a "testing" status. Once testing is completed (See the NGHP User Guide Technical Information Chapter IV for more information on the testing process), 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 BCRC and production reporting may begin immediately thereafter.

4.2.6 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.

Foreign RREs must follow the five steps in the Section 111 registration and account setup process to complete registration like any other RRE. However, since the foreign RRE does not have a TIN and/or US address, there are additional requirements needed to complete registration without that information. **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. For instructions to complete Form SS-4, go the IRS General Instructions URL <http://www.irs.gov/instructions/iss4/ch01.html>.

An individual assigned by the RRE must go to the Section 111 COBSW URL (<https://www.cob.cms.hhs.gov/Section111/>)

1. Click the **New Registration** button' then 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.

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.

2. Supply a valid email address for the Authorized Representative.

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.

3. Contact your EDI Representative or call the EDI Department at 646-458-6740 to continue with the registration process.

4. 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.

5. Upon receipt of the PIN, the Account Manager for the RRE must go to the Section 111 COBSW *Login* page and click the **Account Setup** button to continue with the registration process.

6. If your Account Manager does not have a mailing address in the US, then they 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 BCRC, an email 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 BCRC 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 BCRC 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 52 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 the NGHP User Guide Technical Information Chapter (Section 6.3) and the NGHP User Guide Appendices Chapter V 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 the NGHP User Guide Policy Guidance Chapter III, as applicable, when submitting its initial Claim Input File.

4.3 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.

4.3.1 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 ID deleted. Unused RRE IDs may trigger automated warning notifications and follow-up by the BCRC 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.

4.3.2 Ceasing and Transitioning Reporting

Cease 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 BCRC 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 emails and subsequent follow-up contact by the BCRC to your Authorized Representative and Account Manager related to Section 111 reporting compliance.

Transition Reporting

The transition of reporting responsibility from one RRE to another is the responsibility of the RREs involved. The BCRC 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 the NGHP User Guide Technical Information Chapter IV for more information on submitting claims with ORM and submitting add, delete and update transactions.

Change Reporting Agents

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 BCRC 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

(<https://www.cob.cms.hhs.gov/Section111/>). 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.

4.3.3 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 Section 111 COBSW (<https://www.cob.cms.hhs.gov/Section111/>), 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 the NGHP User Guide Technical Information Chapter IV).

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 Section 111 COBSW may update their own personal information associated with their login ID such as email address or phone number after logging on to the site.

Chapter 5: 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 Data Use Agreement below. 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 BCRC. In addition, all users must agree to similar language, which appears in the Data Use Agreement, 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.

Chapter 6: Section 111 COB Secure Web Site (COBSW)

The BCRC 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 <https://www.cob.cms.hhs.gov/Section111/>.

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 BCRC. 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 Chapter 4 of this guide.

Sources of Help Related to Using the Section 111 COBSW

To access the Section 111 COBSW, go to <https://www.cob.cms.hhs.gov/Section111/> using your Internet browser. Once you click the **I Accept** link and accept the terms of the *Login Warning*, the home page will display.

- Information on the New Registration, Account Setup, and other processes can be found under the *How To* menu at the top of the homepage. A login ID is not needed to access this menu option. Click the menu option and a drop down list will appear. Then click the item desired in the list.
- All pages of the Section 111 COBSW application provide access to *Quick Help* information. Click 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 home page. 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 user guide. The following are additional documents that are only available to NGHP RREs after login:
 - Test Beneficiary Data
 - Excluded ICD-9 Diagnosis Code Data
 - Excluded ICD-10 Diagnosis Code Data
 - Error Code Data
 - HEW Software Download
- **Computer-Based Training (CBT)** modules for the Section 111 application on the COBSW are available free of charge to RREs and their agents. These courses are all available on the Mandatory Insurer Reporting (NGHP) Training Material page at <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-Training-Material/NGHP-CBTs.html> on the CMS web site.
- Contact your assigned **EDI Representative** for additional help and assistance using the COBSW. See Chapter 7 for more information.

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 SFTP (see the NGHP User Guide Technical Information Chapter IV). 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 Chapter 4 for more information.

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 Chapter 4 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 they add you as an Account Designee. You will receive an email 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.

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.

COBSW Maintenance

Routine maintenance on the COBSW and Section 111 SFTP server is typically performed during the third weekend of each month as needed. However, bulletins will be posted to the COBSW login screen to notify RREs of any changes to scheduled maintenance. 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).

Best Practices

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 Emails

Table 6-4 lists the emails that are generated by the system to the Authorized Representative, and/or Account Manager for the RRE ID. Emails will be sent from cobva@section111.cms.hhs.gov. Please do not reply to this email address as replies are not monitored by the BCRC. If additional information or action is needed, please contact your EDI Representative directly.

Table 6-4: System-Generated Emails

Email Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	<p>Sent within 10 business days upon completion of the Account Setup step on the Section 111 COBSW. Includes attachment with profile report. The RRE's Authorized Representative must review, sign and return the profile report to the BCRC within 30 days. If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status.</p> <p>Note: RREs must return their signed profile via email to their assigned EDI Representative. Do not return the signed profile report to the COBVA email address from which it was received. When returning this via email, ensure that the profile report is a scanned copy of the document with a wet signature (i.e., an original signature is included on the profile report).</p>

Email Notification	Recipient	Purpose
Non-Receipt of Signed Profile Report	Authorized Representative, Account Manager	Generated 30 days after the profile report email if a signed copy of the profile report has not been received at the BCRC. The Authorized Representative for the RRE ID must sign and return the profile report. If another copy is needed, contact your EDI Representative.
Successful File Receipt	Account Manager	Sent after an input file has been successfully received but not yet processed at the BCRC. Informational only. No action required. <i>Subsequent emails will be sent regarding the results of actual file processing that may require follow up action.</i>
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 email may be ignored if you have nothing to report for the quarter.
Threshold Error	Account Manager	Sent after the Successful File Receipt email 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 email 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 BCRC. 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 BCRC has completed processing on an input file and the response file is available.
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 email 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 their personal information on the COBSW. Informational only.

Email Notification	Recipient	Purpose
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.

Chapter 7: Customer Service and Reporting Assistance for Section 111

Please be sure to visit the Section 111 page on the CMS web site <https://go.cms.gov/mirnghp> frequently for updated information on Section 111 reporting requirements including updates to this guide. In order to be notified via email of updates to this web page, click the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP *What's New* page.

The Section 111 Resource Mailbox, at PL110-173SEC111-comments@cms.hhs.gov, is a vehicle that Responsible Reporting Entities (RREs) may use to send CMS policy-related questions regarding the Medicare Secondary Payer (MSP) reporting requirements included in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. RREs are requested to send only policy-related questions to the Section 111 Resource Mailbox. If an RRE has a technical question, and if you are unable to contact your Electronic Data Interchange (EDI) Representative, for any reason, call the EDI Hotline at (646) 458-6740. If you have not registered to become an RRE, please directly contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627.

Please note that emails from CMS or the BCRC 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 email addresses.

7.1 Electronic Data Interchange (EDI) Representative

After you register for Section 111 reporting, you will be assigned an 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. Your profile report is sent to the RRE's Authorized Representative and Account Manager via email after the account set up has been completed.

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

7.2 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 BCRC.** 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 EDI Department number at 646-458-6740 for assistance.

The CMS and the BCRC 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 BCRC Management can address and prioritize issues appropriately.

1. Contact your EDI Representative at the BCRC. If you have not yet been assigned an EDI Representative, please call the EDI Department at 646-458-6740 for assistance.
2. If your Section 111 EDI Representative does not respond to your inquiry or issue within **two business days**, you may contact the EDI Department Director, Angel Pagan, at 646-458-2121. Mr. Pagan's email is apagan@ehmedicare.com.
3. If the EDI Director does not respond to your inquiry or issue within **one business day**, you may contact the BCRC Project Director, Jim Brady, who has overall responsibility for the EDI Department and technical aspects of the Section 111 reporting process. Mr. Brady can be reached at 646-458-6682. His email address is JBrady@ehmedicare.com. Please contact Mr. Brady only after attempting to resolve your issue following the escalation protocol provided above.

Chapter 8: Training and Education

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

- CMS Publications—The Section 111 CMS web page (<https://go.cms.gov/mirnghp>) has 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 email of updates to this web page, click the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP *What's New* page.
- Section 111 Teleconferences—CMS conducts Town Hall Teleconferences to provide information and answer questions 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 What's New tab at <https://go.cms.gov/mirnghp>.
- Free Computer Based Training (CBT) Courses—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, DDE and general MSP topics. These courses are all available on the Mandatory Insurer Reporting (NGHP) [Training Material](#) page on the CMS web site.
- *All updated* Section 111 policy guidance published in the form of an Alert can be found on the CMS web page (<https://go.cms.gov/mirnghp>). Any Alert posted after the date of the currently published User Guide supersedes the applicable language in the user guide. All Alerts 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.

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 their 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:

- [Medicare Secondary Payer](#) website
- [Workers' Compensation Medicare Set Aside Arrangements](#) website
- [Internet-Only Manuals \(IOMs\)](#) website (MSP Manual is CMS Publication 100-05)

Chapter 9: Checklist—Summary of Steps to Register, Test and Submit Production Files

The following summarizes the steps needed to participate in the reporting process for Section 111. Reference the Technical Information and Policy Guidance sections for more detailed instruction.

1. Before you begin, determine the following:

- Individuals who will be the RRE's Authorized Representative, Account Manager and Account Designees.
- Whether reporting agents will be used.
- 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.
- 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 BCRC via the CMS Extranet and CMSNet, and create transmission jobs and datasets.

2. Register and set up your account:

- 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 email (within 10 business days after registration is complete) indicating your registration and account setup were accepted by the BCRC.

Once you successfully register:

- The RRE's Authorized Representative must approve the account setup, by physically signing the profile report, which includes the Data Use Agreement, and returning it to the BCRC within 30 days. If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status. Note: It is recommended that RREs return their signed profile via email to their assigned EDI Representative. Do not return signed profile reports to the COBVA email address from which it had initially been received. When returning this via email, ensure that the profile report is a scanned copy of the document with a wet signature (i.e., an original signature is included on the profile report).
- 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 BCRC.

- 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).
- Confirm via email that the information on the annual profile report is correct. Failure to confirm this information may result in deactivation of the RRE ID.

3. Submit your quarterly Claim Input File during your assigned submission periods (ongoing):

- 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. The system requires you to change your password every 60 days.
- Monitor automated emails generated by the system regarding file processing status. These emails are sent to the Account Manager for the RRE ID, who should forward these emails 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.



**MMSEA Section 111
Medicare Secondary Payer Mandatory Reporting**

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

**Chapter III:
POLICY GUIDANCE**

Version 7.1

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Chapter 1: Summary of Version 7.1 Updates

The updates listed below have been made to the Policy Guidance Chapter Version 7.1 of the NGHP User Guide. As indicated on prior Section 111 NGHP Town Hall teleconferences, the Centers for Medicare & Medicaid Services (CMS) continue to review reporting requirements and will post any applicable updates in the form of revisions to Alerts and the user guide as necessary.

To clarify who bears reporting and other responsibilities for Subscription Insurance Policies, a new section has been added (Section 6.1.13).

Chapter 2: Introduction and Important Terms

The Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide has been written for use by all Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation Responsible Reporting Entities (RREs). The five chapters of the user guide—referred to collectively as the “Section 111 NGHP User Guide”—provide information and instructions for the MSP NGHP mandatory reporting implementation requirements pursuant to Section 111 MMSEA.

This **Policy Guidance Chapter** of the MMSEA Section 111 NGHP User Guide provides an overview of Section 111-related legislation and MSP rules, as well as information describing the policy framework behind the MSP liability insurance (including self-insurance), no-fault insurance, and workers' compensation reporting requirements mandated by Section 111 MMSEA. The other four chapters of the NGHP User Guide (Introduction and Overview, Registration Procedures, Technical Information, and Appendices) should be referenced as needed, for applicable guidance.

Please note that CMS continues to update and implement the Section 111 requirements. New versions of the Section 111 User Guide will be issued when necessary to document revised requirements, and when additional information has been added for clarity. At times, certain information will be released in the form of an Alert document. All recent and archived alerts can be found on the Section 111 website: <https://go.cms.gov/mirnghp>. 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 guidance 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.

All official instructions pertinent to Section 111 reporting are on the Section 111 website found at <https://go.cms.gov/mirnghp>. Please check this site often for the latest version of this guide and for other important information, such as new Alerts. In order to be notified via email of updates posted to this web page, click the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. Additional information related to Section 111 can be found on the login page of the Section 111 Coordination of Benefits Secure Website (COBSW) at <https://www.cob.cms.hhs.gov/Section111/>.

Important Terms Used in Section 111 Reporting

The following terms are frequently referred to throughout this Guide, and are critical to understanding the Section 111 NGHP reporting process.

- Entities responsible for complying with Section 111 are referred to as “Responsible Reporting Entities” or “**RREs.**” See Chapter 6 for a detailed description of who qualifies as an RRE.
- Liability insurance (including self-insurance), no-fault insurance, and workers’ compensation are often collectively referred to as “**Non-Group Health Plan**” or “**NGHP.**”
- **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” (medical care) associated with a claim. Typically, ORM only applies to no-fault and workers’ compensation claims. Please see Section 6.3 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 or apart from ORM. A TPOC generally reflects a “one-time” or “lump sum” settlement, judgment, award, or other payment intended to resolve or partially resolve a claim. It is the dollar amount of the total payment obligation to, or on behalf of the injured party in connection with the settlement, judgment, award, or other payment. Individual reimbursements paid for specific medical claims submitted to an RRE, paid due the RRE’s ORM for the claim, **do not** constitute separate TPOC Amounts. 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 80 and 81 of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter V.
- As defined by CMS, the **Date of Incident (DOI)** is:
 - The date of the accident (for an automobile or other accident);
 - The date of first exposure (for claims involving exposure, including; occupational disease);
 - The date of first ingestion (for claims involving ingestion);
 - The date of the implant or date of first implant, if there are multiple implants (for claims involving implant(s); or
 - 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 a medical practitioner (for claims involving cumulative injury).

This CMS definition differs from the definition of that generally used by the insurance industry under specific circumstances. For the DOI used by insurance/workers’ compensation industry, see Field 13 of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter V.

Chapter 3: Medicare Entitlement, Eligibility, and Enrollment

This section provides a general overview of Medicare entitlement, eligibility and enrollment. Please refer to <https://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 (ESRD—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.

Chapter 4: MSP Overview

“Medicare Secondary Payer” (MSP) is the term used when the Medicare program does not have primary payment responsibility—that is, when 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 (and subsequent amendments), Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation. An insurer or workers’ compensation plan cannot, by contract or otherwise, supersede federal law, as by alleging its coverage is “supplemental” to Medicare.

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 coverage data collected through Section 111 reporting is 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. Medicare beneficiaries, insurers, self-insured entities, recovery agents, and attorneys, are always responsible for understanding when there is coverage primary to Medicare, for notifying Medicare when applicable, and for paying appropriately.

Section 111 reporting is a comprehensive method for obtaining information regarding situations where Medicare is appropriately a secondary payer. It does 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 any conditional payments made by Medicare within 60 days of receipt of such settlement, judgment, award, or other payment. The Section 111 reporting requirements do not eliminate this obligation).

4.1 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 the NGHP User Guide Appendices Chapter V is critical.

Additional information can be found on cms.gov [Internet-Only Manuals \(IOM\)](#). The MSP Manual is CMS Publication 100-05. See [Chapter 1: Background and Overview](#).

4.2 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."

Entities and 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. See the NGHP User Guide Appendices Chapter V for the full CMS definition of "self-insurance." (Please note that government entities are considered to be entities engaged in a business.)

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.

4.3 Workers’ Compensation

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. Workers’ compensation is a law or plan that compensates employees who get sick or injured on the job. Most employees are covered under workers’ compensation plans.

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 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” with regard to workers’ compensation.)

4.4 Role of the BCRC and CRC

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 Benefits Coordination & Recovery Center (BCRC) consolidates the activities that support the collection, management, and reporting of other insurance or workers’ compensation coverage for Medicare beneficiaries. The BCRC updates the CMS systems and databases used in

the claims payment and recovery processes. It does not process claims or answer claims-specific inquiries.

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

In situations where Medicare is seeking reimbursement from the beneficiary, the BCRC is also 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.

The Commercial Repayment Center (CRC) is responsible for the recovery of conditional payments where a liability insurer (including a self-insured entity), no-fault insurer or workers' compensation entity had assumed ORM and is the identified debtor. For more information on NGHP recovery, see the NGHP recovery page: <https://go.cms.gov/NGHPR>.

Chapter 5: 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, and 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 were 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 the NGHP User Guide Appendices Chapter V. Section 111 authorizes CMS' implementation of the required reporting by program instruction or otherwise. All implementation instructions, including this user guide, are available on (or through a download at) CMS' dedicated web page: <https://go.cms.gov/mirnghp>.

Section 111:

- Adds reporting rules; it does not eliminate any existing statutory provisions or regulations.
- Does not eliminate CMS' existing processes, including CMS' process for self-identifying pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation claims to CMS' Benefits Coordination & Recovery Center (BCRC) or for MSP recoveries, where appropriate.
- Includes penalties for noncompliance.

Who Must Report:

- An applicable plan.
- The term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:
 - Liability insurance (including self-insurance).
 - No-fault insurance.
 - 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 are 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. See detailed information in the NGHP User Guide Technical Information Chapter IV.

Notices submitted to CMS outside of the processes described or otherwise referenced in this User Guide **do not satisfy** an RRE's reporting obligations with respect to 42 U.S.C § 1395y(b)(8), including:

- Notice to CMS of a pending claim or other pending action by an RRE or any other individual or entity,
- Notice to CMS by the RRE of a settlement, judgment, award, or other payment by telephone, mail, or any means other than through the established Section 111 reporting process, or
- Notice to CMS of a settlement, judgment, award, or other payment by an individual or entity other than the applicable RRE.

Note: To determine if you are an RRE, you must use the applicable statutory language. See the following for help with determining your RRE status and with statutory language:

Attachment A of the PRA in the NGHP User Guide Appendix Chapter V and Section 6.1 (Who Must Report) in order to determine if you are an RRE for purposes of these provisions. The statutory language, the PRA Notice, and the PRA Supporting Statement with Attachments are all available as downloads at <https://go.cms.gov/mirnghp>.

Chapter 6: Responsible Reporting Entities (RREs)

6.1 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:

- Liability insurance (including self-insurance).
- No-fault insurance.
- Workers' compensation laws or plans.”

You must use the information in this Section (as well as the applicable statutory language) in conjunction with the requirements located in the NGHP User Guide Appendices Chapter V (Appendix I—Definitions and Reporting Responsibilities) to determine if your entity is an RRE for purposes of these provisions. The statutory language is available in the NGHP User Guide Appendices Chapter V (Appendix H).

CMS is aware that the industry generally does not use the term “plan” or some other CMS definitions, such as those 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 use CMS’ Section 111 definitions when reviewing and implementing Section 111 instructions.**

Corporate structure and RREs:

- An entity **may not** register as an RRE for a sibling in its corporate structure.
- An entity **may** register as an RRE for itself or for any direct subsidiary in its corporate structure.
- 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.
- 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.
- A subsidiary **may not** register as an RRE for its parent.
- 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.

See the following table for a summary of RRE registration for various corporate structures.

Table 6-1: RRE Registration within a Corporate Structure

Corporate Structure	May Register as	May Not Register as
Entity	RRE for itself RRE for any direct subsidiary in its corporate structure	RRE for a sibling in its corporate structure
Parent Entity	RRE for any subsidiary in its corporate structure regardless of whether the parent would otherwise qualify as an RRE.	N/A
Subsidiary	N/A	RRE for its parent

Example:**Facts:**

Parent Company/Holding Company “A” has 4 subsidiaries (S1, S2, S3, and 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, and S4. (See Table 6-1, Row 2.)
- “A” registers as the RRE for S1, it may report for any of S1’s subsidiaries such as S1 Captive. (See Table 6-1, Row 1 and Row 2.)
- “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 6.2 for more information.)
- 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 Table 6-1, Row 1, & Section 6.2 for more information.)
- S1, S2, S3, and S4 may not register as the RRE for each other. (See Table 6-1, Row 1.)
- S2, S3, and S4 may not register as the RRE for S1 Captive. (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.)
- S1 Captive may not register as the RRE for S1 (its parent) or for any of the other subsidiaries (see Table 6-1, Row 3). 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.

“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.

“Payment:”

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.

Recovery Agents:

Recovery agents as defined by CMS for purposes of 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 recovery agent**.

Note, however, that while entities which meet this definition of a recovery agent generally only act as agents for purposes of liability insurance (including self-insurance), no-fault insurance, or workers’ compensation reporting, they may, under certain specified circumstances, also be an RRE. See, for example, the discussion of State-established “assigned claims funds” later in this section.

Although it may contract with a recovery agent 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 recovery agent, or some other entity to submit data as the RRE’s 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 recovery agent to process claims. The agent is a separate legal entity, makes payment decisions based upon the facts of each case, and issues payment. The liability insurer is the RRE. The liability insurer may not shift its RRE responsibility to the recovery agent.

6.1.1 Acquisition/ Divestiture or Sale (Not Under Bankruptcy Liquidation)

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.

6.1.2 Bankruptcy

When an RRE has filed for bankruptcy, it still 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.

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

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

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 an 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. If the insurer payment is being made to reimburse the injured claimant (or representative of the injured claimant), the insurer is the RRE and reporting by the insurer is required.

Also see Section 6.1.12.

6.1.4 Foreign Insurers (Including Self-Insurance):

Note: The following information related to foreign RREs does not pertain to liability self-insurance or self-insured workers’ compensation.

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-insurance” or “self-insured” 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 or 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 (including self-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 (including self-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))

6.1.5 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.

6.1.6 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. Additional payments would be reported as additional TPOC Amounts.

6.1.7 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 solely 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.

6.1.8 Multi-National Organizations, Foreign Nations, American Indian, and 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.

6.1.9 Self-Insurance Pools

The RRE for liability insurance (including self-insurance) or workers' compensation self-insurance pools—entities self-insured in whole or in part with respect to liability insurance (including self-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 following characteristics are met, the self-insurance pool is the RRE:

- The self-insurance pool is a separate legal entity.
- The self-insurance pool has full responsibility to resolve and pay claims using pool funds.
- The self-insurance pool resolves and pays claims without review or approval authority by the participating self-insured entity. **Note:** When any 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. Each individual self-insured member is an RRE except during the following exception.

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 (including self-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.

6.1.10 State-Established "Assigned Claims Fund"

This subsection addresses the RRE for a state-established "assigned claims fund" which provides benefits for individuals injured in an automobile accident who do not qualify for personal injury protection or 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 insurance carrier is the RRE. (Note: This would be an example of the rare situation where a recovery agent 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 number or obtain a separate RRE ID number for each type of insurance.

6.1.11 Subrogation by an Insurer

Fact pattern:

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

6.1.12 Workers' Compensation

See the “Workers’ Compensation Law or Plan” paragraph of Appendix I (“Definitions and Reporting Responsibilities”) in this user guide.

The “Workers’ Compensation Law or Plan” paragraph in the NGHP User Guide Appendices Chapter V (Appendix I—Definitions and Reporting Responsibilities) 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 workers’ compensation (WC) 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.” (Section 6.1.3).
- Where the applicable WC 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.”) (Section 6.1.3).
- Where the applicable WC 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 WC 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 WC 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.”)

6.1.13 Subscription Insurance Policies

In a subscription insurance policy arrangement, two or more insurers enter into an agreement whereby the risk of the insurance policy is spread among the various insurance entities in some agreed-upon ratio. In such arrangements, a lead insurer is designated for various administrative and business purposes. While there may be many co-insurers on a subscription insurance policy, there is only one lead insurer, and that lead insurer remains so throughout the policy life cycle.

Due to the nature of the subscription insurance market and the way such policies are structured, it is appropriate for the lead insurer to act as the sole RRE as it relates to Section 111 mandatory reporting requirements. The ability for the lead insurer to act as the sole RRE is predicated on the assumption that the lead insurer will avail themselves of all rights, requirements, and responsibilities codified in statute and further set out in regulation and within this and any other sub-regulatory guidance provided by CMS, as is from time to time amended. In any such lead reporting situation, as it relates to subscription insurance policies, CMS will assume that the lead insurer, as the sole RRE, will be responsible for all applicable reporting, recovery, and benefits coordination requirements that presently exist, regardless of the existence of any other co-insurer that may enter into a subscription arrangement or similar contract with the lead insurer.

6.2 Use of Agents

Agents are not RREs for purposes of Section 111 MSP reporting responsibilities. However, the applicable RRE may contract with another 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 exchange Section 111 files with the BCRC on behalf of the RRE.

The RRE must register for reporting and file submission with the BCRC. 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 the NGHP User Guide Registration Procedures Chapter II).

An RRE may **not** shift its responsibility to report under Section 111 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 neither sponsors nor partners with any entities that may be agents. CMS has not and will not endorse any entity as an agent for Section 111 reporting purposes and CMS 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.

Agents do not register for Section 111 reporting with the BCRC. Instead, they are named and invited to participate by their RRE customers. Agents must exchange separate files for each RRE 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 Section 111 COB Secure Website (COBSW) as described in the Registration Procedures Chapter II of the NGHP Guide. However, agents may not be named as the RRE's Authorized Representative.

All communications regarding MSP recovery will be directed to the RRE, not the agent. **Note:** CMS is not changing its standard MSP recovery processes. For example, demands involving liability insurance (including self-insurance) recoveries against a settlement, judgment, award, or other payment are routinely issued to the Medicare beneficiary.

6.3 Ongoing Responsibility for Medicals (ORM) Reporting

The following section reviews the major requirements for reporting the assumption or establishment of ORM for no-fault insurance, liability insurance (including self-insurance), and workers' compensation. Information regarding an RRE's reporting for the assumption of ORM has been presented in other sections of the NGHP User Guide. This section provides the basic policy information. See Table 6-2 for a summarized view of the ORM reporting requirements for no-fault, liability insurance (including self-insurance), and workers' compensation. The Technical Information Chapter IV must also be referenced for additional ORM reporting requirement specifications.

The reference to "ongoing" is not related to "ongoing reporting" or repeated reporting of claims under Section 111, but rather to 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 with 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 for ORM reporting to be required.

If an RRE has assumed ORM, the RRE is reimbursing a provider, or the injured party, for specific medical procedures, treatment, services, or devices (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 (see Section 6.4 for more information on 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 no-fault insurance (such as automobile Personal Injury Protection (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 since the no-fault limit was already reached, but the payment still reflects ORM, **not** a TPOC settlement, judgment or award.

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, or the RRE otherwise no longer has ORM, etc.) the RRE reports an ORM Termination Date. If there was no TPOC settlement, judgment, award, or other payment related to the claim (an actual settlement for medicals and/or lost wages, etc.), **you do not need to report a TPOC Amount on the claim with ORM**. You can just submit the ORM Termination Date.

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. 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.

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 Diagnosis Codes (starting in Field 18) 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/ICD-10 codes provided in these fields must provide enough information for Medicare to identify medical claims related to the underlying Injury, Incident or Illness claim reported by the RRE.

Note: The Alleged Cause of Injury, Incident or Illness (Field 15) is not required.

6.3.1 Ongoing Responsibility for Medicals (ORM) Reporting Summary

No-Fault Insurance ORM

No-fault insurance ORM that existed or exists on or after January 1, 2010 must be reported (Table 6-2).

Liability Insurance ORM

Liability Insurance (including Self-Insurance) ORM that existed or exists on or after January 1, 2010 must be reported.

Workers' Compensation ORM

Workers' Compensation ORM that existed or exists on or after January 1, 2010 must be reported. However, workers' compensation ORM claims are excluded from reporting indefinitely if they meet *ALL* of the following criteria.

Workers' Compensation (Plan Insurance Type “E”) ORM Exclusion

Workers' compensation claims that meet *ALL* of the following criteria are excluded from reporting until further notice:

- The claim is for “medicals only;”

- The associated “lost time” is no more than the number of days permitted by the applicable workers’ compensation law for “medicals only” (or 7 calendar days if applicable law has no such limit);
- All payment(s) has/have been made directly to the medical provider; AND
- Total payment for medicals does not exceed \$750.00.

Note: Once a workers’ compensation ORM claim is excluded from reporting, it does not need to be reported unless the circumstances change such that it no longer meets the exclusion criteria listed. In other words, the claim does not need to be reported unless something other than medicals is included, there is more lost time, a payment is made to someone other than a provider, and/or payments for medicals exceed \$750.

This exclusion does 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.

Table 6-2: ORM Reporting Requirements Summary

Insurance Type	Reportable ORM Dates
No-Fault ORM	Existed or exists on or after 1/1/2010
Liability insurance (including self-insurance) ORM	Existed or exists on or after 1/1/2010
Workers' Compensation ORM	Existed or exists on or after 1/1/2010

6.3.2 ORM Termination

When ORM ends, the RRE should report the date that ORM terminated and should NOT delete the record. Please note that a TPOC amount is not required to report an ORM termination date.

An ORM termination date should not be submitted as long as the ORM is subject to reopening or otherwise subject to an additional request for payment. An ORM termination date should only be submitted if one of the following criteria has been met:

- Where there is no practical likelihood of associated future medical treatment, an RRE may submit a termination date for ORM if it maintains a statement (hard copy or electronic) signed by the beneficiary's treating physician that no additional medical items and/or services associated with the claimed injuries will be required;
- Where there is no practical likelihood of associated future medical treatment, which is reflected by meeting **ALL** of the following:
 - No claims were paid with any diagnoses codes related to alleged ingestion, implantation, or exposure; and
 - No claims were paid, for any medical item or service related to the case, within five (5) years of the date of service of any such claim; and
 - Treatment did not include, nor were any claims paid related to, a medical implantation or prosthetic device; and
 - The total amount paid by the insurer, for all medical claims related to the case, did not exceed \$25,000.

Note: If, at any time, any of the parameters set forth above should no longer be applicable, the insurer must then update the ORM record to reflect that they, once again, have ongoing responsibility for medicals (i.e., update the termination date to all zeroes). Should the case once again fall under these parameters (for example, if five years elapse from the last relevant date of service), then ORM for that case may once again be terminated in accordance with the criteria above.

- Where the insurer's responsibility for ORM has been terminated under applicable state law associated with the insurance contract;
- Where the insurer's responsibility for ORM has been terminated per the terms of the pertinent insurance contract, such as maximum coverage benefits.

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

The general rule is that aside from the “Special Exception’ regarding reporting termination of ORM,” 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.

QUALIFIED EXCEPTION: 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 Date of Incident (DOI), as defined by CMS. Thus, 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. However, RREs may report ORM on claims they consider closed prior to January 1, 2010 at their discretion. “Older” ORM claims will not be rejected. The following table includes some illustrative examples of how to report ORM assumed prior to January 1, 2010.

Table 6-3: Qualified Exception Examples: ORM Assumed Prior to January 1, 2010

Claim Example	Reporting Requirement
RRE assumed ORM March 5, 2009 and is still making payments for medicals as of 1/1/2010.	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 <i>after</i> January 1, 2010. The claim was on the active claim file as of January 1, 2010.
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.

6.4 Total Payment Obligation to the Claimant (TPOC) Reporting

The TPOC Amount refers to the dollar amount of a settlement, judgment, award, or other payment **in addition to or apart from ORM**. A TPOC generally reflects a “one-time” or “lump sum” settlement, judgment, award, or other payment intended to resolve or partially resolve a claim. It is the dollar amount of the total payment obligation to, or on behalf of the injured party in connection with the settlement, judgment, award, or other payment. Individual reimbursements paid for specific medical claims submitted to an RRE, paid due the RRE’s ORM for the claim, **do not** constitute separate TPOC amounts.

The computation of the TPOC amount includes, but is not limited to, all Medicare covered and non-covered medical expenses related to the claim(s), indemnity (lost wages, property damages, etc.), attorney fees, set-aside amount (if applicable), payout totals for all annuities rather than cost or present values, settlement advances, lien payments (including repayment of Medicare conditional payments), and amounts forgiven by the carrier/insurer.

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.

Note: Please refer to the definition of the TPOC Date and TPOC Amount in Fields 80 and 81 of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter V.

6.4.1 TPOC Mandatory Reporting Thresholds

CMS has revised the mandatory reporting thresholds and implementation timeline for all liability insurance (including self-insurance), no-fault insurance, and workers’ compensation TPOC settlements, judgments, awards, or other payments for Section 111 TPOC reporting. The following tables describe the TPOC reporting requirements, timelines and amounts, and mandatory thresholds.

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) (Section 111 MSP reporting requirements for liability insurance (including self-insurance), no-fault insurance, and workers’ compensation).

These thresholds are not exceptions; they 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. CMS reserves the right to change these thresholds and will provide appropriate advance notification of any changes.

Note: All RREs (except for those using DDE), must report during each quarterly submission window. Please see the NGHP User Guide Technical Information Chapter IV, Chapter 5 for more information. DDE submitters are required to report within 45 calendar days of the TPOC Date.

Table 6-4: TPOC Reporting Requirements Summary

Insurance Type	Reportable TPOC Dates	Reportable Amounts	Threshold Applicable
No-Fault	October 1, 2010 & subsequent	Cumulative TPOC Amount that exceeds threshold	Yes
Liability insurance (including self-insurance)	October 1, 2011 & subsequent	Cumulative TPOC Amount that exceeds threshold	Yes
Workers' Compensation	October 1, 2010 & subsequent	Cumulative TPOC Amount that exceeds threshold	Yes

6.4.1.1 Meeting the Mandatory TPOC Reporting Threshold

Where there are multiple TPOCs reported by the same RRE on the same record, the combined 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 in the NGHP User Guide Technical Information Chapter IV (Section 6.4.5: Reporting Multiple TPOCs).

For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the threshold applies to the total of these two figures.

To determine which threshold date range the TPOC falls into, the RRE will compare the most recent (or only) TPOC Date to the threshold date ranges. If the cumulative TPOC Amount associated with the claim is greater than the threshold amount for the threshold date range, the claim record must be reported.

6.4.2 No-Fault Insurance TPOCs

RREs are required to report all no-fault insurance TPOCs with dates of October 1, 2010 and subsequent.

RREs may, but are not required to, include no-fault TPOCs with dates prior to October 1, 2010.

CMS has implemented a \$750 threshold for no-fault insurance TPOC Amounts dated October 1, 2016 or after. RREs are required to report no-fault TPOCs **only** if the cumulative TPOC Amount **exceeds** the reporting threshold for the most recent TPOC Date. The BCRC will total all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.

As of January 1, 2023, CMS will maintain the \$750 threshold for no-fault insurance, where the no-fault insurer does not otherwise have ongoing responsibility for medicals. This threshold does not apply to non-trauma liability reporting for alleged ingestion, implantation, or exposure cases. Any settlement, regardless of amount, should be reported for these types of cases.

RREs **may** submit TPOCs that are less than or equal to the TPOC dollar threshold and will not be penalized for doing so. Detailed reporting requirements are listed in the following table.

Table 6-5: Details: TPOC No-Fault Threshold Timelines and Amounts

Reporting Required for Cumulative Total TPOC Amount(s)	Reporting Optional for Cumulative Total TPOC Amount(s)	Most Recent TPOC Date is on or between	Reporting Required Quarter Beginning
Greater than \$750	Greater than \$0 through \$750	October 1, 2016 or after	January 1, 2017

6.4.2.1 TPOC No-Fault Claim Report Rejection (CJ07) Conditions

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

Table 6-6: Summary: Mandatory TPOC Thresholds for No-Fault

Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over \$750	October 1, 2016	January 1, 2017

6.4.3 Liability Insurance (including Self-Insurance) TPOCs

RREs are required to report TPOC Dates of October 1, 2011 and subsequent. RREs may, but are not required to, include TPOCs with dates prior to October 1, 2011.

As of January 1, 2023, the threshold for physical trauma-based liability insurance settlements will remain at \$750. This threshold does not apply to non-trauma liability reporting for alleged ingestion, implantation, or exposure cases. Any settlement, regardless of amount, should be reported for these types of cases.

RREs are required to report liability insurance (including self-insurance) TPOCs **only** if the cumulative TPOC Amount **exceeds** the reporting threshold for the most recent TPOC Date. The BCRC will total all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.

RREs **may** submit TPOCs that are less than or equal to the TPOC dollar threshold and will not be penalized for doing so.

6.4.3.1 Mandatory TPOC Thresholds for Liability Insurance (including Self-Insurance)

CMS has revised the Implementation Timeline and TPOC Dollar Thresholds for *certain* liability insurance (including self-insurance) (Plan Insurance Type = 'L') TPOC settlements, judgments, awards, or other payments. Detailed reporting requirements for different TPOC Amounts are listed and summarized in the following table.

Table 6-7: Details: TPOC Liability Threshold Timelines and Amounts

Reporting Required for Cumulative Total TPOC Amount(s)	Reporting Optional for Cumulative Total TPOC Amount(s)	Most Recent TPOC Date is on or between	Reporting Required Quarter Beginning
Greater than \$100,000	Greater than \$5,000 through \$100,000	October 1, 2011 to March 31, 2012	January 1, 2012
Greater than \$50,000	Greater than \$5,000 through \$50,000	April 1, 2012 to June 30, 2012	July 1, 2012
Greater than \$25,000	Greater than \$5,000 through \$25,000	July 1, 2012 to Sept. 30, 2012	October 1, 2012
Greater than \$5,000	Greater than \$300 through \$5,000	October 1, 2012 to Sept. 30, 2013	January 1, 2013
Greater than \$2,000	Greater than \$300 through \$2,000	October 1, 2013 to Sept. 30, 2014	January 1, 2014
Greater than \$1,000	NA	October 1, 2014 to Dec. 31, 2016	January 1, 2015
Greater than \$750	Greater than \$0 through \$750	January 1, 2017 or after	April 1, 2017

6.4.3.2 TPOC Liability Claim Report Rejection (CJ07) Conditions

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

Table 6-8: Summary: Mandatory Thresholds for Liability Insurance (including Self-Insurance) TPOC Settlements, Judgments, Awards or Other Payments

Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over \$100,000	October 1, 2011	January 1, 2012
TPOCs over \$50,000	April 1, 2012	July 1, 2012
TPOCs over \$25,000	July 1, 2012	October 1, 2012
TPOCs over \$5,000	October 1, 2012	January 1, 2013
TPOCs over \$2,000	October 1, 2013	January 1, 2014
TPOCs over \$1000	October 1, 2014	January 1, 2015
TPOCs over \$750	January 1, 2017	April 1, 2017

6.4.4 Workers' Compensation TPOCs

RREs are required to report TPOCs with dates of October 1, 2010 and subsequent. RREs may, but are not required to, include TPOCs with dates prior to October 1, 2010.

As of January 1, 2023, CMS will maintain the \$750 threshold for workers' compensation settlements, where the workers' compensation entity does not otherwise have ongoing responsibility for medicals. This threshold does not apply to non-trauma liability reporting for alleged ingestion, implantation, or exposure cases. Any settlement, regardless of amount, should be reported for these types of cases.

RREs are required to report workers' compensation TPOCs **only** if the cumulative TPOC Amount **exceeds** the reporting threshold for the most recent TPOC Date. The BCRC will total all TPOC Amounts reported on the claim record when determining if the claim meets the reporting threshold.

RREs **may** submit TPOCs that are less than or equal to the TPOC dollar threshold and will not be penalized for doing so.

6.4.4.1 Mandatory TPOC Thresholds for Workers' Compensation

CMS has revised the Timeline and TPOC Dollar Thresholds for Workers' Compensation (Plan Insurance Type = 'E') TPOC settlements, judgments, awards, or other payments. The reporting requirements are summarized in Table 6-9.

Table 6-9: Details: TPOC Workers' Compensation Threshold Timelines and Amounts

Reporting Required for Cumulative Total TPOC Amount(s)	Reporting Optional for Cumulative Total TPOC Amount(s)	Most Recent TPOC Date is on or between	Reporting Required Quarter Beginning
Greater than \$5,000	Greater than \$300 through \$5,000	October 1, 2010 to Sept., 30, 2013	January 1, 2011
Greater than \$2,000	Greater than \$300 through \$2,000	October 1, 2013 to Sept. 30, 2014	January 1, 2014
Greater than \$300	NA	October 1, 2014 or after	January 1, 2015
Greater than \$750	Greater than \$0 through \$750	October 1, 2016 or after	January 1, 2017

6.4.4.2 TPOC Workers' Compensation Claim Report Rejection (CJ07) Conditions

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

Table 6-10: Summary: Mandatory Thresholds for Workers' Compensation TPOC Settlements, Judgments, Awards or Other Payments

Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over \$5,000	October 1, 2010	January 1, 2011
TPOCs over \$2,000	October 1, 2013	January 1, 2014
TPOCs over \$300	October 1, 2014	January 1, 2015
TPOCs over \$750	October 1, 2016	January 1, 2017

6.5 Additional Requirements

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

6.5.1 What Claims Are Reportable? When Are Such Claims Reportable?

6.5.1.1 Claims Related to Liability, No-Fault, and Workers' Compensation Insurance

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 reporting thresholds, regardless of the assigned date for a particular RRE's 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 80), **NOT** necessarily when the actual payment was made or the check was cut. A TPOC is reported in total regardless of whether it is funded through a single payment, an annuity or as a structured settlement. See Section 6.4.1 for 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 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 80), **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 6.4.1 for 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 **exist 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 Section 6.3 (Ongoing Responsibility for Medicals (ORM) Reporting) and Section 6.3.1 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.

6.5.1.2 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 (the amount of the settlement, judgement, award, or other payment) for that individual has been determined.
- The RRE knows when the TPOC will be funded or disbursed to the individual or their representative(s).

RREs should retain documentation establishing when these criteria were or will be met. RREs should not report the TPOC until the RRE establishes when the TPOC will be funded or disbursed. In some situations, funding or disbursement of the TPOC may not occur until well after the TPOC Date. RREs may submit the date the TPOC will be funded or disbursed in the corresponding Funding Delayed Beyond TPOC Start Date field when they report the TPOC Date and TPOC Amount, but **must** do so if the TPOC Date and date of the funding of the TPOC are 30 days or more apart.

Timeliness of MMSEA Section 111 reporting for a particular Medicare beneficiary will be based upon the latter of the TPOC Date and the Funding Delayed Beyond TPOC Start Date.

Example:

There is a settlement involving an allegedly defective drug where a large settlement is to be disbursed among many claimants.

The settlement provides a process for subsequently determining who will be paid and how much.

Consequently, there will be payment to or on behalf of a particular individual, but the specific amount of the settlement, judgment, award, or other payment to or on behalf of that individual is not known as of the TPOC Date. RREs are to submit the date of the settlement in the TPOC Date field and the amount of the settlement in the TPOC Amount field.

In this example, the determination of the TPOC Amount, as well as the funding or disbursement of the TPOC, will be delayed after the TPOC Date. Once the TPOC Amount and the date when the TPOC will be funded or disbursed are determined, the RRE should submit the record with the appropriate date in the corresponding Funding Delayed Beyond TPOC Start Date field.

6.5.1.3 Submitting Multiple Records for a Single Individual

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 quarterly 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, or 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. An RRE may need to submit multiple records for the same individual depending on the number of policies at issue for an RRE, and/or the type of insurance or workers' compensation involved. 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 liabilities, 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. If there will be multiple records submitted for the same individual but coming from different RREs 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 51, Plan Insurance Type = 'D'). RREs must combine PIP/Med Pay limits for one policy when they are separate coverages 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.
Note: In some states, depending on various factors associated with the incident being reported, no-fault policy limits may vary. The reported Policy Limit should reflect the amount the RRE has accepted responsibility for at the time the record is submitted or updated. Just as importantly, if the Section 111 record needs to be corrected to reflect a new Policy Limit, the RRE should update the record as soon as possible.

6.5.1.4 Determining When Section 111 Reporting is Required

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 knowing whether or not Section 111 reporting is required for these situations is to determine whether or not the payment is to the injured claimant/representative of the injured claimant or 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

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.

One-time payment for defense evaluation—A payment made directly to the provider or other physician furnishing this service specifically for this purpose 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, if the individual is not a Medicare beneficiary 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).

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. Similarly, “indemnity-only” settlements, which seek to compensate for non-medical damages, should not be reported. The critical variable to consider is whether or not a settlement releases or has the effect of releasing medicals. If it does, regardless of the allocation (or lack thereof), the settlement must be reported.
- 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, provided that the TPOC releases, or has the effect of releasing, 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, or a one-time “indemnity-only” payment or settlement for

obligation(s) other than medical expenses is made to or on behalf of the claimant, the RRE does not report these periodic payments or one-time settlements 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 or settlements are considered to be part of and are reported as ORM. The periodic payments or one-time settlement to compensate for lost wages are not reported as TPOCs, but may be included to compute the total TPOC amount. (**Note:** TPOC computation is outlined in Section 6.4.) In summary, under the aforementioned circumstances, one claim report record is submitted reflecting ORM.

6.5.1.5 Cases Involving Exposure, Ingestion, or Implantation

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.

- When a case involves continued exposure to an environmental hazard, or continued ingestion of a particular substance, Medicare focuses on the date of last exposure or ingestion for purposes of determining whether the exposure or ingestion occurred on or after 12/5/1980. Similarly, in cases involving ruptured implants that allegedly led to a toxic exposure, the exposure guidance or date of last exposure is used. For non-ruptured implanted medical devices, Medicare focuses on the date the implant was removed. (**Note:** the term “exposure” refers to the individual’s actual physical exposure to the alleged environmental toxin not the defendant’s legal exposure to liability.)
 - For example, if the date of first 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.
 - In cases where exposure has ended prior to December 5, 1980, and there is not yet a settlement, judgment, award, or other payment, it would be inappropriate, and counter to the MMSEA Section 111 reporting obligations, to report such a claim.
- In the following situations, Medicare will assert a recovery claim against settlements, judgments, awards, or other payments, and MMSEA Section 111 MSP mandatory reporting rules must be followed:
 - Exposure, ingestion, or the alleged effects of an implant on or after 12/5/1980 is claimed, released, or effectively released in the most recently amended operative complaint or comparable supplemental pleading;
 - A specified length of exposure or ingestion is required in order for the claimant to obtain the settlement, judgment, award, or other payment, and the claimant’s date of first exposure plus the specified length of time in the settlement, judgment, award or other payment equals a date on or after 12/5/1980. This also applies to implanted medical devices; and

- A requirement of the settlement, judgment, award, or other payment is that the claimant was exposed to, or ingested, a substance on or after 12/5/1980. This rule also applies if the settlement, judgment, award, or other payment depends on an implant that was never removed or was removed on or after 12/5/1980.
- When **ALL** of the following criteria are met, Medicare will not assert a recovery claim against a liability insurance (including self-insurance) settlement, judgment, award, or other payment; and MMSEA Section 111 MSP reporting is not required. In these situations, it would be inappropriate to submit an MMSEA Section 111 report. (**Note:** Where multiple defendants are involved and the claimant meets these requirements with respect to any single defendant, the RRE for that defendant is not required to report as long as that defendant has no joint and several liability for the settlement, judgment, award, or other payment.)
 - All exposure or ingestion ended, or the implant was removed before 12/5/1980; and
 - Exposure, ingestion, or an implant on or after 12/5/1980 has not been claimed in the most recently amended operative complaint (or comparable supplemental pleading) and/or specifically released; and
 - There is either no release for the exposure, ingestion, or an implant on or after 12/5/1980; or where there is such a release, it is a broad general release (rather than a specific release), which effectively releases exposure or ingestion on or after 12/5/1980. The rule also applies if the broad general release involves an implant.
- Any operative amended complaint (or comparable supplemental pleading) must occur prior to the date of settlement, judgment, award, or other payment and must not have the effect of improperly shifting the burden to Medicare by amending the prior complaint(s) to remove any claim for medical damages, care, items and/or services, etc.
- Where a complaint is amended by Court Order and that Order limits Medicare's recovery claim based on the criteria contained in this alert, CMS will defer to the Order. CMS will not defer to Orders that contradict governing MSP policy, law, or regulation.
- Table 6-11 includes some illustrative examples of how the policy related to December 5, 1980, should be applied to situations involving exposure, ingestion, and implantation. This table is not all inclusive, as each situation must be evaluated individually on its merits.
 - The parties should make a determination as to whether these criteria are met and act accordingly.
 - When reporting a potential settlement, judgment, award, or other payment related to exposure, ingestion, or implantation, **the date of first exposure/date of first ingestion/date of implantation is the date that MUST be reported as the DOI.**

Table 6-11: Application of 12/5/1980 Policy Examples

Situation	Application of 12/5/1980 Policy
The claimant was exposed to a toxic substance in their house. The claimant moved on 12/4/1980. The claimant did not return to the house.	Exposure ended before 12/5/1980.
The claimant was exposed to a toxic substance in their house. The claimant moved on 12/4/1980. The claimant makes monthly visits to the house because the claimant's mother continues to live in the house.	Exposure did not end before 12/5/1980.
The claimant was exposed to a toxic substance while working in Building A. The claimant was transferred to Building B on 12/4/1980, and did not return to Building A.	Exposure ended before 12/5/1980.
The claimant was exposed to a toxic substance while working in Building A. The claimant was transferred to Building B on 12/4/1980, but routinely goes to Building A for meetings.	Exposure did not end before 12/5/1980.
The claimant had a defective implant removed on 12/4/1980. The implant had not ruptured.	Exposure ended before 12/5/1980.
The claimant had a defective implant that was never removed.	Exposure did not end before 12/5/1980.

6.5.1.6 Other Reporting Scenarios

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 because 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 reporting required.

Note: As indicated earlier, 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. **Note:** 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 reporting thresholds defined in Section 6.4.1.

Payment Pending Appeal

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

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 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).

6.5.1.7 Risk Management Write-Offs and Related 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 for payment to Medicare reflecting the unreduced permissible charge (e.g., the limiting charge amount) 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.

6.5.1.8 Reporting Exception for Qualified Settlement Funds (QSFs)

Reporting Exception for Certain TPOCs where the TPOC has been paid into a Qualified Settlement Fund (QSF) prior to October 1, 2011:

- This exception is applicable for RREs for certain liability insurance (including self-insurance), no-fault insurance, and workers' compensation TPOC settlements, judgments, awards, or other payments, where funds have been paid into a QSF under Section 468B of the IRC prior to October 1, 2011. (Note: QSFs under Section 468B of the IRC are not RREs.) Under this exception, MMSEA Section 111 reporting is not required when **ALL** of the following criteria are met:
 - The settlement, judgment, award or other payment is a liability insurance (including self-insurance) TPOC Amount; where there is no Ongoing Responsibility for Medicals (ORM) involved; and
 - The settlement, judgment, award, or other payment will be issued by a QSF under Section 468B of the IRC, in connection with a State or Federal bankruptcy proceeding; and,
 - The funds at issue were paid into the trust prior to October 1, 2011.

6.6 How to ask CMS Questions about Section 111 Reporting Policy

Please be sure to frequently visit the Section 111 page on the CMS website at <https://go.cms.gov/mirnghp> for updated information on Section 111 reporting requirements, including updates to this Guide. In order to be notified via email of updates made to this web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email

address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP *What's New* page.

The Section 111 Resource Mailbox, at PL110-173SEC111-comments@cms.hhs.gov, is a vehicle that RREs may use to send CMS policy-related questions regarding the Medicare Secondary Payer (MSP) reporting requirements included in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. RREs are requested to send only policy-related questions to the Section 111 Resource Mailbox. If an RRE has a technical question, and if you are unable to contact your Electronic Data Interchange (EDI) Representative, for any reason, call the EDI Hotline at (646) 458-6740. If you have not registered to become an RRE, please directly contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627.

Emails from CMS or the BCRC may come from @section111.cms.hhs.gov, @cms.hhs.gov, @ghimedicare.com and @ehmedicare.com addresses. Update your spam filter software to allow receipt of these email addresses.

Chapter 7: 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 BCRC. In addition, all users must agree to the Data Use Agreement 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.

Chapter 8: Training and Education

A variety of training and educational materials are available to help you with Section 111 reporting, in addition to the material in this guide.

- The Section 111 CMS web page (<https://go.cms.gov/mirnghp>) has links to all CMS publications regarding the MSP Mandatory Reporting Requirements under Section 111 of the MMSEA of 2007. To be notified via email of updates to this web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP *What's New* page.
- CMS conducts Town Hall Teleconferences to provide information and answer questions 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 What's New tab at <https://go.cms.gov/mirnghp>.
- CMS has made available a curriculum of computer-based training (CBT) courses for 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. These courses are all available on the Mandatory Insurer Reporting (NGHP) [Training Material](#) page on the CMS website.
- All updated Section 111 policy guidance published in the form of an Alert can be found on the Section 111 web page (<https://go.cms.gov/mirnghp>). Any Alert posted after the date of the currently published user guide supersedes the applicable language in the user guide. All Alerts 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.

Note: The Section 111 user guides and other instructions do not and are not intended to cover all aspects of the MSP program. Although these materials provide wide-ranging overviews of MSP in general, any individual or entity that is a primary payer to Medicare is responsible for their 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 page:

- [Medicare Secondary Payer](#) website
- [Workers' Compensation Medicare Set Aside Arrangements](#) website
- [Internet-Only Manuals \(IOMs\)](#) website (MSP Manual is CMS Publication 100-05)



**MMSEA Section 111
Medicare Secondary Payer Mandatory
Reporting**

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

**Chapter IV:
TECHNICAL INFORMATION**

Version 7.1

**Rev. 2023/24 April
COBR-Q2-2023-v7.1**

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Chapter 1: Summary of Version 7.1 Updates

The updates listed below have been made to the Technical Information Chapter Version 7.1 of the NGHP User Guide. As indicated on prior Section 111 NGHP Town Hall teleconferences, the Centers for Medicare & Medicaid Services (CMS) continue to review reporting requirements and will post any applicable updates in the form of revisions to Alerts and the user guide, as necessary.

There are no version updates to this chapter.

Chapter 2: Introduction

The Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide has been written for use by all Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation Responsible Reporting Entities (RREs). The five chapters of the user guide - referred to collectively as the "Section 111 NGHP User Guide" - provide information and instructions for the Medicare Secondary Payer (MSP) NGHP reporting requirements mandated by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173).

This **Technical Information Chapter** of the MMSEA Section 111 NGHP User Guide provides detailed information on the technical requirements of Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, and workers' compensation Responsible Reporting Entities (RREs). The other four chapters of the NGHP User Guide: Introduction and Overview, Registration Procedures, Policy Guidance, and Appendices should be references as needed for applicable guidance.

Please note that CMS continues to update and implement the Section 111 requirements. New versions of the Section 111 User Guide will be issued, when necessary, to document revised requirements and add clarity. At times, certain information will be released in the form of an Alert document. All recent and archived alerts can be found on the Section 111 website: <https://go.cms.gov/mirnghp> 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. RREs must refer to the current user guide and any subsequent Alerts for complete information on Section 111 reporting requirements.

All official instructions pertinent to Section 111 reporting are on the Section 111 website found at: <https://go.cms.gov/mirnghp>. Please check this site often for the latest version of this guide and for other important information such as the aforementioned Alerts. In order to be notified via email of updates to this web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. Additional information related to Section 111 can be found on the login page of the Section 111 Coordination of Benefits Secure Website (COBSW) at <https://www.cob.cms.hhs.gov/Section111/>.

Technical questions should be directed to your Electronic Data Interchange (EDI) Representative. Your EDI Representative contact information can be found in your profile report (received after registration has been completed).

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

Chapter 3: Process Overview

Purpose: 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. Section 111 reporting helps CMS determine primary versus secondary payer responsibility—that is, which health insurer pays first, which pays second, and so on. A more detailed explanation of Section 111 related legislation, MSP rules, and the structure of the Section 111 reporting process is provided in the NGHP User Guide Policy Guidance Chapter.

Section 111 RREs: Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities, or “RREs.” Section 111 requires RREs to submit information specified by the Secretary of Health and Human Services (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. For Section 111 reporting, RREs are required to 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, or their designated reporting agents, and the CMS Benefits Coordination & Recovery Center (BCRC). The BCRC manages the technical aspects of the Section 111 data submission process for all Section 111 RREs.

Querying for Medicare eligibility: RREs must be able to determine whether an injured party is a Medicare beneficiary and gather the information required for Section 111 reporting. CMS allows RREs that are file submitters to submit a query to the BCRC to determine the Medicare status of the injured party prior to submitting claim information for Section 111 reporting. The query record must contain the injured party’s Social Security Number (SSN) or Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]), name, date of birth and gender. When submitting an SSN, RREs may report a partial SSN. To do this, enter spaces for the first 4 positions followed by the last 5 digits of the SSN so that the field is populated with the required 9 characters.

- On the query response record, the BCRC will provide information on whether the individual has been identified as a Medicare beneficiary based upon the information submitted and, if so, provide the Medicare ID (and other updated information for the individual) found on the Medicare Beneficiary Database. The reason for Medicare entitlement, and the dates of Medicare entitlement and enrollment (coverage under Medicare) are not returned on the query file response.

Note: DDE reporters can use the Section 111 COBSW application’s beneficiary lookup function.

What should be submitted? For purposes of NGHP data submissions, the term “**claim**” has a specific reference. It is used to signify the overall compensation claim for liability insurance (including self-insurance), no-fault insurance or workers’ compensation, rather than to a single (or disaggregated) claim for a particular medical service or item. NGHP claim information is to be submitted where the injured party is (or was) a Medicare beneficiary and payments for

medical care (“medical”) are claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals.

Website: The BCRC maintains an application on the Section 111 COB Secure Website (the COBSW) for Section 111 processing. Its URL is <https://www.cob.cms.hhs.gov/Section111/>.

Please see Chapter 12 for a more thorough explanation of this website and instructions on how to obtain the Section 111 COBSW User Guide.

Data Submission Method: RREs may choose to submit claim information through either:

- An electronic file exchange, **OR**
- A manual direct data entry (DDE) process using the Section 111 COBSW (if the RRE has a low volume of claim information to submit),

More information on data exchange options can be found in Chapter 10.

RREs who select an electronic file submission method must first fully test the file exchange process. RREs who select the DDE submission method will not perform testing. More information on the testing process can be found in Chapter 9.

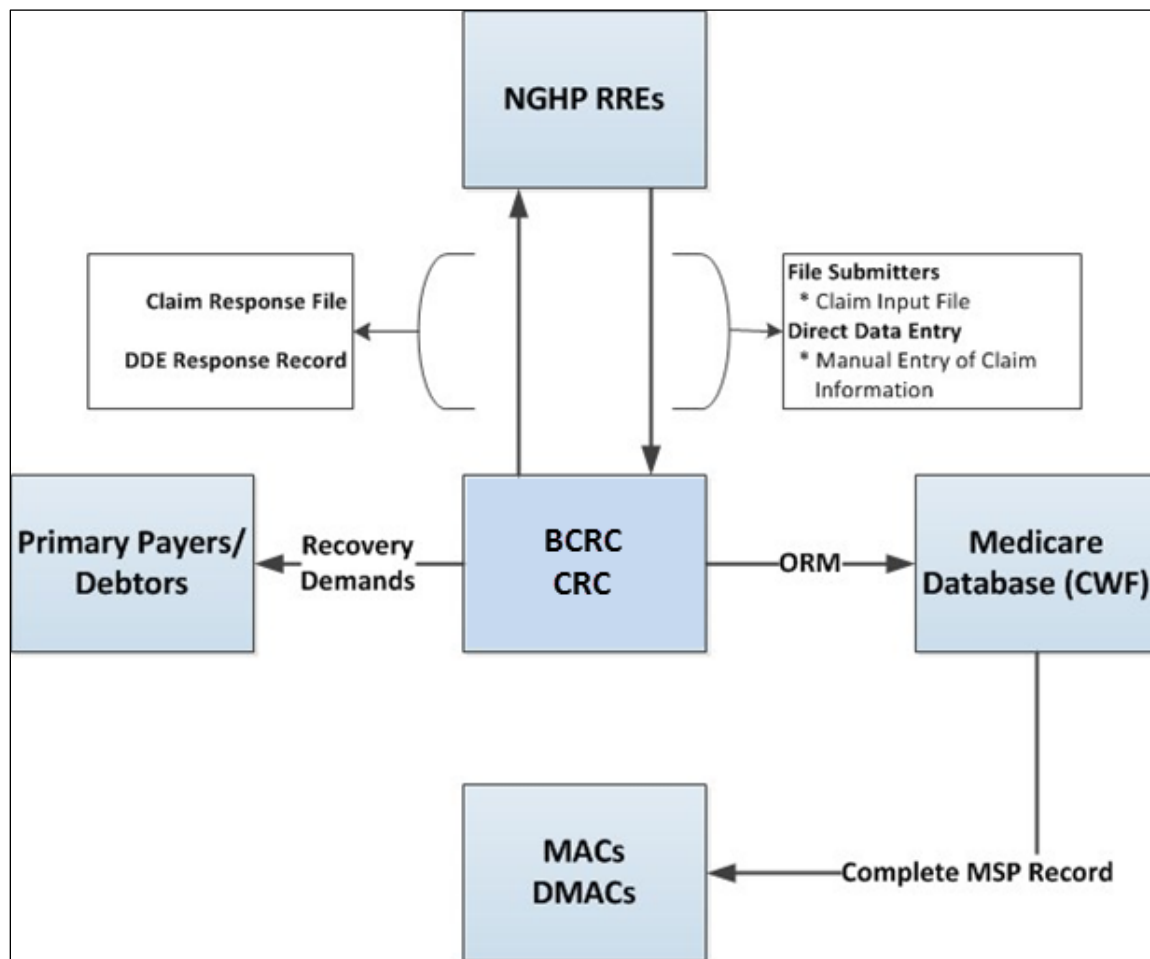
When the BCRC has cleared an RRE for “production” input file submissions, the RRE will submit claim information for all no-fault insurance and workers’ compensation claims involving a Medicare beneficiary as the injured party where the **TPOC Date** for the settlement, judgment, award, or other payment date is **October 1, 2010**, or subsequent, and which meet the reporting thresholds described in the NGHP User Guide Policy Guidance Chapter (Section 6.4).

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 the NGHP User Guide Policy Guidance Chapter (Section 6.4). 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 the NGHP User Guide Policy Guidance Chapter (Section 6.3.2)).

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

Data Exchange Process

This figure illustrates the Data Exchange process. A narrative description of this process directly follows the figure.

Figure 3-1: Data Exchange Process

- RREs that are file submitters electronically transmit their Claim Input File to the BCRC. RREs that are using DDE will manually enter and submit their claim information one claim report at a time using an interactive web application on the Section 111 COBSW.
- The BCRC processes the data in the *input file/DDE submission* by editing the incoming data and determining whether or not the submitted information identifies the injured party as a Medicare beneficiary.
- If the submitted claim information passes the BCRC edit process and is applicable to Medicare coverage, insurance information for Medicare beneficiaries derived from the input file is posted to other CMS databases (e.g., the Common Working File).
- The BCRC and the Commercial Repayment Center (CRC) help protect the Medicare Trust Fund by identifying and recovering Medicare payments that should have been paid by another entity as the primary payer as part of a Non-Group Health Plan (NGHP) claim which includes, but is not limited to liability insurance (including self-insurance), no-fault insurance, and workers' compensation. The primary payers/debtors receive recovery demands advising them of the amount of money owed to the Medicare program.
- The Common Working File (CWF) is a Medicare application that maintains all Medicare beneficiary information and claim transactions. The CWF receives information regarding

claims reported with ORM so that this information can be used by other Medicare contractors (Medicare Administrative Contractors (MACs) and Durable Medical Equipment Administrative Contractors (DME MACs)) for claims processing to ensure Medicare pays secondary when appropriate.

- When the data processing by the BCRC is completed, or the prescribed time limit for sending a response has been reached, the BCRC electronically transmits a response file to RREs that are file submitters and a response on the DDE *Claims Listing* page for those RREs that are using DDE. The response will include information on any errors found, disposition codes that indicate the results of processing, and MSP information as prescribed by the response file format.
- RREs must take the appropriate action, if any, based on the response(s) received.

Detailed specifications for the Section 111 reporting process are provided in the documentation that follows.

The NGHP Data Files

The following describes each MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance and Workers' Compensation Data File Type. Detailed specifications for the Section 111 record layouts are presented in the NGHP User Guide Appendices Chapter.

Table 3-1: NGHP Data File Types

File Type	Description
Claim Input File	This is the data set transmitted from a MMSEA Section 111 RRE to the BCRC 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 BCRC 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 addresses linked to the TIN and Office Code/Site ID combinations. This file is for purposes of both coordination of benefits and recovery. It is transmitted in a flat file format.
TIN Reference Response File	This is the data set transmitted from the BCRC to the RRE after the information supplied in the RRE's TIN Reference File has been processed.

File Type	Description
Query Input File	<p>This is an <i>optional</i> 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.</p> <p>The query file can also be used by an RRE to determine the most recent Medicare entitlement dates as well as Part C and Part D enrollment information for the past 3 years. (Effective 12/11/2021)</p>
Query Response File	<p>After the BCRC has processed a Query Input File it will return a Query Response File with information as to whether or not the data submitted identified an individual as a Medicare beneficiary. This file is transmitted using the ANSI X12 270/271 Entitlement Query transaction set.</p> <p>The response file will include the most recent Part A and Part B entitlement dates, as well as the entitlement dates for the last three years (up to 12 instances) of Part C and Part D coverage. (Effective 12/11/2021)</p>

Chapter 4: File Format

NOTE: This section pertains to those RREs choosing a file submission method, not to those using Direct Data Entry (DDE). For instructions on using DDE for claim submissions, please see Section 10.5.

4.1 General File Standards

Both the Claim Input and TIN Reference Files are transmitted in a flat, text, ASCII file format. The Connect:Direct file transmission method will convert files into EBCDIC. Query Files are transmitted using the ANSI X12 270/271 Entitlement Query transaction set. On request, the BCRC will supply each RRE free software to translate flat file formats to and from the X12 270/271. As described in Chapter 8, the Query File formats are the flat file input and output to the translator software supplied by the BCRC. 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 User Guide page. Note that the BCRC will only accept the 5010A1 version of the X12 270/271 (see Section 8.4). RREs will continue to be given at least 6 months advance notice for any future upgrades.

Mainframe and Windows PC/Server-based versions of the HEW software are available. Due to email server security settings, the only way to obtain the Windows version of the HEW software is to download it from the Section 111 COBSW at <https://www.cob.cms.hhs.gov/Section111/>. You may request a copy of the mainframe version from your EDI Representative or by contacting the EDI Department at 646-458-6740. The HEW software is maintained free of charge by the BCRC. No source code will be provided.

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 located in the NGHP User Guide Appendices Chapter. 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 NGHP User Guide Appendices Chapter. A carriage return/line feed (CRLF) character is in the byte following the end of each record layout defined in the NGHP User Guide Appendices Chapter (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:

- Header Record – each 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 – represents claim information when the injured party is a Medicare beneficiary, or query requests for individual people on the Query Input File.
- Trailer Record – 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. The file submission date supplied on the header record must match the date supplied on the corresponding file 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 entire file will be rejected.

4.2 Data Format Standards

This table 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.**

Table 4-1: Data Type Formatting Standards

Data 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 “0000100000”.	Numeric (5): “12345” Numeric (5): “00045”

Data Type	Formatting Standard	Examples
Alphabetic	<p>A through Z. Left justified. Non-populated bytes padded with spaces.</p> <p>Alphabetic characters sent in lower case will be converted and returned in upper case.</p> <p>Default to all spaces unless otherwise specified in the record layouts.</p> <p>Embedded hyphens (dashes), apostrophes and spaces will be accepted in alphabetic last name fields.</p> <p>First name fields may only contain letters and spaces.</p>	<p>Alpha (12): "TEST EXAMPLE"</p> <p>Alpha (12): "EXAMPLE"</p> <p>Alpha (12): "SMITH-JONES"</p> <p>Alpha (12): "O'CONNOR"</p>
Alphanumeric	<p>A through Z (all alpha) + 0 through 9 (all numeric) + special characters:</p> <p>Comma (,) Ampersand (&) Space () Hyphen/Dash (-) Period (.) Single quote (') Colon (:) Semicolon (;) Number (#) Forward slash (/) At sign (@) Left justified</p> <p>Non-populated bytes padded with spaces</p> <p>Alphabetic characters sent in lower case will be converted and returned in upper case.</p> <p>Default to all spaces unless otherwise specified in the record layouts.</p> <p>Parentheses () are not accepted.</p>	<p>Text (8): "AB55823D"</p> <p>Text (8): "XX299Y"</p> <p>Text (18): "ADDRESS@DOMAIN.COM"</p> <p>Text (12): "800-555-1234"</p> <p>Text (12): "#34 "</p>
Alphanumeric Plus Parens	Same as above but including parentheses ()	"Department Name (DN)"
Numeric Date	<p>Zero through nine (0–9) formatted as CCYYMMDD. No slashes or hyphens.</p> <p>Default to zeroes unless otherwise specified in the file layouts (no spaces are permitted).</p>	<p>A date of March 25, 2011 would be formatted as "20110325"</p> <p>Open ended date: "00000000"</p>
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.	N/A

Chapter 5: File Submission Time Frames

This section pertains to those RREs choosing a file submission method, not to those using Direct Data Entry (DDE). RREs may submit files according to the specifications listed in the following table. A more thorough explanation of these specifications directly follows this table. **Note:** RREs are assigned a *quarterly* file submission timeframe (a file submission “window”), during which they are to submit their production Claim Input Files. The submission timeframe is assigned at the completion of the registration process.

Table 5-1: File Submission Specifications

Type of File	File Name	Submission Frequency	RRE ID Status
Test	Query Input File Claim Input File TIN Reference File	Anytime, unlimited frequency	Test or Production
Production	Query Input File	Once per calendar month, on any day of the month	Test or Production
Production	TIN Reference File	Prior to, or with, the Claim Input File	Production
Production	Claim Input File	Quarterly, during RRE ID’s 7-day file submission timeframe	Production

Test files (Query Input, Claim Input and TIN Reference) may be submitted at any time with unlimited frequency by RRE IDs in test or production status. There is no file submission timeframe assigned to the RRE ID for test files. (See testing requirements in Chapter 9.

Production Query Input Files may be sent as frequently as once per calendar month, on any day of the month, by RRE IDs in test or production status. There is no submission timeframe.

Production TIN Reference Files must be submitted prior to, or with your *initial* production Claim Input File. After the *initial* TIN Reference File is successfully processed, the TIN Reference File is only required to be sent if you have changes or additions to make. Only new or changed TIN records need to be included on subsequent submissions.

Subsequent TIN Reference Files may be sent as often as needed and at any time during a calendar quarter.

There is no file submission timeframe associated with a separately submitted TIN Reference File.

Many RREs choose to submit a current TIN Reference File with every Claim Input File submission.

Production Claim Input Files must be submitted on a quarterly basis by RRE IDs in a production status during the RRE ID’s 7-day file submission timeframe unless the RRE ID has

nothing to report for a particular quarter. The file submission timeframe is assigned to the RRE ID on their profile report which is sent after the BCRC has processed their Section 111 registration and account setup.

Your submission window timeframe is also displayed on the RRE Listing page after logging on to the Section 111 COBSW. Each 3-month calendar quarter has been divided into 12 submission periods, as shown in Table 5-2. 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.

Under appropriate circumstances, NGHP RREs may submit multiple files within a single quarter. The primary purpose for the allowance of subsequent quarterly file submissions is to provide RREs with an avenue to post updates more expediently for records with ORM in situations where ORM has terminated. RREs can now submit ORM Termination Dates in a timelier fashion via their standard electronic submission process. **The two limitations that apply to this are:**

- A subsequent file submission will not be processed until the prior file submission has completed and a response file for that prior submission has been generated. RREs should not submit a subsequent file until the prior file's response file has been received. If a new Claim Input file is submitted before the prior file has completed processing the newly submitted file will be placed in a "System Hold" status. If that occurs, the subsequent file will be released from "System Hold" automatically once the prior file has completed processing.
- **RREs will be limited to only one file submission** every fourteen days.
- **Please note:** Standard quarterly file submissions are still mandated during the NGHP RRE's assigned file submission period. RREs are under no obligation to submit more than one file per quarter.

Table 5-2: Quarterly Claim Input File Submission Time Frames

Dates/Files	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

Chapter 6: Claim Input File

This section pertains to those RREs choosing a file submission method, and to DDE submitters. 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. File submitters transmit this same information in the form of an automated electronic file.

6.1 Overview

As a reminder: For purposes of NGHP data submissions, the term “**claim**” has a specific reference. It is used to signify the overall compensation claim for liability insurance (including self-insurance), no-fault insurance, or workers’ compensation, rather than to a single (or disaggregated) claim for a particular medical service or item.

What is it? The Claim Input File is the data set transmitted from a MMSEA Section 111 RRE to the BCRC 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 (i.e., claims for payment of health care services) are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals.

What should be reported? Claim information should be reported after ORM (Ongoing Responsibility for Medicals) has been assumed by the RRE or after a TPOC (Total Payment Obligation to Claimant) 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 6.4. 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 6.4. A TPOC single payment obligation is reported in total regardless of whether it is funded through a single payment, an annuity, or a structure 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 following sections in the NGHP User Guide Policy Guidance Chapter III: Section 6.3.2: Special Qualified Reporting Exception, Chapter 4 “MSP Overview,” and Section 6.5.1 “What Claims Are Reportable/When Are Such Claims Reportable?” Also refer to the NGHP User Guide Appendices Chapter V for further guidance on the types of claims that must be reported).

How? This file submission is transmitted in a fixed-width, flat file format. The file layout is provided in NGHP User Guide Appendices Chapter V (Appendix A). Field descriptions in this chapter apply to both file submission and information submitted via DDE.

When? 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.

Why? The BCRC will use this information to determine if the injured party reported can be identified by CMS as a Medicare beneficiary 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 6.1.1 for more information on how the BCRC matches input records to its database of Medicare beneficiaries.

What happens with that information? If the claim information provided on the Claim Input File or submitted via DDE passes the BCRC edit process, it is then passed to other Medicare systems and databases including those used by the CMS BCRC and Medicare claims processing contractors. Concurrently, the BCRC will return a response file for each Claim Input File received. This response file will contain a response record corresponding to each input record, indicating the results of processing. The BCRC will begin creation of the response file as soon as all submitted records have finished processing, but no later than 30 days after file submission. Response files may take *up to 33 days* to be created and transmitted to the RRE. Responses are also produced for DDE claim submissions, with results displayed on the "Claim Listing" page of the Section 111 COBSW.

What must the RRE do after they submit? RREs must react to 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 RREs that are file submitters must correct the record and resend it with their next quarterly file submission. DDE submitters must correct and resubmit erroneous claims on the Section 111 COBSW as soon as possible.

RRE Account Managers will receive email notifications from the BCRC when a file has been received and when response files are available. File processing statuses and processing results for submitted Section 111 files will be displayed on the Section 111 COBSW on the File Listing and File Detail pages for the RRE ID. Users associated with the RRE ID will be able to see the following information:

- Date the file was received and processed by the BCRC;
- File status;
- Record counts for each completed file, such as the number of records received, including counts for additions, updates, and deletions; the number of records that were matched to a Medicare beneficiary; the number of records in error; and a count of compliance flags posted by the BCRC.

Historical information on files submitted and processed remains on the Section 111 COBSW for a one-year period.

ORM: 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" (ORM) situations along with the one-time reporting of payments where ongoing responsibility is not assumed.

When reporting ongoing responsibility for medicals, you are **not** to report individual payments for each medical item or service. You are also **not** to report a previously submitted and accepted record each quarter. However, when an RRE has accepted ongoing responsibility for medicals on a claim (as is the case with many workers' compensation and no-fault claims), the RRE will report **two** events: an initial (add) record to reflect the acceptance of ongoing payment responsibility, and a second (an update) record to provide the end date of ongoing payment responsibility (in the ORM Termination Date Field, 79).

ORM Indicator: When termination of ongoing responsibility for medicals is reported, the ORM Indicator in Field 78 *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 and, in the same record, the termination date for such responsibility.

RREs are **not** to submit a report on the Claim Input File every time a payment is made in 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 61) when reporting the assumption of ORM and the Exhaust Date for the Dollar Limit for No-Fault Insurance (Field 62) when ORM is terminated as applicable. See Section 6.6 for more information on reporting ORM.

Matching to Medicare Beneficiaries: RREs must determine whether or not an injured party is a Medicare beneficiary. See Chapter 8 for more information on the query process available for this purpose. RREs must submit the Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) for the injured party (or the Social Security Number [SSN] using either the last 5 digits or all 9 digits of the SSN) on all Claim Input File Detail Records. RREs are instructed to report only 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 match a particular Medicare ID 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 be returned with a value of '51' indicating that the individual was not matched to a Medicare beneficiary based on the submitted information. Complete response file processing is covered in Chapter 7.

RREs with Multiple Lines of Business: 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 in the NGHP User Guide Registration Procedures Chapter.

TIN Reference File: 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 in the TIN reference File to submit. However, if you choose, you may submit a TIN Reference File with every quarterly Claim Input File submission.

File Structure: The file structure will be explained in subsequent sections.

For a high-level picture of what a TIN Reference File would look like, here is a sample TIN Reference File structure:

- 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

For a high-level picture of the associated Claim Input File, here is a sample Claim Input 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

6.1.1 Matching Records to Medicare Beneficiaries

To determine whether an injured party is a Medicare beneficiary, the BCRC must match your data to Medicare's. This matching can be done using (as one data element) either an individual's Medicare ID (HICN or MBI) or an individual's Social Security Number (SSN). You must send either a Medicare ID or an SSN as part of the injured party's record in the Claim Input File or the Query Input File. The Medicare ID is preferred. If an SSN is submitted and the individual's Medicare ID is returned on a response file, the RRE is required to use that Medicare ID on all subsequent transactions involving the individual. When submitting an SSN, RREs may report a partial SSN. To do this, enter the first 4 positions with spaces followed by the last 5 digits of the SSN so that the field is populated with the required 9 characters.

In order to determine if individuals are Medicare beneficiaries the BCRC uses:

- Medicare ID (HICN or MBI) (Field 4) (or SSN [either the last 5 digits or the full 9-digit SSN]), (Field 5)
- First initial of the first name (Field 7)
- First 6 characters of the last name (Field 6)
 - Date of birth (DOB) (Field 10)
 - Gender (Field 9)

First the BCRC must find an exact match on the Medicare ID or SSN (i.e., either an exact match on the partial SSN or full 9-digit SSN, whichever was submitted). Then at least three out of the four remaining data elements must be matched to the individual exactly (four out of four when a partial SSN is used).

If a match is found, you will always be returned the correct, current Medicare ID. You must store this Medicare ID on your internal files and are required to use it on future transactions. With a match, the BCRC 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: When using the query process, if an RRE submits a query transaction with a value of ‘0’ for an “unknown gender” for an individual, the BCRC will change this value to a ‘1’ to attempt to get a match. If the record is matched to a Medicare beneficiary, the Query Response File Record will be 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 will be returned with a ‘51’ disposition code 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.

While Medicare IDs may be changed at times (but only by the Social Security Administration [SSA]), the BCRC is able to crosswalk an old Medicare ID to the new Medicare ID. The BCRC will always return the most current Medicare ID 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 Medicare ID/SSN will still be matched to the current Medicare ID.

If an RRE submits **both** the SSN and Medicare ID on a claim or query record, the system will **only use the Medicare ID** for matching purposes, and the SSN will be ignored. The system will attempt to match the Medicare ID to any current or previously assigned Medicare ID for the individual, but if no match is found using the Medicare ID the BCRC 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 their information with SSA, it will be fed to the BCRC and used in the matching process.

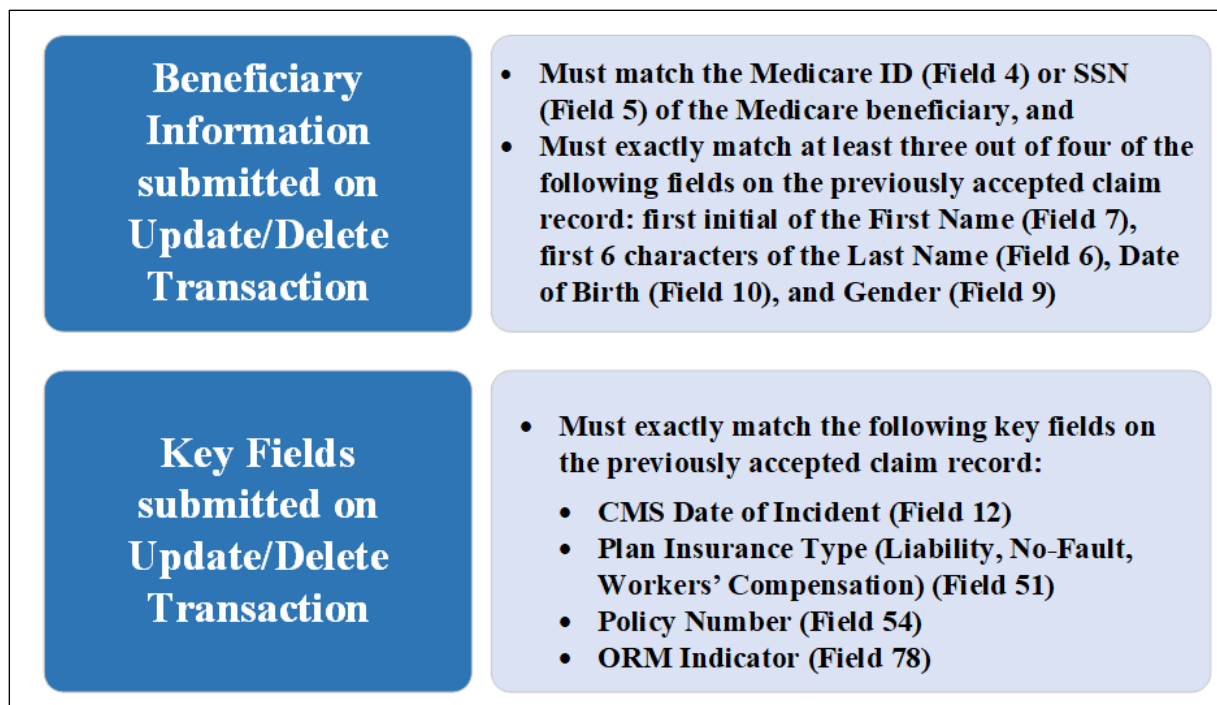
6.1.2 Matching Claim Records

Medicare stores information on claims submitted previously using certain fields that identify the beneficiary as well as the following key fields:

- CMS Date of Incident (Field 12)
- Plan Insurance Type (Liability, No-Fault, Workers’ Compensation- Field 51)
- Policy Number (Field 54)
- ORM Indicator (Field 78)

In order to successfully update or delete a previously submitted and accepted Claim Input File Detail Record, the BCRC must be able to match the beneficiary information and key fields that are submitted on the update/delete transaction to the corresponding information on the previously accepted claim record, as shown in the following figure.

Figure 6-1: Matching Criteria (Update/Delete)



The BCRC passes claim information on to several Medicare systems. One such system is the Common Working File (CWF), which is used by the Medicare claims payment process, among others. The BCRC provides the CWF information regarding claims reported with ORM to prevent Medicare from making an erroneous primary payment for a medical claim that should be paid by Workers' Compensation, No-Fault Insurance or Liability Insurance ORM. The key fields listed above are the key fields used by CWF. **All Non-Group Health Plan** claim records are passed to the BCRC or the CRC (as applicable) for recovery consideration. The BCRC and CRC recognize differing policy and claim numbers on the claim records they receive.

If one individual has different policy and claim numbers, RREs are to send separate records for each (if necessary). 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, on subsequent updates and deletes an RRE must submit the most current, accurate policy and claim number associated with the claim. 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 found in Section 6.6.4.

6.2 Data Elements

Detailed record layouts and data element descriptions for the Claim Input File are in the NGHP User Guide Appendices Chapter V. You must adhere to all requirements specified for each field, as documented in the record layout field descriptions, and associated error codes in the NGHP User Guide Appendices Chapter V.

6.2.1 Header

The first record in the Claim Input File must be a *single header record*. This header record contains the record identifier of 'NGCH', the 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 included on the corresponding trailer record.

6.2.2 Detail Claim Record

The header record is followed by *detail claim records*, which constitute the bulk of the quarterly file submission. Each claim record contains a record identifier (value of 'NGCD'), an RRE-generated Document Control Number (DCN) which is unique for each record on the file, an 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 reporting of an injured party who is deceased.

Each detail record on the Claim Input File must contain a unique DCN, which is generated by the RRE. This DCN is required so that an RRE can more easily track response records and match them with corresponding input records, quickly identifying and resolving any identified problems. The DCN 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. For those RREs using DDE, DCNs are automatically generated by the processing system.

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' policies are making payments to a particular beneficiary, there would be a record derived from the coverage under each policy. There could also be two records coming from coverage under a single automobile insurance policy if the coverage were for 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.

Claimant Information is to be supplied on the Claim Input File Detail Record only in the case of a deceased Medicare beneficiary/injured party and the claimant is the beneficiary's estate or another individual/entity. However, RREs are not required to submit Claimant Information (Fields 84-98) or Claimant 1 Attorney/Other Representative Information (Fields 99 – 112) on the Claim Input File Detail Record even in the case of a deceased beneficiary. These fields are all **Optional**.

Note: Although “Claimant Information” and “Claimant Attorney/Other Representative Information” are no longer required even if the injured party is deceased, if entries are made in any of these fields, it will be edited for validity and completeness. Errors will be returned if submitted “Claimant Information” or “Claimant Attorney/Other Representative Information” is found to be invalid or incomplete. **Be sure to populate Field 84, Claimant 1 Relationship with a space when not supplying Claimant 1 Information.**

6.2.3 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 exists. (Remember that the “claimant” fields on the Claim Input File Detail Record (Fields 84 – 112) 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 Claim Record.

RREs are not required to submit Claimant [2, 3, and 4] Information (Fields 7-21, 36-53, and 65-79) or Claimant [2, 3, and 4] Attorney/Other Representative Information (Fields 22-35, 51-64, and 80-92) on the Claim Input File Auxiliary Record. These fields are all **Optional**.

Note: Although “Claimant Information” and “Claimant Attorney/Other Representative Information” are no longer required even if the injured party is deceased, if entries are made in any of these fields, it will be edited for validity and completeness. Errors will be returned if submitted “Claimant Information” or “Claimant Attorney/Other Representative Information” is found to be invalid or incomplete. **Be sure to populate the Claimant Relationship fields with spaces when not supplying additional Claimant Information on the Auxiliary 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). To remove the information from the claim report that was previously sent and accepted on an auxiliary record, the RRE should re-submit the auxiliary record again with the corresponding detail record and fill in all fields with zeroes or spaces (as applicable); OR, they can simply re-submit the claim detail record and omit sending the corresponding auxiliary record on their next submission.

6.2.4 Trailer

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

6.2.5 ICD-9 and ICD-10 Codes

All add and update records on Claim Input Files and as part of DDE submissions must include International Classification of Diseases, Ninth/Tenth Revision, Clinical Modification (ICD-9/ICD-10) diagnosis codes considered valid (that is, admissible) for purposes of Section 111 reporting in at least the first of the ICD Diagnosis Codes 1–19 beginning in Field 18.

These fields are used to provide a coded description of the alleged illness, injury, or incident claimed and/or released by the settlement, judgment, or award, or for which ORM is assumed. RREs may use diagnosis codes submitted on medical claim records they receive that are related to the claim, or derive ICD-9/ICD-10 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 originating from a provider or supplier of medical services (e.g., physician, hospital, etc.). The ICD-9/ICD-10 codes are used by Medicare to identify claims Medicare may receive, related to the incident, for Medicare claims payment and recovery purposes. RREs are encouraged to supply as many related codes in the ICD Diagnosis Code 1-19 Fields as possible to ensure Medicare correctly identifies the applicable medical claims it receives. Field descriptions are provided in the record layout in the NGHP User Guide Appendices Chapter V (Appendix A), which also provides more information concerning the requirements for these fields.

Certain codes are not valid for No-Fault insurance types (Plan Insurance Type is “D” in field 51), because they are not related to the accident, and may result in inappropriately denied claims. These codes can be viewed on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>.

6.2.5.1 ICD-9 and ICD-10 Diagnosis Code Details

As of October 1, 2015, CMS adopted the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) for diagnosis coding. ICD-10 codes are alphanumeric and contain 3 to 7 digits instead of the 3 to 5 digits used with ICD-9. **Starting October 1, 2015, RREs and their agents are required to submit ICD-10 diagnosis codes on claim reports with a CMS DOI on or after 10/1/2015.**

Valid ICD-9 Diagnosis Codes

ICD-9 diagnosis codes will not be accepted on any Claim Input File Detail record with a CMS DOI of 10/1/2015 or later. Excel files containing the list of ICD-9 diagnosis codes valid for Section 111 reporting are available for download on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>.

Once an ICD-9 diagnosis code is accepted for Section 111 reporting, it will not be removed from the list of valid codes. It may continue to be submitted on subsequent update transactions (unless presently unforeseen updates are made to the list of excluded codes). ICD-9 codes are to be submitted with no decimal point.

If any ICD-9 diagnosis code is submitted that is invalid (that is, inadmissible) for Section 111 reporting, the record will be rejected. The record will be returned with an error associated to the field in which the invalid code was submitted, even if valid codes are supplied in one or more of any other ICD Diagnosis Code fields. More specific requirements are given below.

RREs are advised to use the list of valid ICD-9 diagnosis codes posted to the CMS.gov website.

CMS has also published a list of valid ICD-9 diagnosis codes at: <https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html>. Version 32 is the last ICD-9 file that will be provided by CMS since ICD-10 was implemented on October 1, 2015. CMS will continue to maintain the ICD-9 code website with the posted files (see **Note**).

These are the codes providers (physicians, hospitals, etc.) and suppliers must use when submitting claims to Medicare for payment. These codes form the basis of those used for Section 111 reporting, with some exceptions. The BCRC will consider any ICD-9 diagnosis code found in any of versions 25–32 that is posted to the website above as valid, as long as they do not appear on the excluded lists posted on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>, and do not begin with the letter “V.”

Note: To ensure S111 compliance, CMS advises RREs to download the file of ICD-9 diagnosis codes valid for Section 111 reporting on CMS.gov, and to review the excluded ICD-9 list, rather than working with the files linked above. The ICD diagnosis code(s) reported starting in Field 18 are critical and must accurately describe the injury, incident, or illness being claimed or released or for which ORM is assumed.

In summary, the term “ICD-9 diagnosis code valid for Section 111 reporting” is identified as any ICD-9 code that:

- Exactly matches the first 5 bytes or characters of a record on any of the files incorporated into the BCRC Section 111 process;
- Exists in Versions 25–Version 32;
- Is not found on the list of exclusions, which can be found on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>; and,
- Does not begin with the letter “V.”

Codes that begin with the letter “E” may only be used in field 15, the *Alleged Cause of Illness/Injury* field. In order to be used, such codes must not appear on the list of excluded ICD-9 codes available on the CMS.gov website.

Valid ICD-10 Diagnosis Codes

Excel files containing the list of ICD-10 diagnosis codes valid (that is, admissible) for Section 111 reporting are available for download on the CMS.gov website.

Once an ICD-10 diagnosis code is accepted for Section 111 reporting, it will not be removed from the list of valid codes. It may continue to be submitted on subsequent update transactions

(unless presently unforeseen updates are made to the list of excluded codes). ICD-10 codes are to be submitted with no decimal point.

If any ICD-10 diagnosis code is submitted that is invalid (that is, inadmissible) for Section 111 reporting, or is no longer valid in the industry per the CDC, the record will be rejected. The record will be returned with an error associated to the field in which the invalid code was submitted, even if valid codes are supplied in one or more of any other ICD diagnosis code fields. More specific requirements are given below.

CMS has published lists of valid 2023 ICD-10 diagnosis codes at:

<https://www.cms.gov/medicare/icd-10/2023-icd-10-cm>. These are the codes providers (physicians, hospitals, etc.) and suppliers must use when submitting claims to Medicare for payment with a CMS DOI of 10/1/2015 and later. CMS will add updated codes to this web page for subsequent years. The codes will be posted to the CMS website before the effective October 1 date of the current year and will be incorporated into Section 111 processing as of January 1 of the following year.

In summary, the term “ICD-10 diagnosis code valid for Section 111 reporting” is identified as any ICD-10 code that:

- Exactly matches a record on any of the files incorporated into the BCRC Section 111 process, and
- Is not found on the list of exclusions, which can be found on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>.

RREs are advised to download the file of ICD-10 diagnosis codes acceptable for Section 111 reporting from the CMS.gov website. The ICD diagnosis code(s) reported starting in Field 18 are critical and must accurately describe the injury, incident, or illness being claimed or released or for which ORM is assumed.

Codes that begin with the letters “V,” “W,” “X,” or “Y” may only be used in field 15, the *Alleged Cause of Illness/Injury* field. Such codes used in field 15 must not appear on the list of excluded ICD-10 codes available on the CMS.gov website.

Excluded ICD-9 and ICD-10 Diagnosis Codes

CMS has determined that certain available ICD-9/ICD-10 diagnosis codes as published do not provide enough information related to the cause and nature of an illness, incident, or injury to be adequate for Section 111 reporting. Such codes are therefore excluded from use in Section 111 claim reports. A list of excluded codes is provided on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>, as the list of “Excluded ICD-10 Diagnosis Codes.” These codes will NOT be accepted in the Alleged Cause of Injury, Incident, or Illness (Field 15) or in the ICD Diagnosis Codes beginning in Field 18.

In addition, all ICD-9 diagnosis codes beginning with the letter “V” and all ICD-10 diagnosis codes beginning with the letters “V,” “W,” “X,” and “Y” are only accepted in the Alleged Cause of Injury field (field 15). They are not listed singly on the exclusion list on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>. None of these codes will be accepted for Section 111 diagnosis reporting beginning in Field 18.

About ICD-10 “Z” Codes

As indicated earlier, ICD-9 “V” codes are considered invalid for Section 111 reporting. ICD-9 “V” codes are equivalent to ICD-10 “Z” codes (e.g., factors influencing health status and contact with health services). These “Z” codes, therefore, are also excluded from Section 111 claim reports.

The list of Excluded ICD-9 and ICD-10 Diagnosis Codes may be downloaded from the CMS.gov website.

Summary of Requirements

- When there is a **TPOC** settlement, judgment, award, or other payment, RREs are to submit ICD-9/ICD-10 codes to reflect **all the alleged illnesses/injuries claimed and/or released**. Where **ORM** is reported, RREs are to submit ICD-9/ICD-10 codes for **all alleged injuries/illnesses for which the RRE has assumed ORM**.
- If, due to a subsequent ruling by CMS, an ICD-9/ICD-10 diagnosis code previously submitted no longer applies to the claim, RREs may send an update transaction without that particular ICD-9/ICD-10 diagnosis code but must include all ICD-9/ICD-10 diagnosis codes that still apply.
- CMS encourages RREs to supply as many valid ICD-9/ICD-10 Diagnosis Codes as possible as that will lead to more accurate coordination of benefits, including claims payments and recoveries, when applicable.
- ICD-9/ICD-10 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/ICD-10 diagnosis codes on CMS.gov website. Do not add leading or trailing zeroes just to fill the positions of the field on the file layout.
- Valid ICD-9 diagnosis codes can be 3, 4 and 5 digits long—and no partial codes may be submitted. In other words, you may not submit only the first 3 digits of a 4-digit code, etc.
- Valid ICD-10 diagnosis codes can be 3 to 7 digits long—and no partial codes may be submitted.
- The downloadable list of ICD-9 and ICD-10 codes considered valid by CMS for Section 111 reporting are posted on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>. A submitted ICD-9 diagnosis code must *exactly* match the first 5 bytes/characters of a record on this list. A submitted ICD-10 diagnosis code must *exactly* match the first 7 bytes/characters of a record on this list.
- ICD diagnosis code edits are not applied to delete transactions, but are applied to add and update transactions.
- ICD-10 “Z” codes are excluded from Section 111 claims reporting.
- At least one valid ICD-9/ICD-10 diagnosis code must be provided on all add and update records, entered in Field 18. Additional valid ICD-9/ICD-10 diagnosis codes (numbers 2 through 19) are optional. But remember that RREs must provide as many as possible to adequately describe the injury/illness associated with the TPOC and/or ORM reported, as specified above.

- Any unused ICD Diagnosis Code fields are to be filled with spaces.
- If more than one ICD-9/ICD-10 Diagnosis Code is supplied, all must be valid. If even one code submitted is inadmissible or incorrectly entered, the entire record will be rejected with an “SP” disposition code. The associated error code for the field in error will be included with the rejected file.
- After an initial add record has been submitted and accepted an RRE may add or remove ICD-9/ICD-10 diagnosis codes on subsequent update records. Update records should include all previously submitted ICD-9/ICD-10 diagnosis codes that still apply to the claim report, along with any new codes the RRE needs to submit.
- The **Alleged Cause of Illness/Injury (Field 15) is an optional field. If an ICD-9 diagnosis code is supplied, it must begin with an “E” (be an “E code”)** and be on the list of valid ICD-9 codes for Section 111 reporting. **If an ICD-10 diagnosis code is supplied, it must begin with “V,” “W,” “X,” or “Y,”** and must be on the list of valid ICD-10 codes for Section 111 reporting. In addition, the “V,” “W,” “X,” or “Y,” code supplied must **NOT** be on the list of Excluded ICD-10 Diagnosis Codes provided in the NGHP User Guide Appendices Chapter V. (See Section 6.2.5.2 for a special default code that may be used under only very limited circumstances.) This is the only place these codes (ICD-9 “E” codes and ICD-10 “V,” “W,” “X,” or “Y,” codes) should be used within S111 reporting.

More information related to ICD-9-CM codes and coding may be found at <https://www.cdc.gov/nchs/icd/icd9cm.htm>. More information related to ICD-10-CM codes and coding may be found at <https://www.cdc.gov/nchs/icd/icd-10-cm.htm>. In addition, RREs and reporting agents may find it helpful to do an Internet search on ICD codes; many sources of information regarding ICD-9/ICD-10 diagnosis codes may be found online, including online and downloadable search lists, and free software to assist with deriving codes applicable to specific injuries.

6.2.5.2 Special Default Diagnosis Code for Liability – NOINJ Code

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 the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1 - What Claims Are Reportable/When Are Such Claims Reportable) 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.

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 Field 18 (ICD Diagnosis Code 1).

When submitting the “**NOINJ**” value in Field 18, all of the rest of the diagnosis fields must be left blank and Field 15 (Alleged Cause of Injury, Incident, or Illness) must be submitted with the value “**NOINJ**” or all spaces. All other required fields must be submitted on the claim report.

Important Considerations:

- The default code of ‘NOINJ’ may not be submitted on claim reports reflecting ORM. If a Claim Input File Detail Record is submitted with Y in the ORM Indicator (Field 78) and either the Alleged Cause of Injury, Incident, Illness (Field 15) or any ICD Diagnosis Codes 1-19 (starting at Field 18) contain ‘NOINJ’, the record will be rejected.
- The default code of ‘NOINJ’ may only be used when reporting liability insurance (including self-insurance) claim reports with L in the Plan Insurance Type (Field 51). If the Plan Insurance Type submitted is not L, the record will be rejected.
- ‘NOINJ’ will only be accepted in Fields 15 and 18 on the Claim Input File Detail Record. If ‘NOINJ’ is submitted in any of the ICD Diagnosis Codes 2-19 starting in Field 19, the record will be rejected.
- If ‘NOINJ’ is submitted in Field 15 then ‘NOINJ’ must be submitted in Field 18; otherwise, the record will be rejected.
- If ‘NOINJ’ is submitted in Field 18, then ‘NOINJ’ (or all spaces) must be submitted in Field 15; otherwise, the record will be rejected.
- If ‘NOINJ’ is submitted in Field 18, then all remaining ICD Diagnosis Codes 2-19 (Fields 19-36) must be filled with spaces. If Fields 19-36 contain values other than spaces, the record will be rejected.
- If an ‘NOINJ’ code is incorrectly or inappropriately used, the record will be rejected with the CI25 error code.
- CMS will closely monitor the use of the ‘NOINJ’ default code by RREs to ensure it is used appropriately. RREs using this code erroneously are at risk of non-compliance with Section 111 reporting requirements.

6.2.6 Foreign Addresses

Contact information that is 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 RRE use are available on the TIN Reference File (see Section 6.3 and the NGHP User Guide Appendices Chapter V). 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 the NGHP User Guide Appendices Chapter V (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. It is recommended that an RRE make every effort to supply US contact information in order to avoid further questions regarding contact address information.

6.3 TIN Reference File

A Tax Identification Number (TIN) is submitted in Field 52 of each Claim Detail Record. It is an IRS-provided tax identification code number assigned to the RRE. This code number may also be known as the RRE's federal employer identification number (FEIN or EIN). For those who are self-employed, their business TIN may be an Employer Identification Number (EIN) or a personal Social Security Number (SSN).

For an RRE not based in the United States and without a valid IRS-assigned TIN or EIN, the Section 111-required TIN may be a fake (or pseudo-TIN) created by the RRE during the Section 111 COBSW registration process, using the format of 9999xxxxx where 'xxxxx' is any number of the RRE's choosing (see the NGHP User Guide Registration Procedures Chapter (Section 4.2.6 - Foreign RRE Registration). CMS encourages foreign entities (RREs that have no IRS-assigned TIN and/or US mailing address) to apply for a U.S. federal TIN by completing the Internal Revenue Service (IRS) SS-4 Application and then using that number to register and report, if possible. Note that entities in Guam, Puerto Rico, and the US Virgin Islands are considered within the US, have US addresses, and have IRS-assigned TINs.

The TIN in field 52 of the Claim Input File must match what was submitted in your TIN Reference File. All claims should be reported with the RRE TIN associated with the entity that currently has payment responsibility for the claim. This will mean that, depending on the circumstances, you might submit either the same or different TINs in Field 72 and in the TIN Reference File than you provided when you registered for your RRE ID. As described later, updates may be submitted to change the TIN associated with a previously reported claim, if needed.

Additional TINs for injured parties, other claimants, attorneys, or representatives are submitted on the Claim Detail Record, but only the RRE TINs submitted in Field 52 are to be included on the TIN Reference File. For RRE (Plan) TIN and Office Code (Site ID) combinations reported in Fields 52 and 53 of your Claim Input File Detail Records, you must have submitted a TIN Reference File with those codes.

The TIN Reference File is submitted prior to or with the Claim Input File – doing so makes it unnecessary to repeat the RRE name and address information associated with each TIN 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 information and notifications related to Medicare's recovery efforts, if 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. In such case, each TIN may be associated with a distinct name and mailing address.

To allow for further flexibility, CMS has added an optional field called the Office Code (or Site ID) as Field 53 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 52 of each Claim Detail Record, '000000001' in Field 53 of each workers' compensation Claim Detail Record, and '000000002' in Field 53 of each commercial liability Claim Detail Record.

Foreign RREs with 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, 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. Each of these alphanumeric fields is 32 bytes.

For all RRE reporters: 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 Section 111 COBSW using DDE.

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

Any TIN/Office Code combination submitted in Fields 52 and 53 on a Claim Detail Record must be included on a corresponding record in the TIN Reference File in order for the Claim Input File Detail Record to be processed.

As of October 2011, a submitted TIN Reference File will generate a corresponding TIN Response File. Errors on TIN Reference File records will result in the rejection of subsequently processed Claim Input File Detail Records that have matching RRE TIN/Office Codes (Section 6.3.3). The TIN Reference File layout and field descriptions can be found in the NGHP User Guide Appendices Chapter V (Appendix B).

You do not need to send a TIN Reference File with every Claim Input File submission. 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. Even so, many RREs choose to submit a full TIN Reference File with each Claim Input File submission. Remember that all TINs in each TIN Reference File submitted will be verified, so it is imperative that the TIN information you provide is accurate.

6.3.1 Submission of Recovery Agent Information via the TIN Reference File

Some NGHP RREs use recovery agents to perform or assist with tasks related to MSP recovery demands or potential recovery demands. These RREs provide notice to CMS of their use of such an agent, as well as contact information for the agent. For purposes of MMSEA Section 111 NGHP submission of recovery agent information only, CMS uses the designation of an agent, and submission of that agent's name and address on the TIN Reference File or DDE submission, as an authorization by the RRE for the agent to resolve the Conditional Payment Notice (CPN) and Conditional Payment Letter (CPL) related to claim submissions, with a matching RRE TIN and Office Code and Site ID combination. The agent's authorization by TIN submission ends once a demand is issued; written authorization is needed to pursue any post-demand actions. The designated recovery agent is limited to actions and requests on behalf of the RRE where the RRE is the identified debtor. The authority of the RRE's recovery agent does not extend to the beneficiary. In other words, the recovery agent's authority does not equate to a beneficiary consent to release (CTR) or beneficiary proof of representation (POR) if the identified debtor on the case changes to the beneficiary.

As a temporary workaround, RREs were previously allowed to submit third-party administrator (TPA) information in existing Section 111 NGHP TIN Reference File fields intended for the RRE or insurer address. That process is no longer supported. RREs should submit recovery agent information in dedicated recovery agent fields instead of the RRE address fields. If an RRE submits its recovery agent information using the recovery agent fields, all correspondence related to a recovery case will be sent to the RRE with a copy sent to the recovery agent.

Designation of a recovery agent is **optional**.

Note: If recovery agent information is submitted in fields 6–11 of the TIN Reference File (TIN/Office Code Mailing Name and address fields), all correspondence related to a recovery case will **only** be sent to the recovery agent. No copy will be sent to the RRE.

Note: If DDE reporters submit recovery agent information in this manner, the recovery agent information will apply to ALL of their cases and claims. To submit recovery agent information that does not apply to all cases, DDE reporters should submit that information to the BCRC or CRC manually, and not enter it via DDE.

To submit recovery agent information on the Section 111 NGHP TIN Reference File and indicate that the recovery agent is representing the RRE for claims submitted under the same TIN/Office Code combination:

- Submit the RRE's IRS-assigned tax identification number (TIN) in Field 3
- Submit the applicable Office Code/Site ID in Field 4
- Submit the RRE's name in Field 5
- Submit the recovery agent's name in Field 16
- Submit the recovery agent's address in Fields 17-22
- Submit all other TIN Reference File fields as specified in the file layouts in the NGHP User Guide Appendices Chapter V (Appendix B).

Note: As noted above, any addresses submitted on the TIN Reference File are used by CMS in subsequent business processes. This subsequent activity includes Medicare claims payment processing, and recovery activity performed by the BCRC and the CRC. The submitted TIN address(es) 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 addresses are also used by the BCRC and CRC to direct demand package mailings and other recovery-related notifications. RREs must be prepared to receive such information at the addresses provided on the TIN Reference File and to make sure it is directed to the proper RRE resources for proper handling.

6.3.1.1 Submission of Go Paperless Information

If there is an active Medicare Secondary Payer Recovery Portal (MSPRP) account for the insurer/recovery agent TIN, RREs can set Go Paperless options (i.e., choose to receive letters electronically or by mail) for the insurer and recovery agent address using the TIN Reference File (see Chapter V (Appendix B) for details).

These fields include:

- TIN/Office Code Paperless Indicator (Field 23)
- Recovery Agent Paperless Indicator (Field 24)
- Recovery Agent TIN (Field 25)

6.3.1.2 Recovery Agents to View Open Debt Report

Submitting a recovery agent TIN (Field 25) on the TIN Reference File will allow the recovery agent to view the Open Debt Report on the MSPRP, if the agent has an active MSPRP account with a matching TIN.

6.3.2 TIN Validation

CMS uses the following procedures to process and manage TIN Codes.

- On a Claim Input File Detail Record, a TIN/Office Code combination in Fields 52 and 53 must match a TIN/Office Code combination included on a current or previously submitted TIN Reference File Detail Record. (The Office Code field can be left blank if it is not used.)

- All RRE TINs submitted in Field 52 must be valid IRS-assigned tax IDs (except for foreign RRE pseudo-TINs). Only the TIN will be used in this validation. We do not also match on an associated IRS-assigned name and address.
- If you receive a compliance error on a TIN you believe is valid, please contact your EDI Representative. Upon receipt of the appropriate documentation, your EDI Representative will mark the TIN as valid and it 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’.

6.3.3 Address Validation and TIN Reference Response File

Basic Field Validation

- If an RRE submits a TIN Reference File at the same time as their Claim Input File, the BCRC will process the TIN Reference File first. It will process the Claim Input File after the TIN Reference File processing is complete. RREs may also submit a TIN Reference File alone (without submission of a Claim Input File). In such case the system will process the TIN file in the BCRC’s next scheduled batch cycle. There is no defined file submission timeframe associated with a separately submitted TIN Reference File.
- On all TIN Reference Files submitted, basic field validations will be performed according to the field descriptions in the TIN Reference File layouts in the NGHP User Guide Appendices Chapter V (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 process. In this step, CMS does not require that any name and address submitted with the TIN necessarily has to match the name and address associated with that TIN by the IRS. (But see “Address Validation,” below.)
- If an error is found on an input TIN Reference File Detail Record during the basic field validation step, the TIN Reference Response File will include a ‘TN’ disposition code and error codes specific to the errors identified (See the TIN Response File Error Codes table in the NGHP User Guide Appendices Chapter V).
- As with other Section 111 file processing, when reports of certain severe errors are generated for TIN Reference Files, notification is sent to RREs via email alerts. “Severe errors” include missing header or trailer records, incorrectly formatted header and trailer records or an invalid record count on the trailer. RREs notified of a severe error must contact their assigned EDI Representative and resubmit a corrected TIN Reference File, as instructed.

Address Validation

In this step, mailing addresses associated with TINs have already been validated.

- TIN Reference File records that pass the basic field validation edits will be further processed by the BCRC using a postal software address analysis tool. This tool will be used to validate and improve the standardization of mailing addresses.
- Non-foreign addresses will be reformatted into the standardized format recommended by the U. S. Postal Service (USPS), so that they can be matched against another database of valid, deliverable addresses. This process will involve such changes as correcting misspellings,

changing the order of the individual components of the primary address line(s), 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). When a match to a deliverable address is confirmed, the address is considered valid.
- If a standardized address received by CMS is matched to one that is considered an undeliverable address, such as a vacant lot, the address will be considered invalid.
- The general “return codes” provided by the postal software address analysis tool will be translated into more specific descriptive error codes that will indicate why the address failed to be validated. These descriptive error codes are included in the TIN Response File Error Codes table in the NGHP User Guide Appendices Chapter V (Appendix G).
- Address validation will be applied to the TIN/Office Code Mailing Address submitted in a TIN Reference File Detail Record in Fields 6 – 11, where the TIN/Office Code State (Field 9) is not equal to ‘FC’ (foreign).
- Foreign RRE Addresses, submitted in Fields 12 – 15 on TIN Reference File Detail Records where the State code in Field 9 equals ‘FC’, will *not* be validated in this step. Only the basic field validation steps will apply to the Foreign RRE Address.

TIN Reference Response File

- TIN Reference Response Files will start with a header record, followed by all TIN Reference File Detail Records, and end with a trailer record containing the Detail Record count. Each record is a fixed length of 1000 bytes. The file layout is shown in the NGHP User Guide Appendices Chapter V (Appendix G).
- 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, any submitted foreign RRE address, and an indicator to show whether the system applied changes to the mailing address fields. This file will also include five fields regarding any submitted paperless indicators.
- If a TIN Reference File Detail Record **fails** the TIN and/or TIN address validation, it will be rejected. In such case a corresponding TIN Reference Response File Detail Record will be returned with:
 - A value of ‘TN’ in the TIN Disp Code (Field 22)

Note: A TN30 error will be returned on the response file if Field 22 does not contain four numeric digits, all zeroes, or all spaces. However, the error no longer causes records to reject.
 - Associated errors in the TIN Error 1-10 (Fields 23 - 32), as documented in the TIN Response File Error Codes table in the NGHP User Guide Appendices Chapter V (Appendix G)
 - 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)
 - 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 BCRC will use for subsequent processing in the corresponding Applied TIN/Office Code Mailing Address (Fields 12 - 17)
- The following fields will receive warning codes for invalid values. For these, the record will not be rejected.
 - TN37 (Invalid TIN/Office Code Paperless Indicator) (Field 23)
 - TN39 (Invalid Recovery Agent Paperless Indicator (Field 24)TN38 (TIN does not match to an MSPRP account) or TN40 (Recovery Agent TIN does not match to an MSPRP account) (Field 25)
- 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 (disposition) Code returned. New but erroneous TIN records can replace previously existing TIN records that were valid, and vice versa. **Errors on TIN Reference File records will result in the rejection of subsequently processed Claim Input File Detail Records that have 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 to 7 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 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 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, such as https://tools.usps.com/go/ZipLookupAction_input.

Processing TINs on the Claim Input File

- The TIN and Office Code/Site ID (Claim Input File Fields 52 and 53) 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 claim information by Medicare and also be passed to the BCRC.

- 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 identified and returned on their TIN Reference Response Files** to determine what caused the matching TIN record to be rejected. An RRE will then need to resubmit corrected TIN Reference File records, and also to resubmit the corresponding Claim Input File Detail Records that were rejected, either 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, they do submit the same TIN information online. The Section 111 COBSW does 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 to validate addresses will only be performed in batch.
- If a TIN error is found during batch processing, 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 the NGHP User Guide Appendices Chapter V (Appendix G) 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 BCRC 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 https://tools.usps.com/go/ZipLookupAction_input.

6.4 Total Payment Obligation to the Claimant (TPOC) Reporting

The TPOC Amount refers to the dollar amount of a settlement, judgment, award, or other payment **in addition to or apart from ORM**. A TPOC generally reflects a “one-time” or “lump sum” settlement, judgment, award, or other payment intended to resolve or partially resolve a claim. It is the dollar amount of the total payment obligation to, or on behalf of the injured party in connection with the settlement, judgment, award, or other payment. Individual reimbursements paid for specific medical claims submitted to an RRE, paid due the RRE’s ORM for the claim, **do not** constitute separate TPOC Amounts.

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.

Note: Please refer to the definition of the TPOC Date and TPOC Amount in Fields 80 and 81 of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter V (Appendix A).

6.4.1 TPOC Mandatory Reporting Thresholds

CMS has revised the mandatory reporting thresholds and implementation timeline for all liability insurance (including self-insurance), no-fault insurance, and workers' compensation TPOC settlements, judgments, awards, or other payments for Section 111 TPOC reporting. The following tables describe the TPOC reporting requirements, timelines and amounts, and mandatory thresholds.

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) (Section 111 MSP reporting requirements for liability insurance (including self-insurance), no-fault insurance, and workers' compensation).

These thresholds are not exceptions; they 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. CMS reserves the right to change these thresholds and will provide appropriate advance notification of any changes.

Note: All RREs (except for those using DDE), must report during each quarterly submission window. Please see Chapter 5 for more information. DDE submitters are required to report within 45 calendar days of the TPOC date.

Table 6-1: TPOC Reporting Requirements Summary

Insurance Type	Reportable TPOC Dates	Reportable Amounts	Threshold Applicable
No-Fault	October 1, 2010 & subsequent	Cumulative TPOC Amount that exceeds threshold	Yes
Liability Insurance (Including self-insurance)	October 1, 2011 & subsequent	Cumulative TPOC Amount that exceeds threshold	Yes
Workers' Compensation	October 1, 2010 & subsequent	Cumulative TPOC Amount that exceeds threshold	Yes

6.4.1.1 Meeting the Mandatory TPOC Reporting Threshold

Where there are multiple TPOCs reported by the same RRE on the same record, the combined 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 in the Section 6.4.5.

For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the threshold applies to the total of these two figures.

To determine which threshold date range the TPOC falls into, the RRE will compare the most recent (or only) TPOC Date to the threshold date ranges. If the cumulative TPOC Amount associated with the claim is greater than the threshold amount for the threshold date range, the claim record must be reported.

6.4.2 No-Fault Insurance TPOCs

RREs are required to report all no-fault insurance TPOCs with dates of October 1, 2010 and subsequent.

RREs may, but are not required to, include no-fault TPOCs with dates prior to October 1, 2010.

CMS has implemented a \$750 threshold for no-fault insurance TPOC Amounts dated October 1, 2016 or after. RREs are required to report no-fault TPOCs **only** if the cumulative TPOC Amount **exceeds** the reporting threshold for the most recent TPOC Date. The BCRC will total all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.

As of January 1, 2022, CMS will maintain the \$750 threshold for no-fault insurance, where the no-fault insurer does not otherwise have ongoing responsibility for medicals. This threshold does not apply to non-trauma liability reporting for alleged ingestion, implantation, or exposure cases. Any settlement, regardless of amount, should be reported for these types of cases.

RREs **may** submit TPOCs that are less than or equal to the TPOC dollar threshold and will not be penalized for doing so. Detailed reporting requirements are listed in the following table.

Table 6-2: Details: TPOC No-Fault Threshold Timelines and Amounts

Reporting Required for Cumulative Total TPOC Amount(s)	Reporting Optional for Cumulative Total TPOC Amount(s)	Most Recent TPOC Date is on or between	Reporting Required Quarter Beginning
Greater than \$750	Greater than \$0 through \$750	October 1, 2016 or after	January 1, 2017

6.4.2.1 TPOC No-Fault Claim Report Rejection (CJ07) Conditions

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

Table 6-3: Summary: Mandatory TPOC Thresholds for No-Fault

Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over \$750	October 1, 2016	January 1, 2017

6.4.3 Liability Insurance (including Self-Insurance) TPOCs

RREs are required to report TPOC Dates of October 1, 2011 and subsequent. RREs may, but are not required to, include TPOCs with dates prior to October 1, 2011.

As of January 1, 2022, the threshold for physical trauma-based liability insurance settlements will remain at \$750. This threshold does not apply to non-trauma liability reporting for alleged ingestion, implantation, or exposure cases. Any settlement, regardless of amount, should be reported for these types of cases.

RREs are required to report liability insurance (including self-insurance) TPOCs **only** if the cumulative TPOC Amount **exceeds** the reporting threshold for the most recent TPOC Date. The BCRC will total all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.

RREs **may** submit TPOCs that are less than or equal to the TPOC dollar threshold and will not be penalized for doing so.

6.4.3.1 Mandatory TPOC Thresholds for Liability Insurance (including Self-Insurance)

CMS has revised the Implementation Timeline and TPOC Dollar Thresholds for **certain** liability insurance (including self-insurance) (Plan Insurance Type = 'L') TPOC settlements, judgments, awards, or other payments. Detailed reporting requirements for different TPOC Amounts are listed in Table 6-4 and summarized in Table 6-5.

Table 6-4: Details: TPOC Liability Threshold Timelines and Amounts

Reporting Required for Cumulative Total TPOC Amount(s)	Reporting Optional for Cumulative Total TPOC Amount(s)	Most Recent TPOC Date is on or between	Reporting Required Quarter Beginning
Greater than \$100,000	Greater than \$5,000 through \$100,000	October 1, 2011 to March 31, 2012	January 1, 2012
Greater than \$50,000	Greater than \$5,000 through \$50,000	April 1, 2012 to June 30, 2012	July 1, 2012
Greater than \$25,000	Greater than \$5,000 through \$25,000	July 1, 2012 to Sept. 30, 2012	October 1, 2012
Greater than \$5,000	Greater than \$300 through \$5,000	October 1, 2012 to Sept. 30, 2013	January 1, 2013
Greater than \$2,000	Greater than \$300 through \$2,000	October 1, 2013 to Sept. 30, 2014	January 1, 2014
Greater than \$1,000	NA	October 1, 2014 to Dec. 31, 2016	January 1, 2015
Greater than \$750	Greater than \$0 through \$750	January 1, 2017 or after	April 1, 2017

6.4.3.2 TPOC Liability Claim Report Rejection (CJ07) Conditions

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

Table 6-5: Summary: Mandatory Thresholds for Liability Insurance (including self-insurance) TPOC Settlements, Judgments, Awards or Other Payments

Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over \$100,000	October 1, 2011	January 1, 2012
TPOCs over \$50,000	April 1, 2012	July 1, 2012
TPOCs over \$25,000	July 1, 2012	October 1, 2012
TPOCs over \$5,000	October 1, 2012	January 1, 2013
TPOCs over \$2,000	October 1, 2013	January 1, 2014
TPOCs over \$1000	October 1, 2014	January 1, 2015
TPOCs over \$750	January 1, 2017	April 1, 2017

6.4.4 Workers' Compensation TPOCs

RREs are required to report TPOCs with dates of October 1, 2010 and subsequent. RREs may, but are not required to, include TPOCs with dates prior to October 1, 2010.

As of January 1, 2022, CMS will maintain the \$750 threshold for workers' compensation settlements, where the workers' compensation entity does not otherwise have ongoing responsibility for medicals. This threshold does not apply to non-trauma liability reporting for alleged ingestion, implantation, or exposure cases. Any settlement, regardless of amount, should be reported for these types of cases.

RREs are required to report workers' compensation TPOCs **only** if the cumulative TPOC Amount **exceeds** the reporting threshold for the most recent TPOC Date. The BCRC will total all TPOC Amounts reported on the claim record when determining if the claim meets the reporting threshold.

RREs **may** submit TPOCs that are less than or equal to the TPOC dollar threshold and will not be penalized for doing so.

6.4.4.1 Mandatory TPOC Thresholds for Workers' Compensation

CMS has revised the Timeline and TPOC Dollar Thresholds for Workers' Compensation (Plan Insurance Type = 'E') TPOC settlements, judgments, awards, or other payments. The reporting requirements are summarized in Table 6-7.

Table 6-6: Details: TPOC Workers' Compensation Threshold Timelines and Amounts

Reporting Required for Cumulative Total TPOC Amount(s)	Reporting Optional for Cumulative Total TPOC Amount(s)	Most Recent TPOC Date is on or between	Reporting Required Quarter Beginning
Greater than \$5,000	Greater than \$300 through \$5,000	October 1, 2010 to Sept. 30, 2013	January 1, 2011
Greater than \$2,000	Greater than \$300 through \$2,000	October 1, 2013 to Sept. 30, 2014	January 1, 2014
Greater than \$300	NA	October 1, 2014 or after	January 1, 2015
Greater than \$750	Greater than \$0 through \$750	October 1, 2016 or after	January 1, 2017

6.4.4.2 TPOC Workers' Compensation Claim Report Rejection (CJ07) Conditions

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

Table 6-7: Summary: Mandatory TPOC Thresholds for Workers' Compensation

Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over \$5,000	October 1, 2010	January 1, 2011
TPOCs over \$2,000	October 1, 2013	January 1, 2014
TPOCs over \$300	October 1, 2014	January 1, 2015
TPOCs over \$750	October 1, 2016	January 1, 2017

6.4.5 Reporting Multiple TPOCs

This section provides information on how RREs will report multiple TPOC Dates and Amounts on the Section 111 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 in separate fields.

The following examples illustrate situations where a TPOC should **NOT** be reported in multiple TPOC fields:

- **Single TPOC Example 1:** A settlement was established on 5/16/2011 for \$10,000 that includes two components: attorney fees and costs borne by the beneficiary. One check was made out to the attorney for \$1,500 and another check was made out to the beneficiary for the remaining \$8,500.
 - Do **not** report these amounts as two separate TPOCs.
 - Do combine the amounts from both checks and report the sum as a single TPOC on the Claim Input File Detail Record.
 - Submit 20110516 in the TPOC Date 1 (Field 80) and submit 00001000000 in the TPOC Amount 1 (Field 81).
 - Do not submit any information in the TPOC fields on the Auxiliary Record.
- **Single TPOC Example 2:** A settlement was established on 8/11/2011 for \$12,500 that was set up as installment payments to be paid in increments of \$500 each month.
 - Do **not** report each \$500 payment as a separate TPOC.
 - Do report this as a single TPOC on the Claim Input File Detail Record
 - Submit 20110811 in the TPOC Date 1 (Field 80) and submit 00001250000 entered in the TPOC Amount 1 (Field 81)
 - Do not submit any information in the TPOC fields on the Auxiliary Record.

Before submitting multiple TPOC Amounts, remember that a TPOC is a single total payment obligation reported **in total** regardless of whether it is funded through a single payment, an annuity, or a structured settlement.

When reporting multiple TPOCs, each TPOC should reflect a separate, different settlement, judgment, award, or other payment usually established at different times. As such, the dates in the TPOC Date fields are usually not identical.

- **Multiple TPOC Example:** A medical malpractice case is settled for a single injured party in which two practitioners (two defendants) are involved, and both are covered by the same medical malpractice insurance policy. Two separate settlements were reached under the same policy, one for each defendant. One settlement was established on 5/3/2011 for \$5,000 and the other settlement was established on 5/10/2011 for \$10,000.
- Report each settlement as a separate TPOC:
- Submit one settlement on the Claim Input File Detail Record (e.g., submit 20110503 in the TPOC Date 1 (Field 80) and submit 00000500000 entered in the TPOC Amount 1 (Field 81)
- Submit the additional settlement on the Claim Input File Auxiliary Record (e.g., submit 20110510 in the first TPOC Date (Field 93) and submit 00001000000 entered in the first TPOC Amount (Field 94)

If multiple checks for a single settlement are issued on the same date, do **NOT** report each check as a separate settlement (i.e., as multiple TPOCs). Instead, combine the amounts and enter that sum in the first TPOC Amount field. The following are examples of single settlements:

- Annuity payments
- Structured settlement
- Installment payments

For Section 111 reporting there are five sets of TPOC fields available – one set on the Claim Input File Detail Record, and four sets on the Claim Input File *Auxiliary* Record. Each of these sets of fields includes 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 the NGHP User Guide Appendices Chapter V for the Detail and Auxiliary Records. TPOC fields on the Claim Input File Auxiliary Record only need to be used if the RRE has more than one, distinct, TPOC to report for a claim. Information for reporting using add, delete, and update transactions can be found in other sections of this Guide. Please note: The date submitted in the Funding Delayed Beyond TPOC Start Date fields should always be after what is reported in the TPOC Date fields, and never the same dates.

TPOC fields are “positional,” in the sense that the first settlement/judgment/award/other payment TPOC Amount should be reported on the Detail Record in Fields 80-82, 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. Then, all subsequent reports regarding the claim should maintain the position/field the TPOC was previously reported in (e.g., if TPOC Date 2 and TPOC Amount 2 were previously reported with incorrect data, the corrected data for these fields would be placed in the TPOC Date 2 and Amount fields on the update transaction).

In the Claim Input File, the Auxiliary Record must always directly follow the corresponding Detail Record for the claim report. 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 BCRC, 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 (TPOC 2-5 amounts reported previously but subsequently appropriately removed by the RRE).

Table 6-8 and Table 6-9 illustrate how to submit TPOCs on initial and subsequent claim reports. Directly following each of these tables is supporting text that explains each row in the table.

Table 6-8: Submitting TPOCs on an Initial Claim Report

Submission	Number of TPOCs	Action Type Field 3	TPOC Reported in	TPOC Date and Amount Reported in Field(s)
Initial	1	0 (Add)	Claim Input File Detail Record	TPOC in Fields 80 & 81
Initial	More than 1	0 (Add)	<ul style="list-style-type: none"> Claim Input File Detail Record Claim Input File Auxiliary Record 	<ul style="list-style-type: none"> 1st TPOC in Fields 80 & 81 2nd & subsequent TPOCs beginning in Field 93

Submitting TPOCs on Initial Claim Submissions:

- **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 Claim Input File Detail Record, and place the TPOC Date and Amount in Fields 80 and 81 of the Claim Input File Detail Record. Do not include an Auxiliary Record.
- **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 Claim Input File Detail Record. Place the first TPOC Date and Amount in Fields 80 and 81 of the Claim Input File Detail Record, and place the second and any subsequent TPOC Dates and Amounts in the corresponding TPOC fields on the Claim Input File Auxiliary Record.

Table 6-9: Submitting TPOCs on a Subsequent Claim Report

Submission	Number of TPOCs	Action Type Field 3	TPOC Reported in	TPOC Date and Amount Reported in Field(s)
Subsequent	1	2 (update)	Claim Input File Detail Record	Fields 80 & 81
Subsequent	2 (1 previously reported; 1 being added)	2 (update)	<ul style="list-style-type: none"> Claim Input File Detail Record Claim Input File Auxiliary Record 	<ul style="list-style-type: none"> 1st (previously reported) TPOC in Fields 80 & 81 2nd (new) TPOC in Field 93 & 94
Subsequent	3 (2 previously reported, 1 being added)	2 (update)	<ul style="list-style-type: none"> Claim Input File Detail Record Claim Input File Auxiliary Record 	<ul style="list-style-type: none"> 1st (previously reported) TPOC in Fields 80 & 81 2nd (previously reported) TPOC in Field 93 & 94 3rd (new) TPOC in Field 96 & 97

Submission	Number of	Action	TPOC	TPOC Date and Amount
Subsequent	More than 5 (5 previously reported, 1 or more being added)	2 (update)	<ul style="list-style-type: none"> Claim Input File Detail Record Claim Input File Auxiliary Record 	<ul style="list-style-type: none"> 1st (previously reported) TPOC in Fields 80 & 81 The 2nd through 4th (previously reported) TPOCs should be reported beginning in Field 93 & 94. The 5th (previously reported) & all new TPOCs should be added together and this total should be reported in TPOC Amount 5. The most recent TPOC Date should be reported in TPOC Date 5.

Submitting TPOCs on Subsequent Claim Submissions

- **To report a new first TPOC Amount on a subsequent claim report (record already exists with ORM information only)**, submit an update transaction with a '2' in the Action Type of the Claim Input File Detail Record, and place the TPOC Date and Amount in Fields 80 and 81.
- **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 Claim Input File Detail Record, and place the previously reported first TPOC Date and Amount in Fields 80 and 81 of the Claim Input File Detail Record. Then include an Auxiliary Record, and place the new, additional 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 80 and 81 of the Detail Record. Then include an Auxiliary Record and place the second previously reported TPOC Date and Amount in Fields 93 and 94 on the Auxiliary Record. Then place the new, additional third TPOC Date and Amount in Fields 96 and 97 on the Auxiliary Record. To add subsequent TPOCs, follow the same procedure.
- **To report new additional TPOCs for a single claim, after a previous claim submission containing 5 TPOCs**, submit an update transaction with '2' in the Action Type of the Detail Record. Place the first TPOC Date and Amount in Fields 80 and 81 of the Detail Record. The second through 4th TPOCs should be reported beginning in Field 93 & 94. 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.
- This necessary circumstance will be *very* rare. Remember: you are NOT to report every payment related to individual medical services, procedures, and supplies – if you have assumed responsibility to pay such charges directly you should be reporting ORM. If you have a TPOC settlement, judgment, award, or other payment which includes a direct 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.

- Remember that the total TPOC Amount is reported after settlement, judgment or award, or other payment, not individual installment payments if these were made as part of the servicing of a TPOC.

This table illustrates how to correct or remove TPOC information. Directly following this table is supporting text that explains each row in the table.

Table 6-10: Correcting or Removing TPOCs

Required Result	Action Type (Field 3)	TPOC Date and Amount Reported in Fields
Correct a previously submitted TPOC	2	<ul style="list-style-type: none"> Corrected TPOC Amount and/or Date in the same field previously reported. All other TPOCs reported previously should be placed in their original locations
Remove a previously submitted TPOC	2	<ul style="list-style-type: none"> Place zeroes in the erroneous TPOC Amount and Date in the same field previously reported All other TPOCs reported previously should be placed in their original locations
Remove TPOCs 2-5	2	<ul style="list-style-type: none"> 1st TPOC Date and Amount in the same field previously reported (i.e., fields 80 and 81 on the Claim Input File Detail Record) If there are no additional claimants reported on the Auxiliary Record, do not submit the Claim Input File Auxiliary Record, or submit it with all zeroes or spaces as applicable.
Remove all TPOCs with no ORM on any Claim Records that were submitted in error	1	Place all values previously submitted in the same field previously reported.

Correcting or Removing TPOCs

- To correct a previously submitted TPOC Amount or Date**, submit an update transaction with a value of ‘2’ in the Action Type on the Claim Input File Detail Record and place the *corrected* TPOC Amount and/or Date in the same field it was reported in previously. All other TPOCs reported previously for the claim should be reported with their original values and in their original locations on the Claim Input File Detail or Auxiliary Records, as applicable.
- To remove an erroneous TPOC reported 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 Claim Input File Detail Record. You will place zeroes in the TPOC Date and Amount in the same fields in which they were reported previously on the Claim Input File Detail (or Auxiliary) Record. Subsequent submissions for the claim report should continue to preserve the positional nature of these fields – the removed TPOC should continue to be reported with zeroes on any subsequent report for the claim.
- To remove or zero out all TPOCs 2 – 5 on the Auxiliary Record (where no additional claimants were previously reported on the auxiliary record)**, resubmitting the Claim Input File 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. Then, if you have nothing else to report on the Auxiliary Record, subsequent updates do not need to include that record.

- **To remove all previously reported TPOCs on a previously accepted Claim Input File Detail Record with no ORM (ORM Indicator = ‘N’)**, resubmit the Claim Input File Detail Record as a delete. In this case, the previously accepted record should never have been sent (i.e., the RRE submitted it in error, there was no settlement, judgment, award, or other payment [including assumption of ORM]). Do not submit an update record with no ORM and no TPOC as this will result in the receipt of the CJ07 error. **Note:** As a reminder, if ORM ends, you must submit ORM Indicator is ‘Y’ and the applicable ORM Termination Date to indicate that.

Please Note: If you are unsure how to correctly submit TPOC information, contact your EDI Representative for assistance.

6.5 Initial File Submission

This section describes the requirements for your initial file submission. The initial file submission is the first Section 111 Claim Input File you will submit on or about your production “live” date, after data exchange testing has been successfully completed. Instructions for necessary retroactive reporting are described below (see “File Submission Example 3B,” and following).

The information in this section also applies to DDE submitters. Remember, however, that for DDE submitters, information to be reported is submitted on a claim by claim basis through the Section 111 COBSW rather than via an aggregated 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 or was a Medicare beneficiary, *and where medicals are claimed and/or released (or the settlement, judgment, award, or other payment had the effect of releasing medicals)*.

A TPOC (or “Total Payment Obligation to the Claimant”) single payment obligation is reported in total regardless of how payment is made—as 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.

The subject claims are those which are addressed/resolved (or partially addressed/resolved) through either (1) a no-fault insurance or workers’ compensation settlement, judgment, award, or other payment with a TPOC Date on or after October 1, 2010, or (2) 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 date for your first file submission, whether assigned or made via DDE. Claim reports with earlier TPOC Dates will be accepted but are not required.

In other words, for claims only involving payment due to a TPOC settlement, judgment or award, or other payment, you only need to submit a Section 111 report if the settlement, judgment, award, or other payment date 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 in the NGHP User Guide Appendices Chapter V, Field 80, for an explanation of how to determine the TPOC Date.

You must also report on claims for which the RRE has ORM (ongoing responsibility for medicals) 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. In addition, 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 6.4, 6.4.3 and 6.7 for specific exceptions related to Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, or workers' compensation. See Section 6.4 for Reporting Threshold requirements.

The following table provides a set of examples related to your initial Section 111 submission. However, it is not intended as an all-inclusive list of reporting requirements.

Table 6-11: 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 80 on the Input File Detail Record for further information on the TPOC Date. Remember that TPOC information/date is reportable without regard to responsibility/lack of responsibility for ongoing medicals.
1B	Same basic facts as 1A	The beneficiary sues. A settlement for \$10,000 is signed by both parties on June 3, 2011. However, the settlement requires court approval, which is not obtained until October 10, 2011.	Report settlement for Section 111	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 80 and 81 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.

No.	Situation	Additional	Section 111	Rationale
2A	A Medicare beneficiary is injured on the job on February 15, 2009, and files a workers' compensation claim. Workers' compensation assumes responsibility (including a requirement to pay pending investigation) for the associated medicals.	The claim is still open; workers' compensation continues to have responsibility for the medicals on and after 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	The RRE has assumed ongoing responsibility for medicals (ORM). The ORM exists as of January 1, 2010, or later. See Section 6.7 for exceptions and information regarding termination of workers' compensation ORM.
2B.	Same basic facts as 2A	There was a judgment or award for \$50,000 by the WC court issued on June 23, 2010. This judgment or award left the medicals open.	Report the Section 111 ORM. You are not required to report the judgment or award. (However, if a workers' compensation TPOC amount established prior to 10/1/2010 is reported along with an 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.

No.	Situation	Additional	Section 111	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 their 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.	NA	Do not report the ORM under Section 111.	ORM terminated prior to January 1, 2010.
3B	Same basic facts as 3A	The beneficiary's medicals exceed the cap and/or he or 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 ORM under Section 111. Do report the \$50,000 liability TPOC	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 ORM and the liability settlement on separate claim reports, by insurance type.	No-fault ORM continued in effect January 1, 2010. The liability TPOC date was 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 reporting thresholds with TPOC dates on or after October 1, 2010 (Section 6.4).
- All liability insurance (including self-insurance) TPOC amounts meeting the reporting thresholds described with TPOC dates on or after October 1, 2011 (Section 6.4).
- All ongoing responsibility for medicals (ORM) for no-fault insurance, workers’ compensation, and liability insurance (including self-insurance) that you assumed on or after January 1, 2010.
- All reports of ORM that you initially assumed prior to January 1, 2010, and 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 time slot, 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 10.5). 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 time slot and your initial Claim Input File must be received inside that 7-day window. Those RREs registering for DDE will be in production reporting status immediately after completing the registration process and must begin 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.

6.6 Quarterly File Submissions

The information in this section also applies to DDE submitters, Remember, however, that for DDE, information to be reported is submitted on a claim-by-claim basis through the Section 111 COBSW rather than via an aggregated electronic file.

“Add” and “Update” Records:

For File submitters: Once your initial quarterly Claim Input File has been submitted, your subsequent, quarterly Claim Input File submissions must include records for any new claims where the injured party is a Medicare beneficiary as “add” records. These will reflect settlements, judgments, awards, or other payments (including assumption of ORM) since the last file submission.

Your file may also contain “update” records for previously submitted claims if critical claim information that will affect Medicare claims payment or recovery processes needs to be corrected or changed. See Section 6.6.4 (Event Table) for information about what will trigger an update record submission.

Claim records submitted in error:

If a record was submitted and accepted by the BCRC with a '01' or '02' disposition code in a previous file submission, but that claim record should never have been sent—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 erroneous claim information from Medicare systems and databases.

Quarterly update files must also include the resubmission of any records found in error on the previous file, with the necessary corrections made. Since the original claim record was not accepted by the BCRC, corrected records are to be sent with the same action type given on the original record. **Note: RREs may now submit multiple files in a single quarter. Please see Section 6.6 for more information.**

Response File Processing:

Response file processing will be discussed in detail, in Chapter 7 of this guide, but please note that a record is considered accepted by the BCRC if the corresponding response record is returned with a disposition code of '01' or '02'.

Individual NOT a Medicare Beneficiary:

If an individual was not a Medicare beneficiary at the time responsibility for ongoing medicals was assumed for that individual, the RRE must monitor the status of that person and report when he or she becomes a Medicare beneficiary, unless responsibility for ongoing medicals has terminated before Medicare program participation is established. The Query File can be used to monitor for an injured party's Medicare coverage (See Chapter 8).

New TINs or Office Codes:

If you are reporting any *new* TINs or Office Codes on your Claim Input File, be sure to also submit a TIN Reference File with records for each new TIN/Office Code combination, either prior to or along with the quarterly Claim Input File submission that includes the new TIN/Office Code information.

No new information to report during quarterly 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 one is submitted it will be accepted and processed. Note that for empty Claim Input Files no Claim Response File is generated.

See also, Sections 6.6, 6.7 and 6.8 for specific exceptions related to Section 111 reporting for liability insurance (including self-insurance), no-fault insurance, or workers' compensation. See Section 6.4 for Reporting Threshold requirements.

6.6.1 Add

An “add” is a record submitted to the BCRC for a new claim, one that was either not previously submitted, or that was submitted but not accepted with a ‘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 with the original submission, a claim resubmitted due to corrected key fields (see delete/add example Section 6.6.2), or a claim where the RRE had earlier assumed ongoing responsibility for medicals and the injured party has now become covered by Medicare.

An “add” record or transaction is identified by placing a ‘0’ (zero) in the Action Type (Field 3) of a Claim Detail Record.

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

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

Example 3: An RRE has been submitting production Section 111 Claim Input Files and has received and processed the last quarter’s responses from the BCRC. Subsequently, the RRE determines (through its own ongoing monitoring procedures) that an injured party on a claim where the RRE has ongoing responsibility for medicals (ORM) under Section 111 has become covered by Medicare. The RRE submits the claim for this individual as an add record on its next quarterly file submission.

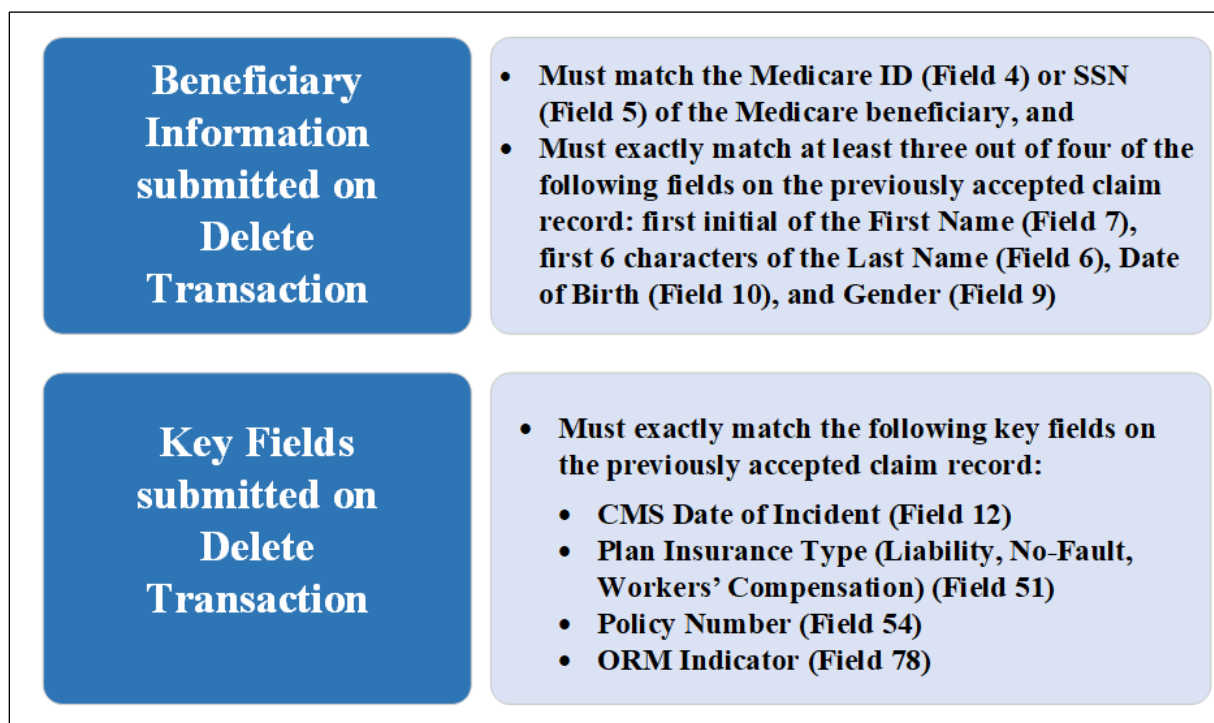
6.6.2 Delete

A “delete” record or transaction is identified by placing a ‘1’ in the Action Type (Field 3) of a Claim Detail Record.

A delete transaction is sent to remove reporting information previously sent to the BCRC. Records accepted by the BCRC receive a ‘01’ or ‘02’ disposition code in the Claim Response File you receive from the BCRC. If an add transaction did not result in the generation of one of these two disposition codes, there is 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 a ‘03’.

Delete transactions should be needed only under rare circumstances. But if you discover a severe error affecting many records on a Section 111 file transmitted to the BCRC, or if key fields have changed, please immediately contact your EDI Representative to discuss the steps that should be taken to correct it.

In order to successfully delete a previously submitted and accepted Claim Input File Detail Record, the BCRC must be able to match the beneficiary information and key fields submitted on the delete transaction to the corresponding information on the previously accepted claim record (Figure 6-2).

Figure 6-2: Matching Criteria (Delete)

Deleting Erroneous Record Submissions

Record deleting actions are used in two situations. First: if the original record should never have been sent in the first place.

Example: 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 a '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 BCRC accepts the record, deletes the claim information from internal Medicare files and returns a '01' disposition code for the delete record.

Correcting Key Fields – Delete/Add

The second situation in which a record should be deleted is when you need to correct a previously submitted and accepted key field, or if key fields have changed. In this situation, 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 operation is often referred to as the "delete/add" process.

Example: An insurance company took over claims from a previous insurance company and, as a result, the policy number changed. On the next Claim Input File, since updates cannot be submitted on previously reported claims using the original policy number, the RRE must first delete the previously reported record and then add a record with the new insurance carrier name and policy number.

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 51)
- Policy Number (Field 54)
- 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 as described in Section 6.6.3 and noted in the Event Table in Section 6.6.4.

NOTE 1: RREs only need to correct the Medicare ID or SSN in cases where an **incorrect person** was submitted and accepted on the input record. Medicare IDs may be changed by the Social Security Administration at times but the BCRC is able to crosswalk the old Medicare ID to the new Medicare ID. Therefore, in those instances where the correct person was previously submitted but the person's Medicare ID changes at a later date, the RRE does **not** need to correct the record - updates may continue to be sent under the originally submitted Medicare ID. However, note that in such cases the BCRC will always return the most current Medicare ID on response records, and we encourage RREs to update their systems with the current Medicare ID and use it on subsequent record transmissions. The new Medicare ID 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 Medicare ID on the response file, the RRE should **not** send a "Delete" and "Add" just to update the beneficiary's information with the newly-identified Medicare ID. The beneficiary's record has already been stored by the BCRC under both the SSN and Medicare ID. However, on subsequent transactions records must be submitted with the individual's Medicare ID.

Example: A record for a liability insurance claim with a settlement, judgment, award, or other payment was submitted on a RRE's previous quarterly file submission and was accepted with a '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 that claim, with the originally submitted values for the key fields listed above, all other claim information originally submitted, 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 puts a '0' in the Action Type. The BCRC processes both records and on the response file returns a record for each with the applicable disposition code. The original record will be deleted from the BCRC system and the updated record with the new DOI supplied will be added.

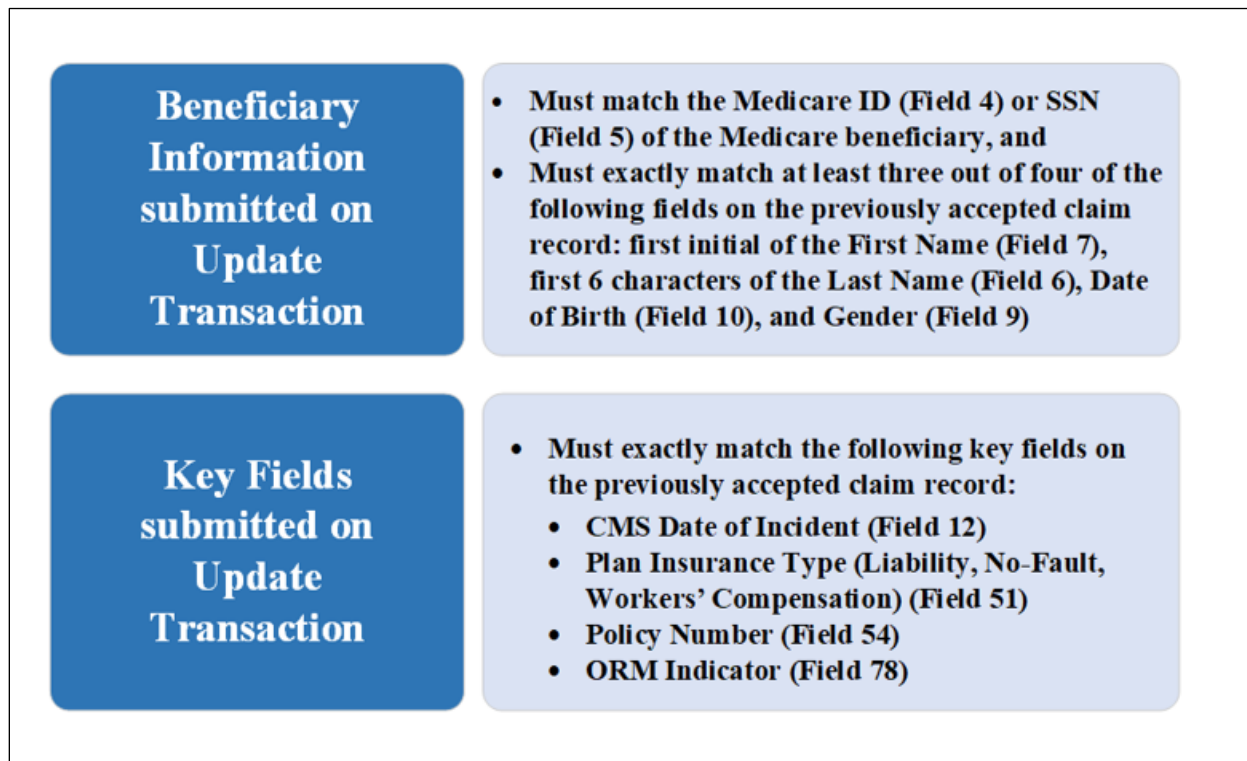
6.6.3 Update

An "update" record or transaction is identified by placing a '2' in the Action Type (Field 3).

An update transaction (Action Type '2') is sent when you need to change information on a record previously submitted and accepted by the BCRC for which you received an '01' or '02' disposition code in your Claim Response File. An update transaction (Action Type '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.

To successfully update a previously submitted and accepted Claim Input File Detail Record, the BCRC must be able to match the beneficiary information and key fields submitted on the update transaction to the corresponding information on the previously accepted claim record.

Figure 6-3: Matching Criteria (Update)



Update records are submitted under three circumstances.

- 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).
- 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.
- To change information critical for use by Medicare in its claims payment and recovery processes.

See the Event Table in Section 6.6.4 for additional information.

If you need to update one of the key fields identified above, follow the “delete-add” process described in the previous section. See the Event Table for additional information.

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

- ICD Diagnosis Codes 1-19 (starting at Field 18 on the Detail Record)
- TIN (Field 52 of the Detail Record)
- TPOC Date1 (Field 80 of the Detail Record)

- TPOC Date 2 -5 (Fields 93, 96, 99, 102 of the Auxiliary Record)
- TPOC Amount 1 (Field 81 of the Detail Record)
- TPOC Amount 2 – 5 (Fields 94, 97, 100, 103 of the Auxiliary Record)
- Claimant 1 Information (Fields 84 – 95 of the Detail Record)
- ORM Termination Date (Field 79)

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

Note: If a previous claim report included an Auxiliary Record (additional claimant information or additional TPOCs) you must submit all subsequent updates with an Auxiliary Record - unless the update is, in effect, removing that information from the report (the information on the Auxiliary Record is no longer applicable to the claim and the RRE is, in effect, removing all of it). Remember that if a previously reported Auxiliary Record is not included on a subsequent update report, the BCRC 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 BCRC for a workers' compensation claim where the RRE assumed ongoing responsibility for medicals (the ORM Indicator Field 78 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 79) 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 BCRC for a no-fault claim where the RRE assumed ongoing responsibility for medicals (the ORM Indicator Field 78 was submitted with a 'Y'). The no-fault limit of the policy applicable to the claim was provided in the No-Fault Insurance Limit (Field 61). 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 79) 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 62). 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 BCRC for a liability insurance claim with a settlement, judgment, award, or other payment information in TPOC Date 1 (Field 80) and TPOC Amount 1 (Field 81). Subsequently, the RRE corrects the TPOC Date 1 (Field 80) 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 80). 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 BCRC 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 80 and 81). 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. The new, additional TPOC date and amount in TPOC Date 2 and TPOC Amount 2 (Fields 93 and 94) is sent 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.

6.6.4 Event Table

The following table is to be used by RREs and their agents to help determine when, and how, to send records on the Claim Input File.

RRE Action reflects Claim Input File record submissions to be included in the next quarterly Section 111 filing after the Event occurs. Please see the Claim Input File record layouts in Appendix A for the requirements for each specific field; this Event Table describes the record submission requirements in only 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 BCRC sent back a disposition code of ‘01’ or ‘02’ on the corresponding Claim Response File Detail Record. See also the definition of Total Payment Obligation to Claimant (TPOC) Amount and Date in Fields 80 and 81 of the Claim Input File Detail Record in Appendix A—it also applies to the TPOC Date and Amount fields on the Auxiliary Record.

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

- **CMS Date of Incident (Field 12)**
- **Plan Insurance Type (Liability, No-Fault, Workers’ Compensation in Field 51)**
- **Policy Number (Field 54)**
- **ORM Indicator (Field 78)**

Do not perform a delete/add transaction to correct or change any other fields. Simply submit an update transaction to correct non-key fields as described in Section 6.6.3 and noted in Table 6-12.

NOTE: RREs only need to correct the Medicare ID (HICN or MBI) or SSN in cases where an incorrect person was submitted and accepted on the input record. Medicare IDs may be changed by the Social Security Administration at times but the BCRC is able to crosswalk the old Medicare ID to the new Medicare ID. Therefore, in those instances where the correct person was previously submitted but the person’s Medicare ID changes at a later date, the RRE does not need to correct the record - updates may continue to be sent under the originally submitted Medicare ID. However, note that in such cases the BCRC will always return the most current

Medicare ID on response records, and we encourage RREs to update their systems with the current Medicare ID and use it on subsequent record transmissions. The new Medicare ID may be used on all subsequent transactions without the RRE performing the “delete/add” procedure.

Table 6-12: Event Table

Event	RRE Action
<p>Single Report – No ORM</p> <ul style="list-style-type: none"> • 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. TPOCs with earlier dates may be included at the RREs discretion. • No ORM 	<p>Send Add Record:</p> <ul style="list-style-type: none"> • ‘0’ (add) in the Action Type • ‘N’ in the ORM Indicator • TPOC Dates and Amounts
<p>Initial Report – with ORM and TPOC (same insurance type, same injuries):</p> <ul style="list-style-type: none"> • 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. TPOCs with earlier dates may be included at the RREs discretion. NOTE: 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. 	<p>Send Add Record:</p> <ul style="list-style-type: none"> • ‘0’ (add) in the Action Type • ‘Y’ in the ORM Indicator • TPOC Dates and Amounts

Event	RRE Action
<p>Initial Report – with ORM and TPOC (same insurance type, ORM for one injury, TPOC and no ORM for another injury)</p> <p>Two (or more) injuries claimed/alleged on the same claim under the same insurance type:</p> <ul style="list-style-type: none"> • 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 reporting thresholds documented in Section 6.4. • Both ORM and TPOC are for the same insurance type, policy, and claim number but for different injuries. 	<p>Send Two Add Records</p> <p>First Add Record for ORM:</p> <ul style="list-style-type: none"> • ‘0’ (add) in the Action Type • ICD 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 Diagnosis Code(s) describing all alleged injuries claimed and/or released related to the TPOC • ‘N’ in the ORM Indicator • TPOC Dates and Amounts <p>Both records may be sent in the same file submission in any order.</p>
<p>Initial Report – with ORM and TPOC (different insurance types)</p> <ul style="list-style-type: none"> • 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. 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 (Example: 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). 	<p>Send Two Add Records:</p> <p>ORM Record:</p> <ul style="list-style-type: none"> • ‘0’ (add) in the Action Type • ‘Y’ in the ORM Indicator • No TPOC Date(s) or Amount(s) • 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(s) and Amount(s) • Applicable Plan Insurance Type (e.g., ‘L’ for Liability) <p>Both records can have the same Injured Party information, Date of Incident, Policy Number, Claim Number, etc., as applicable.</p>

Event	RRE Action
<p>ORM Ends for One Injury Due to TPOC, Continues for Another:</p> <ul style="list-style-type: none"> • Claim previously submitted and accepted with ORM Indicator (Field 78) = 'Y', non-zero ORM Termination Date (Field 79), multiple ICD Diagnosis Codes reflecting ORM assumed for multiple injuries • RRE's ORM subsequently ends for one or more injuries due to a TPOC but ORM continues on the claim for one or more other injuries 	<p>Send one Update Record, and Send one Add Record:</p> <p>First: Send Update Record:</p> <ul style="list-style-type: none"> • '2' in the Action Type • Same values previously reported for (SSN/MBI, CMS DOI, Plan Insurance Type, Policy #, 'Y' in ORM Indicator • Zeroes in the ORM Termination Date (Field 79) • ICD Diagnosis Codes reflecting injuries for which the RRE continues to have ORM (No ICD Diagnosis Codes for which resulted in the TPOC) <p>Second: Send Add Record for TPOC:</p> <ul style="list-style-type: none"> • '0' (add) in the Action Type • ICD Diagnosis describing all injuries claimed and/or released related to TPOC • 'N' in the ORM indicator • TPOC dates and amounts
<p>Initial Report – with ORM, no TPOC</p> <ul style="list-style-type: none"> • 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 	<p>Send Add Record:</p> <ul style="list-style-type: none"> • '0' (add) in the Action Type • 'Y' in the ORM Indicator • Zeroes in TPOC Date and Amount
<p>Termination of ORM – No TPOC</p> <ul style="list-style-type: none"> • Claim with ORM previously reported and accepted by the BCRC • ORM ends and there is no settlement, judgment, award, or other payment TPOC Amount. 	<p>Send Update Record:</p> <ul style="list-style-type: none"> • '2' (update) in the Action Type • 'Y' in the ORM Indicator • Zeroes in TPOC Date and Amount • Date ORM ended in ORM Termination Date field • Include Auxiliary Record if previously submitted and information on it still applies
<p>Termination of ORM – With TPOC</p> <ul style="list-style-type: none"> • Claim with ORM previously reported and accepted by the BCRC • 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. TPOCs with earlier dates may be included at the RREs discretion. Total TPOC Amount may be less than the threshold at the RREs discretion. 	<p>Send Update Record:</p> <ul style="list-style-type: none"> • '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

Event	RRE Action
<p>Initial Report and ORM Termination in One Report – No TPOC</p> <ul style="list-style-type: none"> • 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 	<p>Send Add Record:</p> <ul style="list-style-type: none"> • '0' (add) in the Action Type • 'Y' in the ORM Indicator • Zeroes in TPOC Date and Amount • Date ORM ended in ORM Termination Date
<p>Initial Report and ORM Termination in One Report – With TPOC (same insurance type, same injuries)</p> <ul style="list-style-type: none"> • 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. 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.) 	<p>Send Add Record:</p> <ul style="list-style-type: none"> • '0' (add) in the Action Type • 'Y' in the ORM Indicator • TPOC Date and Amount • Date ORM ended in ORM Termination Date
<p>Key Field Change (Correction) – Delete/Add Transaction</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • CMS Date of Incident (Field 12) • Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51) • Policy Number (Field 54) • ORM Indicator (Field 78) 	<p>Send a Delete Followed by an Add</p> <ol style="list-style-type: none"> 1) Send Delete Record: <ul style="list-style-type: none"> • '1' (delete) in the Action Type • All other fields with matching values sent on the original record 2) Send Add Record: <ul style="list-style-type: none"> • '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

Event	RRE Action
<p>Changed Information (other than Key Field information)</p> <ul style="list-style-type: none"> • Claim previously submitted and accepted • One or more of the following fields has changed after the initial claim record was submitted and accepted: <ul style="list-style-type: none"> • ICD Diagnosis Codes 1-19 • TIN (Field 52) • TPOC Dates 1 - 5 • TPOC Amounts 1 - 5 • Claimant 1 Information (Fields 84 - 95) • ORM Termination Date (Field 79) • No-Fault Insurance Limit (Field 61) 	<p>Send Update Record:</p> <ul style="list-style-type: none"> • ‘2’ (update) in the Action Type • Include Auxiliary Record if previously submitted and information on it still applies • Changed values for <ul style="list-style-type: none"> • ICD Diagnosis Codes 1–19 • TIN (Field 52) • TPOC Dates 1 – 5 • TPOC Amounts 1 – 5 • Claimant 1 Information (Fields 84 - 95) • No-Fault Insurance Limit (Field 61) • Same values previously reported for <ul style="list-style-type: none"> • Injured Party SSN/Medicare ID (HICN or MBI) (Fields 4/5) • CMS Date of Incident (Field 12) • Plan Insurance Type (Field 51) • ORM Indicator and Termination Date (Fields 78 and 79) • Same or updated information for all other fields
<p>Delete/Cancel Prior Record Submission</p> <ul style="list-style-type: none"> • 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 	<p>Send Delete Record</p> <ul style="list-style-type: none"> • ‘1’ (delete) in the Action Type • All other fields with matching values sent on the original record
<p>Record Rejected with Errors</p> <p>Submitted claim record returned with an ‘SP’ disposition code in the corresponding response file record (not accepted, rejected by the BCRC due to errors)</p>	<p>Correct errors</p> <p>Send record with previously submitted Action Type (Add, Update or Delete)</p>
<p>Record in Process at BCRC</p> <p>Submitted claim record returned with a ‘50’ disposition code in the corresponding response file record (still being processed by the BCRC)</p>	<p>Resubmit same record with most current claim information</p>
<p>Ongoing Monitoring – Injured Party Becomes Covered by Medicare</p> <ul style="list-style-type: none"> • Claim record previously submitted and rejected by the BCRC with a ‘51’ or ‘03’ disposition code • RRE continues to have ORM • Injured party becomes covered by Medicare 	<p>Send Add Record:</p> <ul style="list-style-type: none"> • ‘0’ (add) in the Action Type • ‘Y’ in the ORM Indicator • TPOC Dates and Amounts as applicable

Event	RRE Action
<p>Reporting Additional TPOC Amounts</p> <ul style="list-style-type: none"> • 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. For example, if 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 51. Note that this instruction only applies where there are multiple TPOCs for the same record, for the same insurance type, policy, claim number, etc. 	<p>Send Update Record</p> <ul style="list-style-type: none"> • '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/Medicare ID (Fields 4/5) • CMS Date of Incident (Field 12) • Plan Insurance Type (Field 51) • ORM Indicator and Termination Date (Fields 78 and 79) • Same or updated information for all other fields • See the Section 6.4.3 on Reporting Multiple TPOCs for more information
<p>ORM Reopens or Change in ORM Termination Date</p> <ul style="list-style-type: none"> • Claim previously submitted and accepted with ORM Indicator (Field 78) = 'Y', non-zero ORM Termination Date (Field 79) • RRE reopens or reassumes ORM or otherwise changes ORM Termination Date 	<p>Send Update Record</p> <ul style="list-style-type: none"> • '2' in the Action Type • Same values previously reported for • Injured Party SSN/Medicare ID (Fields 4/5) • CMS Date of Incident (Field 12) • Plan Insurance Type (Field 51) • 'Y' in ORM Indicator (Field 78) • Zeroes in the ORM Termination Date (Field 79) 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
<p>ORM Ends for One Injury, Continues for Another</p> <ul style="list-style-type: none"> Claim previously submitted and accepted with ORM Indicator (Field 78) = 'Y', non-zero ORM Termination Date (Field 79), multiple ICD 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 	<p>Send Update Record</p> <ul style="list-style-type: none"> '2' in the Action Type Same values previously reported for <ul style="list-style-type: none"> Injured Party SSN/Medicare ID (Fields 4/5) CMS Date of Incident (Field 12) Plan Insurance Type (Field 51) 'Y' in ORM Indicator (Field 78) Zeros in the ORM Termination Date (Field 79) ICD Diagnosis Codes reflecting injuries for which the RRE continues to have ORM (No ICD Diagnosis Codes related to injuries for which ORM ended) Be sure to submit a valid value, not spaces, in ICD Diagnosis Code 1 (Field 18) 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

6.6.5 Claim Input File Reporting Do's and Don'ts

Here are some helpful reminders for RREs to be successful in submitting Section 111 claim information.

Disposition Code '51'

- RREs will receive this disposition code on their response file if the information submitted to identify a beneficiary is not matched to the information CMS has on file for Medicare beneficiaries. The BCRC must find an exact match on the Medicare ID (HICN or MBI) or SSN (i.e., the last 5 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 (all four 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. Please note: The matching process depends on the quality of the data submitted.
- If a disposition code of '51' is received, the RRE must validate all the information submitted in the injured party information fields.
- The RRE must check to ensure that data entered in these fields was both correct *and correctly submitted*.
- Example: On a Claim Input File Detail Record, the RRE submits correct beneficiary information. 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) exactly match Medicare's records. 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. The RRE must make the appropriate corrections and resubmit the claim report on their next scheduled file submission.

- 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.
- 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 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.
- 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.
- 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 of 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.

Delete Transactions

Delete transactions should only be submitted to:

- Remove an entire record that was created in error (delete record), 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), Policy Number (Field 54), ORM Indicator (Field 78)). In this case, delete the transaction and then add the correction. Do not perform a delete/add to correct or change any other fields. Simply submit an update transaction to correct non-key fields.

RRE Address Validation

- RREs are encouraged to pre-validate insurer and recovery agent addresses using postal verification software or online tools available on the USPS website pages such as https://tools.usps.com/go/ZipLookupAction_input. 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.

Reporting ICD Diagnosis Codes

- 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-9s or ICD-10s (See Section 6.2.5 – ICD-9 and ICD-10 Codes). *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 and ICD-10s.
- *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. Records with any of these invalid entries will be rejected with the errors C105-C1023, depending on the fields in error.

Reporting ORM Information

- 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.
- To terminate the ORM record, submit an update 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.
- 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.

ORM Indicator/TPOC Threshold

- Add records submitted with ‘N’ in the ORM Indicator (Field 78) must contain a TPOC Amount greater than zero. 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.

Reporting the Self-Insured Type

- 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 a CS02 error.

Reporting the Plan Insurance Type

- 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.
- 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).
- Please ensure that the Plan Insurance Type is entered correctly when the RRE is assuming ORM. Analysis of early files has identified numerous records where an RRE is mistakenly reporting Liability with an ORM indicator of “Y”. Assuming ORM in Liability cases is not a common occurrence. While there are instances where this may be correct, RREs should review their information to be certain they have provided the correct Plan Insurance Type/ORM indicator combination.

Reporting the Policy Number

- 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—it may not be left blank. Records submitted with all blanks in the Policy Number field will be rejected with the error CP04.
- If multiple RREs are submitting claims under the same policy number, enter this number consistently and in the same format.
- While the Policy Number is not required when the insurance type is self- insurance, if this number is available, please provide it on all new “add” records.

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

The following section reviews the requirements for reporting the assumption or establishment of ORM for no-fault insurance, liability insurance (including self-insurance), and workers’ compensation. Information regarding an RRE’s reporting for the assumption of ORM has been presented in other sections of the NGHP User Guide. This section provides additional policy information. Please see Table 6-13 for a summarized view of the ORM reporting requirements for no-fault, liability insurance (including self-insurance), and workers’ compensation.

The reference to “ongoing” is not related to “ongoing reporting” or repeated reporting of claims under Section 111, but rather to 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 with 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 for ORM reporting to be required.

If an RRE has assumed ORM, the RRE is reimbursing a provider, or the injured party, for specific medical procedures, treatment, services, or devices (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 (see Section 6.4 for more information on 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 no-fault insurance (such as automobile Personal Injury Protection (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 since the no-fault limit was already reached, but the payment still reflects ORM, *not* a TPOC settlement, judgment, or award.

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, or the RRE otherwise no longer has ORM, etc.) the RRE reports an ORM Termination Date. If there was no TPOC settlement, judgment, award, or other payment related to the claim (an actual settlement for medicals and/or lost wages, etc.), **you do not need to report a TPOC Amount on the claim with ORM**. You can just submit the ORM Termination Date.

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. 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.

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 Diagnosis Codes (starting in Field 18) 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 codes provided in these fields must provide enough information for Medicare to identify medical claims related to the underlying Injury, Incident or Illness claim reported by the RRE.

6.7.1 ORM Additional Technical Requirements - When and What to Report

For claims where the liability insurance (including self-insurance), no-fault insurance, or workers' compensation RRE has assumed ORM associated with the claim, **two** reports under Section 111 are required. The first report is when the RRE assumes ORM. The second is when ORM terminates. In the first report the RRE provides basic information about the claim, including a ‘Y’ in the ORM Indicator, and the no-fault insurance policy limit (if applicable). In the second report, the RRE provides the ORM Termination Date (date when ongoing responsibility for medicals has 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 also have a ‘Y’ in the ORM Indicator.

The RRE does not provide a TPOC Date and TPOC Amount on either ORM report unless there was a settlement, judgment, award, or other payment TPOC amount in addition to the ORM.

NOTE: In situations where the injured party is a Medicare beneficiary, 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 Total Payment Obligation to Claimant (TPOC) date. 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 the additional explanation in the NGHP User Guide Policy Guidance Chapter (Section 2 - Introduction and Important Terms). The RRE provides the TPOC Date (as defined in Field 80 of the Claim Input File Detail Record) and the TPOC Amount (as defined in Field 81 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 Section 6.4 Reporting Thresholds and Section 6.4.3 Reporting Multiple TPOCs for more information on TPOC reporting requirements.

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 the reporting may be done on one record. Example: In January, a workers' compensation claim is opened for an injured employee who is a Medicare beneficiary. The injury is relatively minor, and the ORM terminates in March. Depending upon its specific quarterly submission date, the RRE may only need to report the claim once after 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, which represents a combined total of Med-Pay and PIP, 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 includes or included ORM. CMS' key for claims processing actions is knowing an RRE-reported ORM. **The ORM Indicator is not an on/off switch. Once "on" (a value of "Y"), it stays "on."** 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. Zeroes in the ORM Termination Date indicate that there is yet no established end date for the ORM.

For claims with ORM, an RRE does NOT make a Section 111 report each time it pays for a medical service for the injured party. The actual amounts paid for specific medical services under the assumption of ORM are not reported. It is only the assumption of coverage that is reported, the fact that ORM has been assumed for a particular claim for a particular period of time.

RREs are NOT to report the same, unchanging ORM claim information each quarter. Once the first report is made and they get back a positive response that the record was accepted they do not need to report again until the ORM has terminated, or 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 6.6.4).

In most cases ORM reporting will require two Section 111 reports—one to add the report of ORM, and another to report the termination of ORM. **Note:** there are two exceptions to the need for two claim reports for ORM. The first is when assumption and termination of ORM are reported in the same record. The second is 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 6.6.4 to determine what would trigger an additional update or delete. Example: 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 need to submit an *update record* to correct that error. Example: In some states, depending on various factors associated with the incident being reported, no-fault policy limits may vary. The reported Policy Limit should reflect the amount the RRE has accepted responsibility for at the time the record is submitted or updated. Just as importantly, if the Section 111 record needs to be corrected to reflect a new Policy Limit, the RRE should update the record as soon as possible. Remember that a delete transaction would be sent only if the original record were entirely in error and that record needs to be completely removed from Medicare's databases/systems.

With respect to ORM, 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, this second type of report may never be submitted. In addition, **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 75 years from the current date.**

Note: There is a limited "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 that occurred 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 the individual 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 79).

CMS uses information regarding ORM 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 coverage. Conditional payments are subject to recovery if primary payment responsibility is subsequently established.

If the individual was not a Medicare beneficiary at the time ORM was assumed, the RRE must monitor the status of that individual and report when that individual becomes a Medicare beneficiary, unless the RRE's ORM 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 6.4.4 for thresholds related to exemptions for reporting workers' compensation claims with ORM.

NOTE: Originally, the BCRC was unable to accept an ORM Termination Date (Field 79) 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 necessary. RREs should provide the actual ORM Termination Date as defined in the field description in the NGHP User Guide Appendices Chapter V (Appendix A). RREs are not required to go back and change/correct records reported previously with the "default" ORM termination dates.

Self-Reporting ORM Outside the Section 111 Reporting Process is NOT Required

With the implementation of Section 111 Mandatory Insurer Reporting, a "self-report" for certain ongoing responsibility for medicals (ORM) is no longer needed:

- RREs must report ORM through the Section 111 reporting process at their next submission window (or during the subsequent window if taking advantage of an applicable grace period).
- RREs should no longer "self-report" to the BCRC the exhaustion of benefits.
- RREs must report the termination or exhaustion of ORM through the Section 111 reporting process.

Making an Immediate Report of ORM Termination

Since CMS uses reports of ORM in the Medicare claims adjudication process, it is imperative that any ORM Terminations be reported promptly. See Sections 6.7 and 6.8 for 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 BCRC 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 also submit the report of ORM Termination on its next quarterly Claim Input File submission.

Do not make this report of ORM Termination to your EDI Representative. The BCRC 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: 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired. RREs using the DDE option do not need to contact the BCRC Call Center.

They may update a claim originally entered via DDE with an ORM Termination Date at any time by using the Section 111 COBSW.

Note: RRE self-reports do not eliminate the RRE’s Section 111 reporting obligations. Where an RRE self-reports an ORM termination date, the RRE must still report the termination through the Section 111 reporting process.

6.7.2 Ongoing Responsibility for Medicals (ORM) Reporting Summary

No-Fault Insurance ORM

No-fault insurance ORM that existed or exists on or after January 1, 2010, must be reported.

Liability Insurance ORM

Liability Insurance (including Self-Insurance) ORM that existed or exists on or after January 1, 2010, must be reported.

Workers’ Compensation ORM

Workers’ Compensation ORM that existed or exists on or after January 1, 2010, must be reported. However, workers’ compensation ORM claims are excluded from reporting indefinitely if they meet *ALL* of the following criteria.

6.7.2.1 Workers’ Compensation (Plan Insurance Type “E”) ORM Exclusion:

- The claim is for “medicals only;”
- The associated “lost time” is no more than the number of days permitted by the applicable workers’ compensation law for “medicals only” (or 7 calendar days if applicable law has no such limit);
- All payment(s) has/have been made directly to the medical provider; AND
- Total payment for medicals does not exceed \$750.00

Note: Once a workers’ compensation ORM claim is excluded from reporting, it does not need to be reported unless the circumstances change such that it no longer meets the exclusion criteria listed. In other words, the claim does not need to be reported unless something other than medicals is included, there is more lost time, a payment is made to someone other than a provider, and/or payments for medicals exceed \$750.

This exclusion does 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.

Table 6-13: ORM Reporting Requirements Summary

Insurance Type	Reportable ORM Dates
No-Fault ORM	Existed or exists on or after 1/1/2010
Liability insurance (including self-insurance) ORM	Existed or exists on or after 1/1/2010
Workers’ Compensation ORM	Existed or exists on or after 1/1/2010

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

The general rule is that aside from the “‘Special Exception’ regarding reporting termination of ORM,” 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.

QUALIFIED EXCEPTION: 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 Date of Incident (DOI), as defined by CMS. Thus, 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. However, RREs may report ORM on claims they consider closed prior to January 1, 2010, at their discretion. “Older” ORM claims will not be rejected.

The following table includes some illustrative examples of how to report ORM assumed prior to January 1, 2010.

Table 6-14: Qualified Exception Examples: ORM Assumed Prior to January 1, 2010

Claim Example	Reporting Requirement
RRE assumed ORM March 5, 2009, and is still making payments for medicals as of 1/1/2010.	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 did not 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 has not 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 <i>after</i> January 1, 2010. The claim was on the active claim file as of January 1, 2010.

Claim Example	Reporting Requirement
<p>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.</p> <p>As of January 1, 2010, and subsequent, the claim is still “technically” open and ORM continues, but the RRE has not made a payment since August of 2009.</p> <p>The RRE considers this claim actively closed and removed it from their file of current open/active claims on October 1, 2009.</p>	<p>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.</p>

6.9 Additional Requirements

Note: This information concerns both those RREs choosing a file submission method and DDE submitters. 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. File submitters transmit this same information in the form of an automated electronic file.

6.9.1 Technical Requirements

- Individual reimbursements paid for specific medical claims submitted to an RRE, paid through 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. Instead, 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 80 and 81 of the Claim Input File Detail Record in the NGHP User Guide Appendices Chapter V.
- Claim Input Files must include properly formatted header, detail, and trailer records, as defined in the file layouts provided in this user guide.
- Claim Input Files must be submitted on a quarterly basis, four times a year, unless an RRE has nothing to report in a particular quarterly reporting period.
- Claim Input Files must be submitted within the RRE’s assigned, 7-day submission period each quarter. This file submission time slot will be assigned after successful registration for Section 111 reporting.
- Claim Input Files submitted within 14 calendar days before the start of a quarterly submission period are considered early submissions for that quarter. The file will be held until the start of the submission period.
- RREs must register on the Section 111 COB Secure Website (COBSW) and complete testing prior to submission of production Claim Input Files. After the registration has been processed by the BCRC, the RRE will receive an email with a profile report. The profile report will contain information submitted during registration for verification purposes, the assigned

7-day file submission time slot, 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 BCRC before testing can begin. Once testing requirements have been passed, the RRE ID status will be updated by the BCRC 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.

Some entities may not register initially because they have no expectation of having claims to report. However, they **must** register in time to *allow a full quarter for testing* if they find they have a reasonable expectation that they will soon have to report.

- RREs will be assigned a Section 111 RRE ID during registration, which is to be used on all submitted files.
- Except for DDE RREs, Claim Input File testing is required before an RRE ID can be set to a production status and production files submitted. See Chapter 9.
- 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** in their assigned submission time slot. 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 in their assigned submission time slot.
- RREs that have elected the DDE reporting option were required to commence reporting on the Section 111 COBSW effective July 11, 2011. 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. An ORM Termination Date submission must be made via DDE within 45 calendar days of the ORM Termination Date. RREs using the DDE option must complete their Section 111 registration on the COBSW. There is no file submission testing performed for DDE.
- Foreign RREs (RREs that have no IRS-assigned TIN and/or US mailing address) must register using 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 (Non-Group Health Plan) Claim Input File submissions.
- An RRE (or agent) may not mix data originating from multiple RRE IDs in a single input file from the sending RRE (or agent). Each RRE ID with quarterly data to report must submit a separate unique Section 111 input file. Only one input file may be submitted by an RRE ID per quarter, unless instructed otherwise by the RRE's EDI Representative. In cases of exceptional circumstances – such as when one RRE absorbs the operations of another RRE – obtain and follow the direction of the surviving RRE's EDI Representative.

- All reporting is to be through electronic file exchanges or Direct Data Entry (DDE) as described in this user guide and the Section 111 COBSW User Guide.
- Files may be submitted via the Section 111 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 10.5 for details.
- RREs must implement a process in their claims review procedures to determine whether an injured party is a Medicare beneficiary. RREs must submit either the Medicare ID (Medicare Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) or Social Security Number (SSN) for the injured party on all Section 111 Claim Input File Detail Records. When submitting an SSN, RREs may enter a partial SSN. To do this, enter spaces for the first 4 positions followed by the last 5 digits of the SSN so that the field is populated with the required 9 characters.
- RREs are only to report information about Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award, or other payment). If an individual you report on 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 be returned with a value of '51' indicating that the individual was not matched to a Medicare beneficiary based on the submitted information.
- It is not acceptable for an RRE to send information on every claim record without first attempting to establish 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, and are not simply submitting their entire set of claims to satisfy Section 111 reporting requirements. Please refer to the description of the query process elsewhere in this guide.
- RREs must store any Medicare ID (HICN or MBI) returned on response files in their internal systems. RREs are required to use these Medicare IDs on future transactions. An individual's SSN (either the last 5 digits or full 9 digits of the SSN) may be submitted initially if the RRE does not have an individual's Medicare ID, but once a Medicare ID is returned for that individual it must be used going forward on all subsequent record submissions. The Medicare ID is CMS' identifier for all Medicare beneficiaries and is the "gold standard" ID data element for matching purposes. RREs are encouraged to obtain Medicare IDs from those injured parties who are Medicare beneficiaries (the Medicare ID is printed on the Medicare Card) and use them, rather than SSNs, 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 52 of Claim Input File Detail Records. All Plan TIN and Office Code/Site ID Codes submitted in Fields 52 and 53 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 1) changes to previously submitted TIN/Office Code information must be submitted, or 2) new TIN/Office Code combinations have been added.

- Quarterly Claim Input Files must include records for any new claims involving a Medicare beneficiary, reflecting settlement, judgment, award, or other payment since the last file submission.
- Information regarding a settlement, judgement, award, or other payment must be reported within 135 calendar days (approximately 4.5 months) of the TPOC Date. Records not received on time will be processed, but marked as late, and will be accounted for in subsequent compliance tracking. A code indicating a late submission was received will be placed in the first available *Compliance Flag* field (Fields 38–47) of the corresponding Claim Response File Detail Record (Chapter V, Appendix C-2). See Section 7.4 for more information on timeliness and compliance flags.
- All subsequent quarterly update files must include pertinent updates/corrections/deletions to any previously submitted records.
- Quarterly update files must include the resubmission of all records found to be in error on the previous file, with corrections made.
- 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. If one submitted, however, it will be accepted and processed.
- Email notifications will be sent to the RRE’s Account Manager after a file has been received by the BCRC and when a response file has been transmitted or is available for download. Using the Section 111 COBSW, all users with login IDs associated to the RRE ID may monitor the status of submitted files.
- Each Detail Record on the Claim Input File must contain a unique Document Control Number (DCN) developed and generated by the RRE. This DCN is required so that response records can be matched to input records and any problems more easily identified and resolved. The DCN can be any format of the RRE’s 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. A new DCN may be generated for the claim report each time it is submitted in subsequent files. For RREs using the DDE option, DCNs are automatically generated by the system.
- The BCRC will create the Claim Response File directly after all input records have completed processing, or by no later than 30 days after the Claim Input File receipt date if some records are still being processed. RREs can expect to receive Claim Response Files within 33 days of their Claim Input File receipt date.

Chapter 7: Claim Response File

In general, this information concerns both those RREs choosing a file submission method, and DDE submitters. But for DDE submitters, remember that response information is returned by the BCRC on a claim-by-claim basis and shown on the Section 111 COBSW. File submitters receive this same information in the form of an automated electronic file.

For Section 111 reporting, file submitters send a completed Claim Input File to the BCRC. If it is successfully transmitted without severe errors, in return the BCRC will send you a Claim Response File. The Claim Response File specifications are in the NGHP User Guide Appendices Chapter V (Appendix C).

Records for an injured party who could not be identified as a Medicare beneficiary (on or up to 3 months from the submission date) will be returned with an error. If the BCRC can match the injured party identified by the RRE to a Medicare beneficiary, based upon the information submitted on the input record, the response record will always contain the Medicare ID (HICN or MBI) for that individual. You must save the Medicare ID returned for Medicare the beneficiary and use it on any subsequent Claim Input File records for that beneficiary. The Medicare ID is CMS' official beneficiary identifier, and is always the preferred data element for use in matching your information to Medicare beneficiaries.

The response file will be returned to you within 48 days of receipt of your input file using the same method you used to send your input file (HTTPS, SFTP, or Connect:Direct). The response file contains a header record, followed by a file of detail records corresponding to each record you submitted on your input file, followed by a trailer record that contains a count of the detail records being returned to you. This count does not include the header and trailer records.

The detail response record contains "supplied" data, those which the RRE had submitted on the corresponding input record. It also contains "applied" data, field values derived from information on Medicare's general and MSP files

The Claim Response File Detail Records contain:

- The same DCN submitted on the corresponding Claim Input File Detail Record (Submitted DCN Field 2)
- The information the RRE supplied on the input record for the injured party and for the RRE TIN/Office Code:
- Submitted Action Type (Field 3)
- Injured Party Medicare ID (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, 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 Medicare ID (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 should (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 Medicare beneficiary. You must use the Applied Injured Party Medicare ID to update your internal system and submit this Medicare ID 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 any errors contained in the record (Fields 28–37)
- Compliance Flags (Fields 38–47) indicating that there were fields that were not reported according to Section 111 requirements or that the record was not submitted on a timely basis.

You must develop processing to appropriately react to the response file. Your own processing of the response file you receive must be finished before submission of your next quarterly Claim Input File.

Disposition codes, Claim Input/Response File error codes, TIN Reference Input/Response File error codes, and compliance flag codes are documented in the NGHP User Guide Appendices Chapter V.

7.1 Disposition Codes

The Applied Disposition Code is Field 27 on the Claim Response File Detail Record. Disposition code values are listed in the NGHP User Guide Appendices Chapter V along with the actions (if any) the RRE must take upon receipt of each disposition code.

Every Claim Input File Detail Record will receive a disposition code on the corresponding Claim Response File Detail Record. Records without any errors—those returned with a ‘01’, ‘02’ or ‘03’ disposition code because the injured party was identified as a Medicare beneficiary—only

need to be resubmitted under certain circumstances, as specified below. Records that are rejected due to errors receive an ‘SP’ disposition code and must be corrected and resubmitted. Records concerning an injured party who could not be identified as a Medicare beneficiary receive a ‘51’ disposition code. Finally, in the rare case of records that have not finished processing by the time the response file to you is generated, a disposition code of ‘50’ will be returned. Any records with this disposition code must be resubmitted in your next quarterly file submission.

After examining the Disposition Codes received, RREs must take the following actions.

- **‘SP’ Disposition Code – Record in Error**

Records returned with an ‘SP’ disposition code failed BCRC edits due to errors in submitted data. These records **must be corrected and resent on your next quarterly submission**, unless otherwise specified in the error code description. The associated error codes will be placed in Fields 28 - 37. The edits performed and associated error codes are documented in the NGHP User Guide Appendices Chapter V.

Note: RREs should not submit a record known to be missing required data elements. Submitting a record known to be in error will not make the RRE more compliant or serve any other purpose. Prior to submitting claim information, the RRE should obtain all required information, correct all known errors, and then submit the claim record.

- **‘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 (Medicare ID (HICN or MBI)/SSN, name, date of birth, and gender) to make sure it was correctly gathered, entered, and submitted in the proper fields.
- As long as you confirm that the injured party information you originally 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 or until 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 responsibility for ORM remains open—if or when the injured party becomes covered by Medicare, Medicare may be a secondary payer. (Your monitoring process might include ongoing communication with the injured party, use of the Section 111 Query process described in Chapter 8: Query Files and/or use of the Beneficiary Lookup feature on the Section 111 COBSW.) When the RRE determines the injured party does become covered by Medicare, the record must be resubmitted on the next submission of the Claim Input File.

However, your monitoring of such individuals may stop before they become Medicare beneficiaries 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 Section 6.7 regarding reporting termination of ORM is met. In such event, 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 where there is ORM**

Records accepted with an ‘01’ disposition code were accepted by the BCRC 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 in Section 6.6.4). The response record will be returned with:

- Applied MSP Effective and Termination Dates and MSP Type Indicator
- Applied Injured Party Medicare ID, Name, DOB, Gender
- Any applicable compliance flags
- **‘02’ Disposition Code – Record Accepted for Individual Identified as a Medicare Beneficiary and No ORM**

Records accepted with a ‘02’ disposition code were accepted by the BCRC 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 (No ORM)**. 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 Medicare ID, Name, DOB, Gender
- Any applicable compliance flags.
- **‘03’ Disposition Code – Record for Individual Matched to a Medicare Beneficiary but Outside Medicare Coverage Period**

Records returned with a ‘03’ disposition code were found to be error-free and the injured party submitted was matched to a Medicare beneficiary, but the Medicare coverage dates for the beneficiary are outside the time frame that is between the date of incident, and TPOC Date or the date ORM ended, as applicable. For example, the individual may have once been covered by Medicare, but Medicare’s 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 participation does not or did not overlap the applicable coverage time reflected on the submitted claim.

The response record will be returned with:

- Applied Injured Party Medicare ID, Name, DOB, Gender
- No error codes
- No compliance flags.

As long as you confirm that the injured party information you originally 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 or until 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 Medicare status of the injured party as long as the responsibility for ORM remains open—if or when the injured party becomes covered by Medicare, Medicare may be a secondary payer. Your monitoring process might include ongoing 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 the injured party’s Medicare coverage is re-activated

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).

However, your monitoring of such individuals may stop before they become Medicare beneficiaries 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 Section 6.7 regarding reporting termination of ORM is met. In such event, one final claim report should be submitted after an ORM Termination Date has been reached.

When resubmitting claim reports that previously were returned with a ‘03’ disposition code, provide the most current claim information you have available at the time of resubmission.

- **‘50’ Disposition Code – Record Still in Process at the BCRC**

A record returned with a disposition code ‘50’ indicates that the BCRC 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 disposition codes described above.

A record returned with a ‘50’ will continue to be processed to completion by the BCRC. 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 BCRC 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’ Disposition Code was returned.

If you find you need to change key fields (see Section 6.6.2) after getting a disposition code ‘50’, but before resubmission, assume the record was accepted with a ‘01’ or ‘02’ disposition code. In the next quarter send “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.

However, if the original record returned with disposition code ‘50’ was NOT actually processed and accepted by the system after the ‘50’ was returned, the delete you send 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. In this case you can then ignore those codes and assume there is nothing to delete, since you will know that original record was never accepted. The add record with the new key fields you sent 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.

Notes:

If you receive a disposition code other than those documented above, report the code (or codes) immediately to your EDI Representative.

Several Section 111 input record errors that would cause a record to reject will no longer cause the input records to be rejected. RREs, however, will continue to receive the errors on their response files, and they should correct and resubmit on their next quarterly file submission (see NGHP Chapter V).

7.2 Error Codes

Error codes are documented in the NGHP User Guide Appendices Chapter V (Appendix G). Review both the error code descriptions in the NGHP User Guide Appendices Chapter V (Appendix G) and the field descriptions in the file layouts documented in the NGHP User Guide Appendices Chapter V (Appendix A). Up to ten error codes may be returned on a Claim Response File Detail Record.

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 using the Section 111 COBSW. A few errors, specified in the error code descriptions, do not require correction 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 time frame is required.

Note that errors that result in rejection of *TIN Reference File Detail Records* may also cause rejection of associated Claim Input File Detail Records. Your TIN Reference File must be processed successfully, either prior to or in conjunction with the associated Claim Input File (See Section 6.3). 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 they may have that are related to disposition and error codes returned or about error handling. If you receive an error code other than those documented in the NGHP User Guide Appendices Chapter V, report this immediately to your EDI Representative.

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. These may be caused because:

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

The distinction between the three errors is not important to an RRE—it is only meaningful internally to the BCRC. Your error handling for SP47, SP48, and SP49 is the same, and 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 BCRC already has a matching record of a claim with ORM and that matching record has been locked by the BCRC to prevent subsequent changes by any entity other than the BCRC. 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 as documentation of your attempt to report for future reference. Contact your EDI Representative with questions. If you believe changes to this existing ORM record are necessary, contact the BCRC Call Center Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired. Be prepared to supply your RRE ID when making this call.

7.3 File Level and Threshold Errors

7.3.1 Severe Errors

A file that is submitted with any of the following Severe Errors will be *suspended from processing*.

- 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 Account Manager for the RRE ID will receive an email notification identifying all severe errors. You must contact your EDI Representative (see Section 7.3) to resolve all severe errors. You must send a corrected file, as instructed by your EDI Representative. Files with severe errors will be deleted by your EDI Representative.

The following table provides some additional information for each severe error an RRE may receive. RREs must always contact their EDI Representative when notice of a severe error is received.

Table 7-1: Correction Methods for Severe Errors

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 (2220 bytes for the Claim Input File and TIN Reference File and 200 bytes for the Query Input File).
File empty	A file with no records was transmitted to the BCRC. 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.
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.

Severe Error	Correction
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 BCRC. 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	Record Identifier must be NGTD.
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.

7.3.2 Threshold Errors

After completion of data quality edits, the BCRC will check your Claim Input File to ensure it does not exceed any threshold restrictions. Threshold checks are performed to identify a file that may be in error and to prevent erroneous information from being accepted and processed by the BCRC. The file threshold checks include:

- There are delete transactions for more than 5% of the total records submitted
- 20% or more of the total records failed, with a disposition code of “SP,” due to errors
- TPOC amount or No-Fault Insurance Limit exceeds 100 million dollars

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

Table 7-2 provides some additional information about each threshold error an RRE may receive. However, RREs must *always* contact their EDI Representative when notice of a threshold error is received.

Table 7-2: Correction Methods for Threshold Errors

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 that were previously accepted with a ‘01’ or ‘02’ disposition code. Very small files may suspend even if they have very few delete records. If the delete transaction was used correctly, your EDI Representative will release the file for normal processing. Note: If the RRE is unable to provide a sufficient explanation for these deletions, the BCRC will not allow the file to process
20% or more of records failed record level edits	Error messages will display in the email. Contact your EDI Representative to discuss the most common errors found. Your EDI Representative will provide further instruction. Very small files may suspend even if they have very few records in error. In that case, your EDI Representative may release the file for processing. Note: If a small file errors-out in its entirety, and the EDI Representative can assist the RRE in correcting the errors, the RRE may be able to resubmit a corrected file without the need to process the initial file with the errors.
Suspect amount found in field [#]	<p>A threshold error will trigger if any record within the Claim Input File contains a No-Fault Insurance Limit value (current detail record field 61) greater than \$99,999,999.99.</p> <p>A second threshold will trigger if the cumulative value of all reported TPOC amounts (current detail record field 81 and auxiliary record fields 94, 97, 100, and 103) exceeds \$99,999,999.99.</p> <p>Exception: The No-Fault Insurance Limit field (Field 61) will still accept all “9s” as a default value.</p>
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 time slot will be considered early and placed in a hold status. Once the assigned file submission time slot arrives, the file will automatically be released for processing. If you believe this file should be processed immediately, contact your EDI Representative.
A file from the prior submission period is still processing	A file of the same type submitted previously is still processing. The earlier file must finish processing before the new file can be released for processing by your EDI Representative.
File held - watch list	Your RRE ID has been put on a “watch list” by the BCRC due to numerous past problems with erroneous file submissions. Contact your EDI Representative to resolve.

7.4 Compliance Flags

“Compliance flags” are indicators that provide information on issues related to your compliance with the reporting requirements. The Claim Response File contains space for ten 2-byte Compliance Flags, in Fields 38–47. The possible values that could be indicated by these flags are documented in the Compliance Flag Code table in the NGHP User Guide Appendices Chapter V.

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, the code will be placed in the first flag field. If additional issues are found additional compliance flag codes will be placed in the second and subsequent flag fields (i.e., in the next available flag field). Compliance flags will only be “set” for records receiving a ‘01’ or ‘02’ Applied Disposition Code.

Compliance flags are different from error codes. Unlike an error code, a record will **not** be rejected if one of the conditions that will set a compliance flag is found on the record. The record is processed normally. However, the BCRC will set any flags, track the reason(s) for any flags, and include the findings on compliance reports.

Compliance flags provide the RRE notice that the submitted record was not in compliance with certain Section 111 reporting requirements. When a compliance flag is received due to a late submission, the RRE must take the appropriate steps to ensure that subsequent submissions are submitted timely.

The first compliance flag has a value of ‘01’, which indicates that the submitted **add** record that contains one or more TPOC Dates was not sent in time. ‘01’ is put in the first available Compliance Flag field when **the most recent TPOC Date** (or Funding Delayed Beyond TPOC Start Date, where applicable) **submitted** on the **add** record is more than 135 calendar days (approximately 4.5 months) older than the File Receipt Date. (This compliance flag does not apply to update or delete records.)

You may receive a value of ‘03’ in a Compliance Flag field, which indicates that the submitted record containing the **ORM Termination Date** was not sent in time. It is put in the first available Compliance Flag field when the ORM Termination Date on an **add** or update record is more than 135 calendar days (approximately 4.5 months) older than the File Receipt Date.

The establishment or 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 78 on the Claim Input File Detail Record). However, CMS does reserve 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 on a reported claim was assumed and was then terminated, and when such ongoing responsibility for medicals was reported to the BCRC under Section 111, in order to establish timely reporting.

7.5 NGHP Unsolicited Response File

As of July 2023, RREs may opt in to receive a monthly NGHP Unsolicited Response File for NGHP ORM records. This file will alert them to records they submitted that were updated by an entity other than the RRE over the last month. New RREs may opt in during the registration process for the Section 111 COBSW application, while existing RREs may opt in or out using the *RRE Information* option on the *RRE Listing* page. Files are transmitted in the manner in which the original submission was made. The file will cover applied records submitted by the RRE in the last 12 months, and will include the following information:

- Key matching fields, including the last DCN submitted by the RRE
- Current values for the unchanged portions of the records in question

- The most recent beneficiary entitlement and enrollment information (though changes to this information will not trigger the NGHP Unsolicited Response File)
- The source of the update
- The reason for the update
- The date the record was last changed

For the full file layout, see Chapter V of this guide. To opt in or out, see details in the Section 111 COBSW user guide.

Note: If more than one change is made by another entity to a particular NGHP ORM occurrence during a month, only one NGHP Unsolicited Response Detail Record will be created reflecting the most recent change applied.

Some fields of interest on the NGHP Unsolicited Response File include the following:

- Field 9 (Last Transaction Type) will identify the last action performed on the NGHP ORM occurrence by an entity other than the participating RRE. A value of '0' means the other entity updated the occurrence. A value of '1' means the other entity deleted the occurrence.
- Fields 10-30 will contain the current MSP information for the occurrence.
- Field 29 (Modifier Type Code) & Field 30 (Modifier Name) will contain information related to the updating source. Field 29 will indicate the type of entity that applied the modification to the MSP occurrence. Field 30 will identify the name of the source of the modification (if available).
- Field 31 (Change Reason Code) will indicate why the occurrence was modified (if known). If a reason for change cannot be determined the value of 'UK' (Unknown) or blank will be returned.
- Field 32 (Last Update Applied Date). This field will identify the date the BCRC last changed the occurrence.

Table 7-3: Modifier Type Code and Modifier Name

Modifier Type Code (Field 29)	Value in Modifier Name if available (Field 30)	Description
BCR	BCRC Contractor	Change made by a BCRC CSR/Analyst
CBN	Beneficiary Name	Change made by a BCRC CSR/Analyst due to information received from a Medicare beneficiary
CIN	Insurer Name	Change made by a BCRC CSR/Analyst due to information received outside the Section 111 reporting process from an insurer or TPA

Modifier Type Code (Field 29)	Value in Modifier Name if available (Field 30)	Description
ECR	<p>Contractor number 11139, 11141, 11142 or 11143.</p> <p>If the change was made due to Group Health Plan Recovery, the Modifier Name will contain the value 11139.</p> <p>If the change was made due to Non-Group Health Plan Non-ORM Recovery, the Modifier Name will contain the value 11141.</p> <p>If the change was made due to Non-Group Health Plan ORM Recovery, the Modifier Name will contain the value 11142.</p> <p>If the change was made due to a Part C/Medicare Advantage Plan request, the Modifier Name will contain the value 11143.</p>	Change was made due to information received from another Medicare contractor
RRE	Name of the RRE	Systematic change applied due to a transaction submitted by an RRE other than the participating RRE
WCS	From the Workers' Compensation Review Contractor	Change made by a WCRC analyst due to information received from a beneficiary or employer

Table 7-4: Change Reason Description (Field 31)

Change Reason Code	Description
CT	Change termination date
DO	Mark occurrence for deletion
II	Insurance information change
UK	Unknown
Blank	System-generated, reason unknown

Chapter 8: Query Files

NOTE: 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. For more information on DDE, see Section 10.5.

8.1 Query Process

RREs must determine whether an injured party is a Medicare beneficiary. If a reported individual is not identified as a Medicare beneficiary based on the claim information submitted by the RRE, the BCRC will reject the record for that individual. RREs must submit either the injured party's Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) or Social Security Number (SSN) on all Claim Input File Detail Records. When submitting an SSN, RREs may report a partial SSN. To do this, enter spaces for the first 4 positions followed by the last 5 digits of the SSN so that the field is populated with the required 9 characters. RREs are only to report information about Medicare beneficiaries (including a deceased beneficiary if the individual was deceased at the time of the settlement, judgment, award, or other payment).

Two methods of querying the Medicare status of an injured party are available to Section 111 RREs:

- Query Input and Response File exchange with the BCRC, and
- Limited online query feature using the Section 111 COBSW, as described in Section 8.5.

The Query Input File is a dataset transmitted from a Section 111 RRE to the BCRC, to request information about whether a particular injured party is or was a Medicare beneficiary prior to submitting a claim. Use of Query Input and Response Files is optional under Section 111 reporting. However, you may use the query process to help you determine whether a particular claim must be reported under Section 111 because the injured party is a Medicare beneficiary. The query process is to be used only for Section 111 reporting purposes. **Please review the Data Use Agreement in Chapter 11 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 BCRC must match the data you submit to Medicare's own data. To determine if an individual is a Medicare beneficiary the BCRC must be provided:

- A Medicare ID or SSN
- The first initial of the first name
- The first 6 characters of the last name
- A date of birth (DOB)
- Gender (M/F)

First the BCRC must find an exact match on the Medicare ID or SSN (i.e., either an exact match on the last 5 digits or full 9-digit SSN) you have submitted. Then at least three out of the four remaining matching criteria must match exactly (all four if a partial SSN is used).

If a match is found, you will always be returned the correct Medicare ID for the individual you are querying on. You must store this Medicare ID on your internal files and use it on future Claim Input File transactions. This is CMS' official identifier for the beneficiary, and it will be used by the BCRC when matching claim records to Medicare beneficiaries. Also using CMS' data, the BCRC will 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.

Note: The SSN returned on the response record will always be the SSN that was submitted on the query input record by the RRE. The BCRC will never return an updated or corrected SSN on the Query Response File.

Other than the Medicare ID, 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 BCRC 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. Finally, due to privacy concerns this Response file does not provide the actual dates of Medicare entitlement and enrollment or the reason for entitlement.

The Query Input and Response Files are transmitted using the ANSI X12 270/271 Entitlement Query transaction set (currently using version 5010A1). However, the BCRC 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 Version 4.0.0 of the HEW software are documented in the NGHP User Guide Appendices Chapter V.

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 NGHP User Guide page. ("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 early in your claim review process that the injured individual is or was a Medicare beneficiary, 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 or she files a claim or for whom you are initially unable to identify as a beneficiary, you **must** also determine the person's 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 Medicare ID and Medicare coverage start dates are frequently established and on the BCRC database in advance of the actual Medicare coverage effective dates. **Consequently, 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.** Although 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 their 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. Submit this information on a 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 6.6 for more information on the timeliness of claim reports.

8.2 HEW Software

The HIPAA Eligibility Wrapper (HEW) refers to the translator software needed to transmit Query Files. 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 HEW software, to submit a Query Input File and process the Query Response File.

The HEW software is maintained by the BCRC. It is provided free of charge if you wish to use it. Mainframe and Windows PC/Server-based versions of the HEW software are available. You may download the latest Windows version of the HEW software after logging on to the Section 111 COBSW at <https://www.cob.cms.hhs.gov/Section111/>. You may request a copy of the mainframe version from your EDI Representative or by contacting the EDI Department at 646-458-6740. 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 the NGHP User Guide, Appendices, Chapter V. The file format for the current version is provided there. Also see Chapter V for details on how to install and configure the HEW software.

You will install and run the HEW software in your data center. To use the HEW software, you first will create an input file according to the specifications in the NGHP User Guide, Appendices, Chapter V (Appendix E). This flat file is then used as input to the HEW software. The HEW software produces the X12 270 eligibility query file format which you then transmit to the BCRC. The BCRC will send back your response file in the X12 271 file format. You will feed that into the HEW software to produce the Query Response File, according to the specifications in the NGHP User Guide, Appendices, Chapter V (Appendix E). The Medicare information for the individuals identified as Medicare beneficiaries 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' in Field 8 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 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 HEW only converts incoming/outgoing files. Telecommunications must be done separately. **Note:** When using the HEW software, RREs should select the "S111/VDSA" processing format for the Section 111 output file.

See Chapter 10 for more detailed information on file transmission options.

8.3 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 within the month. These files do not have to be submitted during a specific submission time frame.
- 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 this second file is indeed suspended due to another file still in process, you must contact your EDI Representative to have the suspended file released for processing. Note that 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 email 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.
- Email 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 Medicare ID (HICN or MBI) or SSN (i.e., either an exact match on the last 5 digits or full 9-digit SSN) 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 (all four if a partial SSN is used) 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 or 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 Medicare ID 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.

It will also include the most recent Medicare entitlement dates as well as Part C and Part D enrollment information for the past 3 years. **Note:** a beneficiary enrolled in a Medicare Advantage Prescription Drug (MAPD) plan will receive a Part C Contract/Plan and Part D Contract/Plan for this one enrollment (Effective 12/11/21)

- If a match is not found, the record will be returned with fields as they were submitted on the input record. No information regarding "partial matches" or why a match was not found is provided.
- The SSN returned on the response record will **always** be the same SSN that was submitted on the query input record by the RRE.
- If an RRE submits a value of '0' for an unknown gender for an individual, the BCRC 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 4.0.0 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 BCRC 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.

8.4 Query Files and HEW Software Requirements

The BCRC will only accept test and production query files submitted using Version 5010A1 (and the latest HEW version) of the ASC X12 270/271.

- A copy of the latest PC/server of the HEW software is available for download on the Section 111 COBSW at <https://www.cob.cms.hhs.gov/Section111/>. (**Note:** You must log into the application to download.)
- RREs using the mainframe version of the HEW may request a copy of the latest HEW version from their EDI Representative.
- Query files submitted 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.

8.5 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 the RRE to submit a query online to see if the individual can be matched to a Medicare beneficiary.

If you are an NGHP RRE, and are in production status, you have the Beneficiary Lookup function available to you on the RRE Listing page, after logging on to the Section 111 COBSW (<https://www.cob.cms.hhs.gov/Section111/>). The COBSW Beneficiary Lookup function uses the same matching criteria used by the Query Input File and the Claim Input File.

To use the Beneficiary Lookup tool:

1. Log on to the Section 111 COBSW.
The RRE Listing page will display.
2. Click on the *Actions* drop-down box for the RRE ID under which you wish to query.
3. Select the **Beneficiary Lookup** action from the list and click on the **Go** button.
The *Beneficiary Lookup* page will display
4. On the *Beneficiary Lookup* page, enter the following required information
 - Medicare ID (HICN or MBI) or SSN (When submitting an SSN, RREs may report a partial SSN. To do this, space-fill the first 4 positions followed by the last 5 digits of the SSN so that the field is populated with the required 9 characters.)
 - Injured Party First Name
 - Injured Party Last Name
 - Injured Party Date of Birth
 - Injured Party Gender
5. 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.

In instances where a duplicate is returned, indicated by the disposition code “DP” or messaging on the *Beneficiary Not Found* page, RREs need to take certain actions to remain in compliance with reporting requirements. See Chapter V (Table F-1) for details.

Important Considerations:

- Using the Beneficiary Lookup on the COBSW, non-DDE RREs are limited to 500 query requests per RRE ID per calendar month.
- Use of the Beneficiary Lookup action is limited to that prescribed by the Section 111 Data Use Agreement as documented in Chapter 11, and as 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 RREs that are in a production status.
- 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, but may lead to fewer errors on your Claim Response File. It is available to all RRE IDs. No special application or sign-up is required.
- Non-DDE RREs using the Beneficiary Lookup action may continue to submit the Query Input File.

Chapter 9: Testing the Section 111 Reporting Process

NOTE: The information in this section does **not** apply to RREs that have chosen the DDE reporting option. If you are reporting via DDE, you may go directly to Chapter 10, Electronic Data Exchange.

9.1 Testing Overview

Many entities that report under Section 111 have (or will have) more than one RRE ID. Remember that Section 111 data exchanges are by RRE ID—each entity associated with an RRE ID is responsible for the data exchanges under that registration ID.

RREs using a file submission method must pass a testing process involving the Claim Input and Response Files prior to the RRE's sending of production Section 111 Claim Input Files. The testing process will ensure that the RRE has developed the capability of capturing and reporting data to the BCRC, and of processing the corresponding response files. A series of test files will be submitted to the BCRC in order to verify that the RRE can: transmit input files successfully in the correct format(s); accept and process response files; and properly submit add, update, and delete records. If the RRE is using an agent to do the RRE's data exchanges, the agent must participate in and pass the testing process on behalf of the RRE. Testing must be completed for each RRE ID that has registered unless the RRE has selected the DDE reporting option. No data exchange testing is done for RREs using the DDE option.

9.2 Claim File Testing

Claim Input File testing requirements:

Before an RRE begins testing:

- RREs must complete the registration and account setup process on the COBSW and return the signed profile report to the BCRC before testing may begin. Once the BCRC 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. Testing must be completed prior to the time claims must be reported. See Section 6.6 for more information on timely reporting. If you find you may not complete testing on time, please notify your EDI Representative immediately. You may continue to send test files for any file type as you deem necessary, even after your RRE ID has been put in a production status.

Important Testing Information:

- Testing must be completed for each RRE ID.
- The RRE must transmit test files to the BCRC using the same transmission method as that chosen for production files (HTTPS, SFTP, or Connect:Direct).

- For the data exchange test environment, the BCRC maintains a mirror image of the COB Beneficiary Master Database containing all beneficiary information the BCRC has in production, and programs that mimic the way the files would be processed in production. However, data used in testing will not actually update data in Medicare systems and databases. While this “test environment” will be refreshed, information returned on test response files should *not* be used in production applications.
- Test Medicare beneficiary data may be downloaded from the Section 111 COBSW for RREs to use in testing. After accepting the Login Warning, the Section 111 COBSW Login page displays. Click on the Reference Materials menu option to view the test beneficiary data files available for download. The test data includes: the SSN, Medicare ID (HICN or MBI), name, date of birth and gender of the test beneficiaries. It does not include claim information.
- RREs may use actual production claim information, or their own fabricated test data. RREs should submit some test records using the test Medicare beneficiary identifiers for the injured party to test their ability to match to a Medicare beneficiary. On other test records, injured party information that does not match 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 (these counts exclude 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 with, or prior to, your test Claim Input Files. RREs should submit and complete successful processing of test TIN Reference Files prior to attempting submission of production Claim Input Files, as the TIN information is required for successful processing of Claim Input Files.
- 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
- Your EDI Representative will be your main point of contact to assist you throughout the testing process.
- Query File Testing—Data exchange testing of Query Files is optional but highly recommended. An RRE ID must be in test **or** production status for production Query Input Files to be accepted. An RRE ID must be in production status 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 time slot assigned to the RRE ID for test files. There is no limit to the number of test files an RRE ID may submit.

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: 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:

- Two Claim Response Files that correspond to a submitted test Claim Input File. Note: The BCRC 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 a ‘01’ disposition code on TIN Reference Response File Detail Records.
- Post at least 25 new claims with add records in *one* file submission. These records must receive either a ‘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 are approved by your EDI Representative.*

The BCRC 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.

Testing progress and completion dates will be tracked and reported in the system by the BCRC. 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 EDI Representative has moved the RRE ID to a production status, an email will be sent to the RRE’s Authorized Representative and Account Manager as notification of the change in status and that the RRE may now begin submitting production files.

Once an RRE is in production status:

- Once an RRE ID has moved to a production status, any subsequent test files received will continue to be processed by the BCRC and results will be displayed on the COBSW. RREs may continue to submit test files even after production files have been submitted. This will allow RREs to test any changes to their internal reporting processes without disruption to their production reporting. Test response files will be produced and transmitted.

9.3 Query File Testing

The RRE file exchange testing process is focused on the results of the required production Claim Input and Response File exchanges. Since the use of the query process is optional, 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.

However, there are certain test environment requirements for Query Input and Response Files. Query Input files **must** be limited to 100 records. RREs will submit test files using the same method they chose 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 query responses. You may provide your first test Query Input File to the BCRC after the BCRC has received your signed profile report and the RRE ID has been updated to a testing status.

Note: When using the HTTPS file transmission method, only files with the file extension of .txt are allowed for uploading. Any other file type will generate an Invalid File error message.

After processing the test Query Input File, the BCRC will provide you a test Query Response File identifying those individuals recognized as Medicare beneficiaries and those individuals who could not be identified as Medicare beneficiaries based upon the information submitted, and as prescribed by the file record layouts in Appendix E (in the NGHP User Guide Appendices Chapter V) (if using the HEW software) or as documented in the Section 111 X12 270/271 companion guide. Within a week of the receipt of your test file the BCRC will return a Query Response File. After you and the BCRC 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 either a test or production status.

Specific Query File testing requirements:

- RREs must complete the registration and account setup process and return the signed profile report to the BCRC before testing may begin. Once the BCRC has recorded receipt of the signed profile report, the RRE ID will be updated to a test status and Query test and production files will be accepted.
- The RRE must transmit test files to the BCRC using the same transmission method it has chosen for production files.

- For the data exchange test environment, the BCRC maintains a mirror image of the COB Beneficiary Master Database containing all beneficiary information the BCRC has in production, and programs that mimic the way the files would be processed in production. While this “test environment” will be refreshed, 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 to simulate realistic situations. Include records for individuals aged 65 and over 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.
- RREs should process at least the following test input response files sent back by the BCRC:
 - One (1) corresponding Query Response File.
 - Additional response files as needed.
- The BCRC 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 it will use for production files.

Chapter 10: Electronic Data Exchange

10.1 Overview

There are four different methods of data transmission that Section 111 RREs may use. Three involve the submission of electronic files. The fourth method is Direct Data Entry (DDE) using an application on the Section 111 COBSW. As part of your registration for Section 111 on the COBSW, you will indicate the data transmission method you will use and submit the applicable transmission information.

Each file type (that is, Claim Input File or Query Input File) can be set up to use the same file transmission method—or you may select separate file transmission methods for each. However, the method selected for the Input File type will also be used to transmit the corresponding Response File back to the RRE (or its agent). If you select DDE, you will enter claim information directly, using an application on the Section 111 COBSW, instead of transmitting an electronic file. Remember that DDE is limited to RREs with few claims to report per year. See Section 10.5 for more information on the use of DDE.

Generally speaking, if you expect to be transmitting files with more than 24,000 records at once (in one file submission) on a regular basis, it is strongly suggested that you use either the Connect:Direct or SFTP methods, both of which are described below. HTTPS is more suitable for use with smaller files, due to the time it may take using HTTPS to upload and download files during an active user session. File sizes greater than 20 MB will not be accepted via HTTPS.

You may 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 (Claim or Query) 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:** you may *not* set up an RRE ID to use just for query-only purposes

10.2 Connect:Direct (NDM via CMS EFT)

RREs with a very large transmission volume may wish to consider using Connect:Direct (formerly known as Network Data Mover or NDM) via the CMS Electronic File Transfer (CMS EFT) protocol, which then connects to the CMS Extranet Network and CMS' private CMSNet network hosted by Verizon Business Network Services. Please contact the EDI Department at (646) 458-6740 or your EDI Representative for information on how to establish this connectivity.

During your COBSW account setup, you will select the Connect:Direct option and provide the dataset names you want the BCRC 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 BCRC will email 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 BCRC under this method is:

Production or Test Files (Submission)

MSP Input/TIN Reference Files:	P#/T#EFT.ON.MRNGHPCL.Rxxxxxxx.Dyymmdd.Thhmsst
Non-MSP Files:	P#/T#EFT.ON.MRNMSP.Rxxxxxxx.Dyymmdd.Thhmsst
Query-Only Files:	P#/T#EFT.ON.MRNGHPQO.Rxxxxxxx.Dyymmdd.Thhmsst

Response Files (sent to the RRE) (Submission)

MSP NGHP Files:	HLQ.Rxxxxxxx.NGHPCLM.Dyymmdd.Thhmsst
Non-MSP Files:	HLQ.Rxxxxxxx.NONMSP.Dyymmdd.Thhmsst
Claim TIN Reference Files:	HLQ.Rxxxxxxx.TIN.Dyymmdd.Thhmsst
Query Files:	HLQ.Rxxxxxxx.QRY.Dyymmdd.Thhmsst
Unsolicited:	HLQ.Rxxxxxxx.UNS.Dyymmdd.Thhmsst

Notes:

- **P#/T#** = Production or test
- **HLQ** = Customer-defined high-level qualifier, one for production and one for test
- **Xnnnn** = Assigned Exchange ID that uniquely identifies the recipient for CMS EFT routing
- **Dyymmdd.Thhmsst** = Current date and time
- **Rxxxxxxx** = RRE ID padded with zeros (i.e., R0080043)

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

- Test and production destination dataset names to which you want the BCRC to send your response files
- Optional special instructions such as file triggers you want the BCRC 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 entered, 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 at a later time to do the account setup again, from the beginning.

10.3 Secure File Transfer Protocol (SFTP)

RREs who select the SFTP method for Section 111 reporting will transmit files over the Internet to and from the BCRC using directories (mailboxes) created on the BCRC Section 111 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. All the mailboxes (directories) 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 and that is 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, when performing setup for multiple RRE IDs, use their previously defined login ID). The Account Manager may then log in to the site and invite other users associated with the RRE ID to become Account Designees. Each Account Designee will need to obtain a login ID and password. These 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 one COBSW login ID and password to transmit files for all RRE clients via SFTP as long as their 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. All passwords are exactly eight characters. 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 BCRC recommends that you login to the COBSW and perform the Change Password function once a month to avoid password expiration.

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

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

Table 10-1: SFTP Server Configuration

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 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 BCRC does not transmit response files back to the RRE or its agent. The RRE or agent must pull/download all response files from the COB SFTP mailbox directories.

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: Effective October 1, 2011, TIN Reference Response Files are placed in the “claim” folders.

Using your SFTP client or other software (such as a 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 as 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. 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, you will automatically be routed into the directory for the single RRE ID with which you are associated.
- 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 (production) 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 BCRC will determine the file type from the file contents and test/prod directory to which it is uploaded.

Download

- After going to the response directory, navigate (change directories) to either the test or prod (production) 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 that will be 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. This will help ensure that you only pull new response files added by the BCRC since your last access. Response files remain on the Section 111 SFTP server for 60 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 BCRC 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: P/T#EFT.ON.Xnnnn.Rxxxxxx.CLM.Dyymmdd.Thhmsst.TXT
 TIN Response: P/T#EFT.ON.Xnnnn.Rxxxxxx.TIN.Dyymmdd.Thhmsst.TXT
 Query Response: P/T#EFT.ON.Xnnnn.Rxxxxxx.QRY.Dyymmdd.Thhmsst.TXT

Where 'Dccyymmdd' is 'D' followed by a date as century/year/month/day and
 'Thhmm####' is 'T' followed by a time as hours/minutes and a number from 0000 to 9999.

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

Response files will remain available for downloading for 60 days. Response files can be downloaded more than once as needed. You cannot delete response files from the COBSW SFTP server. The BCRC will remove these files automatically after 60 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.

10.4 Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)

Files uploaded via HTTPS are sent over the Internet to the Section 111 COBSW. This is done using the Section 111 COBSW application. There is no additional software or cost 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 on 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 at one time on a regular basis).

During account setup on the COBSW, your Account Manager can select use of this method for file transfer. The account setup process is described in the NGHP User Guide Registration Procedures Chapter. The RRE's Account Manager obtains a COBSW login ID and password during the account setup process. After that, the Account Manager and the Account Designees can sign on to the COBSW. All users associated with the RRE's account will have the ability to upload input files and download response files.

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

Note: When using the HTTPS file transmission method, only files with the file extension of .txt are allowed for uploading. Any other file type will generate an Invalid File error message.

Files successfully uploaded by the RRE to the Section 111 COBSW are not subsequently accessible by users of the Section 111 COBSW. A user cannot view or delete a file once uploaded. If you uploaded a file in error, you should contact your EDI Representative for assistance.

Response files will remain available for downloading for 60 days. Response files can be downloaded more than once as needed. COBSW users cannot delete response files from the COBSW. The BCRC will remove these files automatically after 60 days.

When uploading input files, no specific naming convention is needed when uploading input files. The BCRC 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.Thhmm####.TXT
 TIN Response: PCOB.BA.MR.NGHPTIN.RESP.Dccyymmdd.Thhmm####.TXT
 Query Response: PCOB.BA.MR.NGHPQRY.RESP.Dccyymmdd.Thhmm####.TXT

Where 'Dccyymmdd' is 'D' followed by a date as century/year/month/day and
 'Thhmm####' is 'T' followed by a time as hours/minutes and a number from 0000 to 9999.

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

You should use an ASCII format for 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.

10.5 Direct Data Entry (DDE)

This section of the user guide was created to provide a high-level overview on DDE. Detailed information on the Direct Data Entry (DDE) option can be found in the Section 111 COBSW User Guide available for download after logging in at <https://www.cob.cms.hhs.gov/Section111/>. There are also computer-based training modules (CBTs) available free of charge that provide both an overview and step-by-step instructions for DDE. See Chapter 14 for information on how to enroll in the CBT courses.

Please note: DDE RREs are responsible for following all of the instructions set forth in the NGHP User Guide except for the instructions that pertain specifically to the physical creation and transmission of electronic files. DDE RREs are required to submit the same data elements and adhere to essentially the same Section 111 reporting requirements as file submitters. The only difference is that 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.

Who has Access to the DDE Option?

DDE is only available for the use of “Small Reporters.” A Small Reporter is an RRE that will submit **500 or fewer** NGHP claim reports per calendar year. (Please see the “Query” discussion below for information about the annual submission limit of 500.)

What is the DDE Option?

The DDE Option is available to small reporters in lieu of using one of the file-based data exchange methods (HTTPS, SFTP, Connect:Direct). Small Reporters may use the Section 111 Coordination of Benefits Secure Website (COBSW) at <https://www.cob.cms.hhs.gov/Section111/> to manually enter and submit individual NGHP claim reports online instead of submitting a multiple-record electronic file. 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 the Section 111 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 one of the current file-based transmission methods and wants to change to the DDE option, the Account Manager for the RRE ID should log in to the COBSW and change from a file transmission reporting method to DDE. To do so, select “Register for DDE” under the Actions drop-down menu 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 after the signed profile report is received at the BCRC; testing is not required or needed; production reporting may begin immediately thereafter.

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

Testing:

- No testing is performed by 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 information must adhere to the reporting thresholds that have been established for Section 111 reporting on initial and subsequent DDE submissions. See Section 6.4.
- All add and update claim reports must include all required data elements as defined in the NGHP User Guide Appendices Chapter V (Appendix A and Appendix B).

This includes RRE TIN and RRE TIN address information. The Section 111 COBSW will perform basic editing of the TIN information.

Note: The Document Control Number (DCN) will be automatically generated by the processing system for DDE claim reports.

- 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.
- An ORM Termination Date submission must be made via DDE within 45 calendar days of the ORM Termination Date. Do not call your EDI Representative to report an ORM Termination Date.

Response File:

- DDE RREs will receive a Claim Response for each claim report submitted, on a one-for-one basis. Responses to submitted claim reports will be shown on the Section 111 COBSW on the *Claims Listing* page. For a detailed description of the claim response file process, see Chapter 7.
- RREs must react to and take action, when necessary, on the information returned and 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, it must be corrected and resubmitted on the Section 111 COBSW as soon as possible.

Query:

- A *separate* query function is available under the DDE option—the beneficiary lookup function on the Section 111 COBSW. The initial step in the DDE process also provides this functionality.
- Injured party information will be matched online in real-time to the BCRC’s file of Medicare beneficiary information, as the DDE data is entered on the Section 111 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 DDE “non-match” will be essentially the same as receiving a “51” disposition code on a Claim Response File.

- Even if an injured party's information does not match to a Medicare beneficiary, the DDE claim submission *will still count* toward the RRE's limit of 500 claim submissions per year. The beneficiary lookup function does not count towards this limit.

Issues to Consider Before Selecting the DDE Option:

- Small Reporters that use the DDE option have the same responsibility and accountability as any other Section 111 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.

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 ongoing basis are advised to use any of the current file submission methods instead of the DDE option to ensure that RREs are able to adhere to the timely reporting requirements.
- Remember: RREs selecting the DDE option have a very real limit to the number of claims they can submit each year. RREs that select the DDE option can only submit 500 (or fewer) claim reports per calendar year, and claim reports resulting in a "no beneficiary match" do count against the 500-claim report limit.

Chapter 11: 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 BCRC. In addition, all users must agree to the Data User Agreement 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 that is exchanged and to 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.

Chapter 12: Section 111 COB Secure Website (COBSW)

The BCRC maintains an interactive application on the Section 111 COB Secure Website (COBSW) to support Section 111 reporting. Section 111 Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation RREs use the COBSW to register for Section 111 reporting and to set up their accounts. The COBSW URL is <https://www.cob.cms.hhs.gov/Section111/>.

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

- Complete the registration process and obtain RRE IDs for each account under which the RRE will submit files.
- Obtain login IDs and assign users for Section 111 RRE ID COBSW accounts.
- Exchange files via HTTPS directly with the BCRC. As an alternative (if qualified), submit claim information via the Direct Data Entry option.
- View and update Section 111 reporting account profile information such as contacts and other 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(s) and processing.
- View statistics related to compliance with the Section 111 reporting requirements such as whether files and records have been submitted on a timely basis.
- Use 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.

Note: SFTP file submitters will use their Section 111 COBSW credentials (login ID and password) to exchange files with the BCRC via the SFTP server.

The registration and account setup processes are described in the NGHP User Guide Chapter II, Registration Procedures.

Sources of Help Related to Using the Section 111 COBSW

There are various helpful guides available directly on the COBSW. To access the Section 111 COBSW, go to <https://www.cob.cms.hhs.gov/Section111/> 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 COBSW home page. A login ID is not needed to access this menu option. Click on this menu option and a drop-down menu 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 in to 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. The following are additional documents that are only available to NGHP RREs after login:
 - Test Beneficiary Data
 - HEW Software Download
- **Computer-Based Training (CBT)** modules for the Section 111 application on the COBSW are available free of charge to RREs and their agents.
- These courses are all available on the Mandatory Insurer Reporting (NGHP) [Training Materials](#) page on the CMS website.

Contact your assigned EDI Representative for additional help and assistance using the COBSW.

Login IDs

Each person using the Section 111 COBSW application 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 SFTP (Chapter 10). You can have one of two functional responsibilities under an RRE ID with your single login ID - Account Manager or Account Designee. Authorized Representatives **cannot** be users of the COBSW (see the NGHP User Guide Registration Procedures, Chapter II).

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 the NGHP User Guide Registration Procedures, Chapter II, 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 email 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.

Account Manager and Account Designees

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 the NGHP User Guide Registration Procedures Chapter II), obtain a login ID and complete the account setup tasks.
- Can be an Account Manager associated with another RRE ID if he or she receives the authorized PIN from the BCRC 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 their 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 the file transmission history.
- Can review any file-processing status and all 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 personal information.
- Can query the Medicare status of an injured party using the Beneficiary Lookup feature.
- Cannot be an Authorized Representative for any 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 that can be 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 a separate 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 their 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 any file-processing status and all file statistics.

- Can change their personal information.
- Can remove himself/herself from the RRE ID.
- Can query the Medicare status of an injured party using the Beneficiary Lookup feature.
- Cannot be an Authorized Representative for any 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 can 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. Once you have used your personal login ID and password, the functions you perform on the COBSW are specific to your relationship to the RRE ID you are working under.

COBSW Routine Maintenance

Routine maintenance on the COBSW and Section 111 SFTP server is typically performed during the third weekend of each month as needed. However, bulletins will be posted to the COBSW Login screen to notify RREs of any changes to scheduled maintenance. 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 notifying 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).

Best Practices

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 log in to CMS resources.

System-Generated Emails

The following email notifications are generated by the system to the Authorized Representative and/or Account Manager for the RRE ID. Emails will be sent from COBVA@ehmedicare.com. Please do not reply to this email address as replies are not monitored by the BCRC. If additional information or action is needed, please contact your EDI Representative directly.

Table 12-1: System-Generated Emails

Email Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	<p>Sent within 10 business days upon completion of the Account Setup step on the Section 111 COBSW. Includes attachment with profile report. The RRE's Authorized Representative must review, sign, and return the profile report to the BCRC within 30 days. If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status.</p> <p>Note: RREs must return their signed profile via email to their assigned EDI Representative. Do not return the signed profile report to the COBVA email address from which it was received. When returning this via email, ensure that the profile report is a scanned copy of the document with a wet signature (i.e., an original signature is included on the profile report).</p>
Non-Receipt of Signed Profile Report	Authorized Representative, Account Manager	Generated 30 days after the profile report email if a signed copy of the profile report has not been received at the BCRC. The Authorized Representative for the RRE ID must sign and return the profile report. If another copy is needed, contact your EDI Representative.
Successful File Receipt	Account Manager	<p>Sent after an input file has been successfully received but not yet processed at the BCRC. Informational only. No action required.</p> <p>Subsequent emails will be sent regarding the results of actual file processing that may require follow up action.</p>
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 email may be ignored if you have nothing to report for the quarter.
Threshold Error	Account Manager	Sent after the Successful File Receipt email 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 email 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 BCRC. The RRE may begin testing.

Email Notification	Recipient	Purpose
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 BCRC has completed processing on an input file and the response file is available.
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 email 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 their 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.

Chapter 13: Customer Service and Reporting Assistance for Section 111

Please be sure to visit the Section 111 page on the CMS website <https://go.cms.gov/mirnghp> frequently for updated information on Section 111 reporting requirements including updates to this guide. In order to be notified via email of updates to this web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP *What's New* page.

The Section 111 Resource Mailbox, at PL110-173SEC111-comments@cms.hhs.gov, is a vehicle that Responsible Reporting Entities (RREs) may use to send CMS policy-related questions regarding the Medicare Secondary Payer (MSP) reporting requirements included in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. RREs are requested to send only policy-related questions to the Section 111 Resource Mailbox. If an RRE has a technical question, and if you are unable to contact your Electronic Data Interchange (EDI) Representative, for any reason, call the EDI Hotline at (646) 458-6740. If you have not registered to become an RRE, please directly contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627.

Please note that emails from CMS or the BCRC 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 email addresses.

13.1 Electronic Data Interchange (EDI) Representative

After you register for Section 111 reporting, you will be assigned an 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 the COBSW screens after completion of the New Registration portion of the registration process and will also be included within your profile report which is generated upon completion of the Account Setup portion of the registration process.

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

13.2 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, you should first contact your EDI Representative at the BCRC. Your EDI Representative should always be sought out first to help you answer any questions, and to help find solutions to any issues or problems you may experience.

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

Escalation Process

The BCRC places great importance on providing exceptional service to its customers. To that end, we have developed the following escalation process to ensure our customers' needs are met:

- If your Section 111 EDI Representative does not respond to your inquiry or issue within **two business days**, you may contact the EDI Director, Angel Pagan, at 646-458-2121. Mr. Pagan's email is apagan@ehmedicare.com.
- If the EDI Director does not respond to your inquiry or issue within **one business day**, you may contact the BCRC Project Director, Jim Brady, who has overall responsibility for the EDI Department and technical aspects of the Section 111 reporting process. Mr. Brady can be reached at 646-458-6682. His email address is JBrady@ehmedicare.com. Please contact Mr. Brady only after attempting to resolve your issue following the escalation protocol provided above.

Chapter 14: Training and Education

A variety of training and educational materials are available to help you with Section 111 reporting, in addition to the material in this guide.

- The Section 111 CMS web page (<https://go.cms.gov/mirnghp>) has links to all CMS publications regarding the MSP Mandatory Reporting Requirements under Section 111 of the MMSEA of 2007. To be notified via email of updates to this web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. CMS conducts Town Hall Teleconferences to provide information and answer questions 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 What's New tab at <https://go.cms.gov/mirnghp>.
- CMS has made available a curriculum of computer-based training (CBT) courses for 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. These courses are all available on the Mandatory Insurer Reporting (NGHP) [Training Material](#) page on the CMS website. All updated Section 111 policy guidance published in the form of an Alert can be found on the CMS web page (<https://go.cms.gov/mirnghp>). Any Alert posted after the date of the currently published user guide supersedes the applicable language in the user guide. All Alerts 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. The NGHP User Guide Appendices Chapter V (Appendix L) contains a list of all the applicable NGHP Alerts posted prior to the publication of this user guide.

Note: The Section 111 user guides and other instructions do not and are not intended to cover all aspects of the MSP program. Although these materials provide wide-ranging overviews of MSP in general, any individual or entity that is a primary payer to Medicare is responsible for their 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:

- [Medicare Secondary Payer](#) website
- [Workers' Compensation Medicare Set Aside Arrangements](#) website
- [Internet-Only Manuals \(IOMs\)](#) website (MSP Manual is CMS Publication 100-05)

Chapter 15: Checklist—Summary of Steps to Register, Test, and Submit Production Files

The following summarizes the steps needed to participate in the reporting process for Section 111. Reference the Registration, Technical, and Policy sections for more detailed instruction.

Before you begin, determine the following:

- Individuals who will be the RRE's Authorized Representative, Account Manager, and Account Designees.
- Whether reporting agents will be used.
- 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.
- 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 BCRC via the CMS Extranet and CMSNet, and create transmission jobs and datasets.

Note: When using the HTTPS file transmission method, only files with the file extension of .txt are allowed for uploading. Any other file type will generate an Invalid File error message.

Register and set up your account:

- 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 email (within 10 business days after registration is complete) indicating your registration and account setup were accepted by the BCRC.

Once you successfully register:

- The RRE's Authorized Representative must approve the account setup, by physically signing the profile report, which includes the Data Use Agreement, and returning it to the BCRC within 30 days. If the BCRC has not received this signed report within 60 days, the RRE ID will be placed in "Discontinued" status. Note: It is recommended that RREs return their signed profile via email directly to their assigned EDI Representative. When returning this via email, ensure that the profile report is a scanned copy of the document with a wet signature (i.e., an original signature is included on the profile report).
- 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 BCRC.

- 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 during your assigned submission periods (ongoing):

- 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. The system requires you to change your password every 60 days.
- Monitor automated emails generated by the system regarding file processing status. These emails are sent to the Account Manager for the RRE ID who should forward these emails 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.
- The RRE's profile report is emailed to the Authorized Representative and Account Manager annually, based upon the receipt date of the last signed profile report. The RRE should confirm via email that their current information is correct. Failure to confirm this information may result in deactivation of the RRE ID.



MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting

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

Chapter V: APPENDICES

Version 7.1

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Chapter 1: Summary of Version 7.1 Updates

The updates listed below have been made to the Appendices Chapter Version 7.1 of the NGHP User Guide. As indicated on prior Section 111 NGHP Town Hall teleconferences, the Centers for Medicare & Medicaid Services (CMS) continue to review reporting requirements and will post any applicable updates in the form of revisions to Alerts and the user guide as necessary.

The *File Type* value in the *NGHP Unsolicited Response File Header Record* now reads “USOL” (Appendix F).

Chapter 2: Introduction

The Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide has been written for use by all Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation Responsible Reporting Entities (RREs). The five chapters of the User Guide—referred to collectively as the “Section 111 NGHP User Guide”—provide information and instructions for the Medicare Secondary Payer (MSP) NGHP reporting requirements mandated by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173).

This **Appendices Chapter** of the MMSEA Section 111 NGHP User Guide provides detailed information on Section 111 file format standards, and record and field specifications for the files used to report Section 111 claim information. The other four chapters of the NGHP User Guide: Introduction and Overview, Registration Procedures, Policy Guidance, and Technical Information should be referenced as needed for applicable guidance.

Please note that CMS will continue to update and to implement the Section 111 requirements. New versions of the Section 111 User Guide will be issued, when necessary, to document revised requirements and add clarity. At times, certain information will 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. RREs must refer to the current user guide and any subsequent Alerts for complete information on Section 111 reporting requirements.

All information pertinent to Section 111 reporting can be found on the various pages of the Section 111 website (<https://go.cms.gov/mirnghp>). Please check this site often for the latest version of this guide and for other important information such as the aforementioned Alerts. To be notified via email of updates to this Web page, click on the [Subscription Sign-up for Mandatory Insurer Reporting \(NGHP\) Web Page Update Notification](#) link found in the Related Links section of the web page and add your email address to the distribution list. When new information regarding mandatory insurer reporting for NGHPs is available, you will be notified. These announcements will also be posted to the NGHP **What's New** page. Additional information related to Section 111 can be found on the login page of the Section 111 Coordination of Benefits Secure Website (COBSW) at <https://www.cob.cms.hhs.gov/Section111/>.

Technical questions should be directed to your Electronic Data Interchange (EDI) Representative. Your EDI Representative contact information can be found in your profile report (received after registration has been completed).

Note: Section 3 (File Formats) apply to RREs using a file submission method.

Chapter 3: File Formats

3.1 General File Standards

Both the Claim Input and TIN Reference Files are transmitted in a flat, text, ASCII file format. The Connect:Direct file transmission method will convert files into EBCDIC. Query Files are transmitted using the ANSI X12 270/271 Entitlement Query transaction set. On request, the BCRC will supply each RRE free software to translate flat file formats to and from the X12 270/271. As described in the NGHP User Guide Technical Information Chapter IV, the Query File formats are the flat file input and output to the translator software supplied by the BCRC. 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 Use Guide page. Note that the BCRC will only accept files transmitted using the 5010A1 version of the X12 270/271. RREs will continue to be given at least 6 months advance notice of any future upgrades.

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 <https://www.cob.cms.hhs.gov/Section111/>. You may request a copy of both the mainframe and Windows versions from your EDI Representative or by contacting the EDI Department at 646-458-6740. The HEW software is maintained free of charge by the BCRC. No source code will be provided.

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. A carriage return/line feed (CRLF) character is in the byte following the end of each record layout defined in this chapter of the NGHP User Guide (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 (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.

- Header Record—each 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 individuals on the Query Input File.
- Trailer Record—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. The file submission date supplied on the header record must match the date supplied on the corresponding file 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 entire file will be rejected.

3.2 Data Format Standards

The following table 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.**

Table 3-1: Data Format Standards

DataType	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 “0000100000.”	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. First name fields may only contain letters and spaces.	Alpha (12): “TEST EXAMPLE” Alpha (12): “EXAMPLE” Alpha (12): “SMITH-JONES “ Alpha (12): “O’CONNOR”

DataType	Formatting Standard	Examples
Alphanumeric	<p>A through Z (all alpha) + 0 through 9 (all numeric) + special characters:</p> <p>Comma (,)</p> <p>Ampersand (&)</p> <p>Space ()</p> <p>Hyphen/Dash (-)</p> <p>Period (.)</p> <p>Single quote (‘)</p> <p>Colon (:)</p> <p>Semicolon (;)</p> <p>Number (#)</p> <p>Forward slash (/)</p> <p>At sign (@)</p> <p>Left justified</p> <p>Non-populated bytes padded with spaces</p> <p>Alphabetic characters sent in lower case will be converted and returned in upper case.</p> <p>Default to all spaces unless otherwise specified in the record layouts.</p> <p>Parentheses () are not accepted.</p>	<p>Text (8): “AB55823D”</p> <p>Text (8): “XX299Y”</p> <p>Text (18): “ADDRESS@DOMAIN.COM”</p> <p>Text (12): “ 800-555-1234”</p> <p>Text (12): “#34 “</p>
Alphanumeric Plus Parens	Same as above but including Parentheses ()	“Department Name (DN)”
Numeric Date	<p>Zero through nine (0—9) formatted as CCYYMMDD. No slashes or hyphens.</p> <p>Default to zeroes unless otherwise specified in the file layouts (no spaces are permitted).</p>	<p>A date of March 25, 2011 would be formatted as “20110325”</p> <p>Open ended date: “00000000”</p>
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.	-

Appendix A: Claim Input File Layout

Claim Input File Header Record

Table A-1: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Header Record – 2220 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alphabetic	Must be "NGCH." Required.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Pad with leading zeroes. Required.
3	Section 111 Reporting File Type	7	14	20	Alphabetic	Must be "NGHPCLM." Required.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the BCRC. 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

Note: This record is used to submit Injured Party/Medicare Beneficiary Information when the injured party is/was a Medicare beneficiary. Please see Table A-2 for supplementary information and specific reporting instructions for certain fields on the Claim Input File Detail Record Layout in addition to the individual field descriptions on the Claim Input File Detail Record Layout in Table A-3.

Table A-2: Claim Input File Supplementary Information and Specific Reporting Instructions

Fields	Description	Specific Reporting Instructions
44 & 45	Self-Insured Information	This information is required to: <ul style="list-style-type: none"> Indicate if the reportable event involves "self-insurance" as defined by CMS; and If yes, specific information regarding the self-insured individual or entity

Fields	Description	Specific Reporting Instructions
64-76	Injured Party’s Attorney or Other Representative Information	<p>Attorney/Representative information required only if injured party has a representative.</p> <p>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 64-76) with spaces if not supplying Representative Information.</p>
84-97	Claimant Information	<p>These fields are Optional.</p> <p>This section is only to be used if the injured party is deceased. The claimant may be the beneficiary’s estate, or other claimant in the case of wrongful death or survivor action. Additional claimants may be listed on the Auxiliary Record.</p> <p>If not supplying Claimant 1 information (Claimant 1 Relationship is a space), default each field (Fields 84-97) to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 84-97) with spaces.</p> <p>If supplying information in these fields, it will be edited for validity and completeness and errors will be returned if field requirements are not met</p> <p>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.</p>
99-111	Claimant 1 Attorney/Other Representative Information	<p>These fields are Optional.</p> <p>This section is only to be used if the injured party is deceased and the claimant has representation.</p> <p>If not supplying Claimant 1 Representative information (C1 Representative Indicator is a space), default each field in this section (Fields 99-111) to its appropriate default value per the field type (zeroes or spaces) or fill the entire section (Fields 99-111) with spaces.</p> <p>If supplying information in these fields, it will be edited for validity and completeness and errors will be returned if field requirements are not met.</p>

Table A-3: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Detail Record – 2220 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alphabetic	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 BCRC 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 Total Payment Obligation to the Claimant (TPOC) amounts or to add additional TPOCs, report use "2." Required.
4	Injured Party Medicare ID	12	21	32	Alpha-Numeric	Medicare Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) Fill with spaces if unknown and Social Security Number (SSN) provided. Do not include 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 Medicare ID provided. No dashes, hyphens or special characters allowed. Note: When submitting an SSN, this field may contain either the last 5 digits or the full 9 digits of the SSN. If a partial SSN is submitted, space fill the first four characters followed by the last 5 digits of the SSN. Required if Medicare ID not provided.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
6	Injured Party Last Name	40	42	81	Alphabetic	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	Alphabetic	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	Alphabetic	First letter of Injured Party middle name. Name should be submitted as it appears on the individual's Social Security or Medicare Insurance card. Fill with space if unknown.
9	Injured Party Gender	1	113	113	Numeric	Code to reflect the sex of the injured party. Valid values: 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.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
12	CMS Date of Incident (DOI): DOI as defined by CMS	8	142	149	Numeric Date	<p>Date of Incident (DOI) as defined by CMS:</p> <ul style="list-style-type: none"> For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of first exposure. For claims involving ingestion (for example, a recalled drug), it is the date of first ingestion. For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants). 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. <p>Note: CMS's 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.</p> <p>Must be numeric and a valid date prior to or equal to the current BCRC processing date. Field cannot contain spaces, alpha characters or all zeroes.</p> <p>Format: CCYYMMDD</p> <p>Required.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
13	Industry Date of Incident (DOI): DOI routinely used by the insurance/workers' compensation industry	8	150	157	Numeric Date	<p>Date of Incident (DOI) <i>used by the insurance/workers' compensation industry</i>:</p> <p>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.</p> <p>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.</p> <p>Field must contain all zeroes or a valid date prior to or equal to the current BCRC processing date.</p> <p>Format: CCYYMMDD</p> <p>Optional.</p>
14	Reserved for Future Use	1	158	158	Alpha-Numeric	Fill with spaces.

Field	Name	Size	Start	End	Data	Description
15	Alleged Cause of Injury, Incident, or Illness	7	159	165	Alpha-Numeric	<p>ICD-9-CM/ICD-10-CM (International Classification of Diseases, Ninth/Tenth Revision, Clinical Modification) External Cause of Injury Code describing the alleged cause of injury/illness.</p> <p>Optional.</p> <p>Left justify. Do not include decimal point.</p> <p>See the NGHP User Guide Technical Information Chapter (Section 6.2.5) for complete information. In this field only, an ICD-9 code must begin with the letter “E,” and an ICD-10 code must begin with “V,” “W,” “X,” or “Y.” Codes in this field must NOT be on the list of Excluded ICD-9/ICD-10 Diagnosis Codes found on CMS.gov at https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists.</p> <p>Special default for liability reporting: If, and only if:</p> <ul style="list-style-type: none"> • The ORM Indicator (Field 78) is N and the Plan Insurance Type (Field 51) is L; • 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; • There is no allegation of a situation involving medical care or a physical or mental injury; • The settlement, judgment, award or other payment releases or has the effect of releasing medicals; then a value of “NOINJ” may be submitted. <p>If “NOINJ” is submitted in Field 15 then “NOINJ” must be submitted in Field 18.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
16	State of Venue	2	166	167	Alphabetic	<p>US postal abbreviation corresponding to the US State (including The District of Columbia, American Samoa, Guam, Puerto Rico, Washington DC and the US Virgin Islands) whose state law controls resolution of the claim.</p> <p>See http://www.usps.com</p> <p>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.</p> <p>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.</p> <p>Required.</p>
17	ICD Indicator	1	168	168	Alpha-Numeric	<p>Code to reflect the type of ICD diagnosis codes submitted on the record.</p> <p>Valid values:</p> <ul style="list-style-type: none"> • "0" – ICD-10-CM diagnosis codes • "9" – ICD-9-CM diagnosis codes • Space – ICD-9-CM diagnosis codes <p>Required.</p> <p>Note: Claims submitted with a CMS DOI on or after October 1, 2015 that contain an ICD indicator of "9" or space will be rejected with a CI31 error.</p>

Field	Name	Size	Start	End	Data	Description
18	ICD Diagnosis Code 1	7	169	175	Alpha-Numeric	<p>ICD-9-CM/ICD-10-CM 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.</p> <p>See the NGHP User Guide Technical Information Chapter (Section 6.2.5) for complete information. ICD-9 codes cannot begin with the letter “E” and cannot begin with the letter “V.” ICD-10 codes cannot begin with the letters “V,” “W,” “X,” or “Y.” Codes used here must NOT be on the list of Excluded ICD-9/ICD-10 Diagnosis Codes found on CMS.gov at https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists.</p> <p>Special default for liability reporting: If, and only if:</p> <ul style="list-style-type: none"> • ORM Indicator (Field 78) is N and the Plan Insurance Type (Field 51) is L; • 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; • No allegation of a situation involving medical care or a physical or mental injury; • Settlement, judgment, award or other payment releases or has the effect of releasing medicals; then a value of “NOINJ” may be submitted. <p>If “NOINJ” is submitted in Field 18 then all remaining ICD Diagnosis Codes 2-19 must be filled with spaces.</p>
19	ICD Diagnosis Code 2	7	176	182	Alpha-Numeric	<p>See explanation for Field 18. May include additional, valid ICD Diagnosis Code as specified in the requirements for Field 18.</p> <p>Required when multiple body parts are affected.</p> <p>Provide if available/applicable.</p>

Field	Name	Size	Start	End	Data	Description
20	ICDDiagnosis Code 3	7	183	189	Alpha-Numeric	See explanation for Field 18 and 19. Required when 3 or more body parts are affected. Provide if available/applicable.
21	ICDDiagnosis Code 4	7	190	196	Alpha-Numeric	See explanation for Field 18 and 19. Required when 4 or more body parts are affected. Provide if available/applicable.
22	ICD Diagnosis Code 5	7	197	203	Alpha-Numeric	See explanation for Field 18 and 19. Required when 5 or more body parts are affected. Provide if available/applicable.
23	ICD Diagnosis Code 6	7	204	210	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
24	ICDDiagnosis Code 7	7	211	217	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
25	ICDDiagnosis Code 8	7	218	224	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
26	ICDDiagnosis Code 9	7	225	231	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
27	ICDDiagnosis Code 10	7	232	238	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
28	ICDDiagnosis Code 11	7	239	245	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
29	ICDDiagnosis Code 12	7	246	252	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
30	ICDDiagnosis Code 13	7	253	259	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
31	ICDDiagnosis Code 14	7	260	266	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
32	ICDDiagnosis Code 15	7	267	273	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
33	ICDDiagnosis Code 16	7	274	280	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
34	ICDDiagnosis Code 17	7	281	287	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
35	ICDDiagnosis Code 18	7	288	294	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.

Field	Name	Size	Start	End	Data	Description
36	ICDDiagnosis Code 19	7	295	301	Alpha-Numeric	See explanation for Field 18 and 19. Provide if available/applicable.
37	Reserved for Future Use	107	302	408	Alpha-Numeric	Fill with spaces.
38	Product Liability Indicator	1	409	409	Alpha-Numeric	Fill with spaces.
39	Product Generic Name	40	410	449	Alpha-Numeric	Fill with spaces.
40	Product Brand Name	40	450	489	Alpha-Numeric	Fill with spaces.
41	Product Manufacturer	40	490	529	Alpha-Numeric	Fill with spaces.
42	Product Alleged Harm	200	530	729	Alpha-Numeric	Fill with spaces.
43	Reserved for Future Use	20	730	749	Alpha-Numeric	Fill with spaces.
44	Self Insured Indicator	1	750	750	Alphabetic	<p>Indication of whether the reportable event involves self-insurance <u>as defined by CMS</u>. Valid values: Y = Yes N = No</p> <p>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 I. You must use this definition of self-insurance for purposes of this reporting.</p> <p>Used by CMS if Plan Insurance Type (Field 51) is E or L (Workers’ Compensation or Liability). The self-insurance rules applicable to Liability and WC do not apply to No-Fault.</p> <p>Required. If Plan Insurance Type is E or L, this field must equal Y or N. If Plan Insurance Type is D, this field must equal N or space.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
45	Self-Insured Type	1	751	751	Alphabetic	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 44 is N or space) Required and must contain a value of I or O if the Self Insured Indicator (Field 44) is Y. If the Self Insured Indicator is N or space, must equal space.
46	Policyholder Last Name	40	752	791	Alphabetic	Surname of policyholder or self-insured individual. Embedded hyphens (dashes), apostrophes and spaces accepted. If Self-Insured Type (Field 45) = 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.
47	Policyholder First Name	30	792	821	Alphabetic	Given/First name of policyholder or self-insured individual. May only contain letters and spaces. If Self-Insured Type (Field 45) = I, must contain only letters and/or spaces. If Self Insured Type is not equal to I, must be all spaces.
48	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 45) = O and Legal Name (Field 49) not provided. If supplied, must be at least 2 characters long. If Self Insured Type (Field 45) = I, must be blank.
49	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 45) = O and DBA Name (Field 48) not provided. If supplied, must be at least 2 characters long. If Self Insured Type (Field 45) = I, must be blank.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
50	Reserved for Future Use	20	962	981	Alpha-Numeric	Fill with spaces.
51	Plan Insurance Type	1	982	982	Alphabetic	<p>Type of insurance coverage or line of business provided by the plan policy or self-insurance.</p> <p>Valid values: D = No-Fault E = Workers' Compensation L = Liability</p> <p>Required.</p> <p><i>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.</i></p> <p>"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."</p>
52	TIN	9	983	991	Numeric	<p>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.</p> <p>Must contain a valid 9-digit Internal Revenue Service (IRS)-assigned Federal Tax Identification Number or foreign RRE pseudo-TIN. Must be numeric. Include leading zeroes. Do not include hyphens.</p> <p>In the case of a foreign RRE without a valid IRS-assigned TIN, supply the pseudo-TIN created during Section 111 registration.</p> <p>Must have a corresponding entry with associated Office Code/Site ID on the TIN Reference File.</p> <p>Required.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
53	Office Code/Site ID	9	992	1000	Alpha-Numeric	<p>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.</p> <p>If only one address will be used per reported TIN, leave blank.</p> <p>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.</p> <p>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 special characters are accepted</p> <p>Optional.</p>
54	Policy Number	30	1001	1030	Alpha-Numeric Plus Parens	<p>The unique identifier for the policy under which the underlying claim was filed.</p> <p>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.</p> <p>Required.</p> <p>If multiple RREs are submitting claims under the same policy number, enter this number consistently and in the same format.</p> <p>While not required when the insurance type is self-insurance, if this number is available, please provide it on all new "add" records.</p>
55	Claim Number	30	1031	1060	Alpha-Numeric Plus Parens	<p>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.</p> <p>Required.</p>
56	Plan Contact Department Name	70	1061	1130	Alpha-Numeric Plus Parens	<p>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.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
57	Plan Contact Last Name	40	1131	1170	Alphabetic	<p>Surname 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.</p> <p>If not left blank, first position must be an alphabetic character. Other positions may contain a letter, hyphen, apostrophe or space.</p> <p>Optional.</p>
58	Plan Contact First Name	30	1171	1200	Alphabetic	<p>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.</p> <p>May only contain letters and spaces. If not left blank, first position must be an alphabetic character. Other positions must contain letters or spaces.</p> <p>Optional.</p>
59	Plan Contact Phone	10	1201	1210	Numeric	<p>Telephone number of individual that should be contacted at the Plan for claim-related communication.</p> <p>Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333).</p> <p>Must contain 10-digit numeric value. Fill with zeroes if not available.</p> <p>Optional.</p>
60	Plan Contact Phone Extension	5	1211	1215	Alpha-Numeric	<p>Telephone extension number of individual that should be contacted at the Plan for claim-related communication.</p> <p>Must be left-justified and unused bytes filled with spaces. Fill with all spaces if unknown or not applicable.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
61	No-Fault Insurance Limit	11	1216	1226	Numeric	<p>Dollar amount of limit on no-fault insurance. (Note: This amount represents a combined total of Med-Pay and PIP.)</p> <p>Specify dollars and cents with implied decimal. No formatting (no \$ or , or .) For example, a limit of \$10,500.00 should be coded as 00001050000.</p> <p>Note: the last two positions reflect cents. For example, an amount of 500 dollars and no cents must be submitted as "00000050000,"</p> <p>Field may not be blank (all spaces). Must contain a valid numeric amount, all zeroes or all 9s as specified below.</p> <p>Required if Plan Insurance Type (Field 51) is D (No-Fault Insurance). If Plan Insurance Type is D and there is no such dollar limit, fill with all 9s, otherwise specify amount. All zeroes is not a valid value if the Plan Insurance Type is D.</p> <p>If Plan Insurance Type (Field 51) is E (Workers' Compensation) or L (Liability Insurance), must be filled with all zeroes.</p>
62	Exhaust Date for Dollar Limit for No-Fault Insurance	8	1227	1234	Numeric Date	<p>Date on which limit was reached or benefits exhausted for No-Fault Insurance Limit (Field 61).</p> <p>Format: CCYYMMDD</p> <p>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 62, the same date should be supplied in the ORM Termination Date (Field 79).</p> <p>If Plan Insurance Type (Field 51) 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 79).</p> <p>If Plan Insurance Type (Field 51) is E (Workers' Compensation) or L (Liability Insurance), must be filled with all zeroes.</p>
63	Reserved for Future Use	20	1235	1254	Alpha-Numeric	Fill with spaces

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
64	Injured Party Representative Indicator	1	1255	1255	Alphabetic	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 64 – 76 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.
65	Representative Last Name	40	1256	1295	Alphabetic	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 64) is blank.
66	Representative First Name	30	1296	1325	Alphabetic	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 64) is blank.
67	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 64) is blank. If supplied, must be at least 2 alphanumeric characters.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
68	Representative TIN	9	1396	1404	Alpha-Numeric	<p>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).</p> <p>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 64) is blank.</p> <p>Optional.</p>
69	Representative Mailing Address Line 1	50	1405	1454	Alpha-Numeric	<p>First line of the mailing address 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.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>Required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 64) is blank or Representative State (Field 72) = "FC."</p>
70	Representative Mailing Address Line 2	50	1455	1504	Alpha-Numeric	<p>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.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>Must be blank if Injured Party Representative Indicator (Field 64) is blank.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
71	Representative City	30	1505	1534	Alpha-Numeric	<p>Mailing address city for the representative named above.</p> <p>Field may contain only alphabetic, Space, Comma, &—' . @ # / ; : characters. No numeric characters allowed.</p> <p>If no US address is available, fill with spaces and supply “FC” in the corresponding State Code.</p> <p>Required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 64) is blank or Representative State (Field 72) = “FC.”</p>
72	Representative State	2	1535	1536	Alphabetic	<p>US Postal abbreviation State Code for the representative named above.</p> <p>See http://www.usps.com</p> <p>If no US address is available, supply “FC.” The District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses.</p> <p>Required if Injured Party has a representative. Must be blank if Injured Party Representative Indicator (Field 64) is blank.</p>
73	Representative Mail Zip Code	5	1537	1541	Alpha-Numeric	<p>5-digit Zip Code for the representative named above.</p> <p>If no US address is available, fill with zeroes and supply “FC” in the corresponding State Code.</p> <p>Required if Injured Party has a representative. Must be blank or all zeroes if Injured Party Representative Indicator (Field 64) is blank or Representative State (Field 72) = “FC.”</p>
74	Representative Mail Zip+4	4	1542	1545	Alpha-Numeric	<p>4-digit Zip+4 Code for the representative named above.</p> <p>If not applicable or unknown, fill with zeroes (0000). Must be blank or all zeroes if Injured Party Representative Indicator (Field 64) is blank or Representative State (Field 72) = “FC.”</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
75	Representative Phone	10	1546	1555	Alpha-Numeric	<p>Telephone number of the representative named above.</p> <p>Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333).</p> <p>If no US phone number is available, fill with zeroes and supply "FC" in the corresponding State Code.</p> <p>Required if Injured Party has a representative. Must be blank or all zeroes if Injured Party Representative Indicator (Field 64) is blank or Representative State (Field 72) = "FC."</p>
76	Representative Phone Extension	5	1556	1560	Alpha-Numeric	<p>Telephone extension number of representative named above.</p> <p>Fill with all spaces if unknown or not applicable. Must be blank if Injured Party Representative Indicator (Field 64) is blank or Representative State (Field 72) = "FC."</p>
77	Reserved for Future Use	20	1561	1580	Alpha-Numeric	Fill with spaces.
78	ORM Indicator	1	1581	1581	Alphabetic	<p>Indication of whether there is on-going responsibility for medicals (ORM). Fill with Y if there is ongoing responsibility for medicals.</p> <p>Valid values: Y – Yes N – No</p> <p>The Y value remains in this field even when an ORM Termination Date (Field 79) is submitted in this same record or a subsequent record.</p> <p>Required.</p>

Field	Name	Size	Start	End	Data	Description
79	ORM Termination Date	8	1582	1589	Numeric Date	<p>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."</p> <p>ORM Termination Date is not applicable if claimant retains the ability to submit/apply for payment for additional medicals related to the claim. See NGHP User Guide Technical Information Chapter IV (Sections 6.7 and 6.8) for information concerning exceptions regarding reporting ORM.</p> <p>Future dates are accepted but cannot exceed more than 75 years from the current date.</p> <p>When an ORM termination date is submitted, the ORM indicator in Field 78 must remain as "Y."</p> <p>Format: CCYYMMDD</p> <p>Fill with zeroes if ORM Indicator = "N" or if a date for the termination of ORM has not been established.</p> <p>Note: If no ORM Termination Date is provided but an Exhaust Date for Dollar Limit for No-Fault Insurance (Field 62) is provided, then this date will be used to auto populate the ORM Termination Date.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
80	TPOC Date 1	8	1590	1597	Numeric Date	<p>Date of associated Total Payment Obligation to the Claimant (TPOC) without regard to <u>ongoing</u> 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.</p> <p>Format: CCYYMMDD</p> <p>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.</p> <p>Required for all other claim reports.</p> <p>Must be non-zero if a non-zero value is submitted in TPOC Amount 1. Must be greater than the CMS Date of Incident (Field 12) and less or equal to the file submission date. No future dates allowed. Must be all zeroes if TPOC Amount 1 is all zeroes.</p> <p>Use the TPOC fields on the Auxiliary Record to report additional, separate TPOCs as required.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
81	TPOC Amount 1	11	1598	1608	Numeric	<p>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. Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as “0000100000.” Specify dollars and cents with implied decimal. No formatting (no \$, .) For example, an amount of \$20,500.55 should be coded as 00002050055.</p> <p>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.</p>

Field	Name	Size	Start	End	Data	Description
82	Funding Delayed Beyond TPOC Start Date 1	8	1609	1616	Numeric Date	<p>If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed.</p> <p>Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).</p> <p>Format: CCYYMMDD</p> <p>Fill with all zeroes if not applicable.</p>
83	Reserved for Future Use	20	1617	1636	Alpha-Numeric	Fill with spaces.
84	Claimant 1 Relationship	1	1637	1637	Alphabetic	<p>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").</p> <p>Valid values:</p> <p>E = Estate, Individual Name Provided</p> <p>F = Family Member, Individual Name Provided</p> <p>O = Other, Individual Name Provided</p> <p>X = Estate, Entity Name Provided (e.g., "The Estate of John Doe")</p> <p>Y = Family, Entity Name Provided (e.g., "The Family of John Doe")</p> <p>Z = Other, Entity Name Provided (e.g., "The Trust of John Doe")</p> <p>Space = Claimant Information Not Supplied (Fields 84 – 98 must contain default values according to Data Type, or all spaces)</p> <p>This section is only to be used if the injured party is deceased.</p> <p>Optional.</p>
85	Claimant 1 TIN	9	1638	1646	Alpha-Numeric	<p>Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 1.</p> <p>May contain only spaces or numbers. Must not match other claimant(s) listed on the Auxiliary Record.</p> <p>If Claimant 1 Relationship (Field 84) is equal to a space, must contain all zeroes or all spaces.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
86	Claimant 1 Last Name	40	1647	1686	Alphabetic	Surname of Claimant 1. Embedded hyphens (dashes), apostrophes and spaces accepted. If Claimant 1 Relationship (Field 84) is equal to a space, must contain all spaces. Optional.
87	Claimant 1 First Name	30	1687	1716	Alphabetic	Given/First name of Claimant 1. May only contain letters and spaces. If Claimant 1 Relationship (Field 84) is equal to a space, must contain all spaces. Optional.
88	Claimant 1 Middle Initial	1	1717	1717	Alphabetic	First letter of Claimant 1's middle name. If Claimant 1 Relationship (Field 84) is equal to a space, must contain all spaces. Optional.
89	Claimant 1 Entity/Organization Name	71	1647	1717	Alpha-Numeric	Name of Claimant 1 Entity/Organization. Redefines Fields 86-88 (is made up of the same bytes, is in the same location as Fields 86-88). Use either Field 89 or Fields 86-88 depending on the Relationship code submitted. If supplied, must contain at least 2 alphanumeric characters. If Claimant 1 Relationship (Field 84) is equal to a space, must contain all spaces. Optional.
90	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 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 supplied, must contain at least 2 alphanumeric characters. If Claimant 1 Relationship (Field 84) is equal to a space, must contain all spaces. Optional.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
91	Claimant 1 Mailing Address Line 2	50	1768	1817	Alpha-Numeric	<p>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.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>If supplied, must contain at least 2 alphanumeric characters.</p> <p>If Claimant 1 Relationship (Field 84) is equal to a space, must contain all spaces.</p> <p>Optional.</p>
92	Claimant 1 City	30	1818	1847	Alpha-Numeric	<p>Mailing address city for the claimant named above.</p> <p>Field may contain only alphabetic, Space, Comma, &—' . @ # / ; : characters. No numeric characters allowed.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>If Claimant 1 Relationship (Field 84) is equal to a space or Claimant 1 State (Field 93) = "FC," must contain all spaces.</p> <p>Optional.</p>
93	Claimant 1 State	2	1848	1849	Alphabetic	<p>US Postal abbreviation State Code for the claimant named above.</p> <p>See http://www.usps.com</p> <p>If no US address is available, supply "FC." The District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses.</p> <p>If Claimant 1 Relationship (Field 84) is equal to a space, must contain all spaces.</p> <p>Optional.</p>
94	Claimant 1 Zip	5	1850	1854	Alpha-Numeric	<p>5-digit Zip Code for the claimant named above.</p> <p>If no US address is available, fill with zeroes and supply "FC" in the corresponding State Code.</p> <p>If Claimant 1 Relationship (Field 84) is equal to a space or Claimant 1 State (Field 93) = "FC," must contain all spaces or all zeroes.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
95	Claimant 1 Zip+4	4	1855	1858	Alpha-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 84) is equal to a space or Claimant 1 State (Field 93) = "FC," must contain all spaces or all zeroes. Optional.
96	Claimant 1 Phone	10	1859	1868	Alpha-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. If Claimant 1 Relationship (Field 84) is equal to a space or Claimant 1 State (Field 93) = "FC," must contain all spaces or all zeroes. Optional.
97	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 84) is equal to a space, must contain all spaces. Optional.
98	Reserved for Future Use	20	1874	1893	Alpha-Numeric	Fill with spaces.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
99	Claimant 1 (C1) Representative Indicator	1	1894	1894	Alphabetic	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 = Claimant Representative Information Not Supplied. (Fields 99 – 111 must contain default values according to Data Type, or all spaces). If a value is submitted in this field, data must be supplied in Fields 100-111. If Claimant 1 has more than one representative, provide information for their attorney if available. Optional.
100	C1 Representative Last Name	40	1895	1934	Alphabetic	Surname of C1 representative. Embedded hyphens (dashes), apostrophes and spaces accepted. If C1 Representative Indicator (Field 99) is equal to a space, must contain all spaces.
101	C1 Representative First Name	30	1935	1964	Alphabetic	Given or first name of C1 representative. May only contain letters and spaces. If supplied, must contain at least 2 characters and first character must be alphabetic. If C1 Representative Indicator (Field 99) is equal to a space, must contain all spaces. Optional.
102	C1 Representative Firm Name	70	1965	2034	Alpha-Numeric	C1 Representative's firm name. If supplied, must contain at least 2 alphanumeric characters. If C1 Representative Indicator (Field 99) is equal to a space, must contain all spaces. Optional.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
103	C1 Representative TIN	9	2035	2043	Alpha-Numeric	<p>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).</p> <p>May contain only spaces or numbers. If no C1 Representative TIN is available, fill with spaces or all zeroes.</p> <p>If supplied, cannot = TIN (field 52).</p> <p>If C1 Representative Indicator (Field 99) is equal to a space, must contain all spaces or all zeroes.</p> <p>Optional.</p>
104	C1 Representative Mailing Address 1	50	2044	2093	Alpha-Numeric	<p>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.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>If C1 Representative Indicator (Field 99) is equal to a space or C1 Representative State (field 107) = "FC," must contain all spaces.</p> <p>Optional.</p>
105	C1 Representative Mailing Address 2	50	2094	2143	Alpha-Numeric	<p>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.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>If supplied, must contain at least 2 alphanumeric characters.</p> <p>If C1 Representative Indicator (Field 99) is equal to a space, must contain all spaces.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
106	C1 Representative Mailing City	30	2144	2173	Alpha-Numeric	<p>Mailing address city for the C1 representative named above.</p> <p>Field may contain only alphabetic, Space, Comma, &—' . @ # / ; : characters. No numeric characters allowed.</p> <p>If no US address is available, fill with spaces and supply “FC” in the corresponding State Code.</p> <p>If C1 Representative Indicator (Field 99) is equal to a space or C1 Representative State (field 107) = “FC,” must contain all spaces.</p> <p>Optional.</p>
107	C1 Representative State	2	2174	2175	Alphabetic	<p>US Postal abbreviation State Code for the C1 representative named above.</p> <p>See http://www.usps.com</p> <p>If no US address is available, supply “FC.” The District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses.</p> <p>If C1 Representative Indicator (Field 99) is equal to a space, must contain all spaces.</p> <p>Optional.</p>
108	C1 Representative Zip	5	2176	2180	Alpha-Numeric	<p>5-digit Zip Code for the C1 representative named above.</p> <p>If no US address is available, fill with zeroes and supply “FC” in the corresponding State Code.</p> <p>If C1 Representative Indicator (Field 99) is equal to a space or C1 Representative State (Field 107) = “FC,” must contain all spaces or all zeroes.</p> <p>Optional.</p>
109	C1 Representative Zip+4	4	2181	2184	Alpha-Numeric	<p>4-digit Zip+4 Code for the C1 representative named above.</p> <p>If not applicable or unknown, fill with zeroes (0000). If C1 Representative Indicator (Field 99) is equal to a space or C1 Representative State (Field 107) = “FC,” must contain all spaces or all zeroes.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
110	C1 Representative Phone	10	2185	2194	Alpha-Numeric	<p>Telephone number of the C1 representative named above.</p> <p>Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333).</p> <p>If no US phone number is available, fill with zeroes and supply "FC" in the corresponding State Code.</p> <p>If C1 Representative Indicator (Field 99) is equal to a space or C1 Representative State (Field 127107 = "FC," must contain all spaces or all zeroes.</p> <p>Optional.</p>
111	C1 Representative Phone Extension	5	2195	2199	Alpha-Numeric	<p>Telephone extension number of the C1 representative named above.</p> <p>Fill with all spaces if unknown or not applicable. If C1 Representative Indicator (Field 99) is equal to a space, must contain all spaces.</p> <p>Optional.</p>
112	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 to 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.

Please see the following for supplementary information and specific reporting instructions for certain fields on the Claim Input File Auxiliary Record Layout in addition to the individual field descriptions on the Claim Input File Auxiliary Record Layout in Table A-5.

Table A-4: Claim Input File Auxiliary Record Supplementary Information and Specific Reporting Instructions

Fields	Description	Specific Reporting Instructions
7-21	Claimant 2 Information	<p>These fields are Optional.</p> <p>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.</p> <p>If supplying information in these fields, it will be edited for validity and completeness and errors will be returned if field requirements are not met.</p>
22-35	Claimant 2 Attorney/Other Representative Information	<p>These fields are Optional.</p> <p>This section is only required if Claimant 2 has a representative.</p> <p>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.</p> <p>If supplying information in these fields, it will be edited for validity and completeness and errors will be returned if field requirements are not met.</p>
36-50	Claimant 3 Information	<p>These fields are Optional.</p> <p>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.</p> <p>If supplying information in these fields, it will be edited for validity and completeness and errors will be returned if field requirements are not met.</p>

Fields	Description	Specific Reporting Instructions
51-64	Claimant 3 Attorney/Representative Information	<p>These fields are Optional.</p> <p>This section is only required if Claimant 3 has a representative.</p> <p>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.</p> <p>If supplying information in these fields, it will be edited for validity and completeness and errors will be returned if field requirements are not met.</p>
65-79	Claimant 4 Information	<p>These fields are Optional.</p> <p>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.</p> <p>If supplying information in these fields, it will be edited for validity and completeness and errors will be returned if field requirements are not met.</p>
80-92	Claimant 4 Attorney/Representative Information	<p>These fields are Optional.</p> <p>This section is only required if Claimant 4 has a representative.</p> <p>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.</p> <p>If supplying information in these fields, it will be edited for validity and completeness and errors will be returned if field requirements are not met.</p>

Table A-5: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Input File Auxiliary Record – 2220 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alphabetic	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 Medicare ID	12	20	31	Alpha-Numeric	Must match the value in this field on the Claim Input File Detail Record. Required if SSN not provided.

Field	Name	Size	Start	End	Data	Description
4	Injured Party SSN	9	32	40	Alpha-Numeric	Must match the value in this field on the Claim Input File Detail Record. Required if Medicare ID not provided.
5	Injured Party Last Name	40	41	80	Alphabetic	Must match the value in this field on the Claim Input File Detail Record. Required.
6	Injured Party First Name	30	81	110	Alphabetic	Must match the value in this field on the Claim Input File Detail Record. Required.
7	Claimant 2 Relationship	1	111	111	Alphabetic	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 = Claimant Information Not Supplied (Fields 7 – 21 must contain default values according to Data Type, or all spaces) Optional.
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. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all zeroes or all spaces. Optional.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
9	Claimant 2 Last Name	40	121	160	Alphabetic	Surname of Claimant 2. Embedded hyphens (dashes), apostrophes and spaces accepted. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces. Optional.
10	Claimant 2 First Name	30	161	190	Alphabetic	Given/First name of Claimant 2. May only contain letters and spaces. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces. Optional.
11	Claimant 2 Middle Initial	1	191	191	Alphabetic	First letter of Claimant 2's middle name. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces. Optional.
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. If supplied, must contain at least 2 alphanumeric characters. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces. Optional.
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. If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces. Optional.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
14	Claimant 2 Mailing Address Line 2	50	242	291	Alpha-Numeric	<p>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.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>If supplied, must contain at least 2 alphanumeric characters.</p> <p>If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.</p> <p>Optional.</p>
15	Claimant 2 City	30	292	321	Alpha-Numeric	<p>Mailing address city for Claimant 2 named above.</p> <p>Field may contain only alphabetic, Space, Comma, &—' . @ # / ; : characters. No numeric characters allowed.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>If Claimant 2 Relationship (Field 7) is equal to a space or Claimant 2 State (Field 16) = "FC," must contain all spaces.</p> <p>Optional.</p>
16	Claimant 2 State	2	322	323	Alphabetic	<p>US Postal abbreviation State Code for Claimant 2 named above.</p> <p>See http://www.usps.com</p> <p>If no US address is available, supply "FC." The District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses.</p> <p>If Claimant 2 Relationship (Field 7) is equal to a space, must contain all spaces.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
17	Claimant 2 Zip	5	324	328	Alpha-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. If Claimant 2 Relationship (Field 7) is equal to a space or Claimant 2 State (Field 16) = "FC," must contain all spaces or all zeroes. Optional.
18	Claimant 2 Zip+4	4	329	332	Alpha-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 or Claimant 2 State (Field 16) = "FC," must contain all spaces or all zeroes. Optional.
19	Claimant 2 Phone	10	333	342	Alpha-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. If Claimant 2 Relationship (Field 7) is equal to a space or Claimant 2 State (Field 16) = "FC," must contain all spaces or all zeroes. Optional.
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. Optional.
21	Reserved for Future Use	20	348	367	Alpha-Numeric	Fill with spaces.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
22	Claimant 2 (C2) Representative Indicator	1	368	368	Alphabetic	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 = Claimant Information Not Supplied (Fields 22—35 must contain default values according to Data Type, or all spaces). If a value is submitted in this field, data must be supplied in Fields 23-35. If Claimant 2 has more than one representative, provide information for their attorney if available. Optional.
23	C2 Representative Last Name	40	369	408	Alphabetic	Surname of C2 representative. Embedded hyphens (dashes), apostrophes and spaces accepted. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces. Optional.
24	C2 Representative First Name	30	409	438	Alphabetic	Given or first name of C2 representative. May only contain letters and spaces. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces. Optional.
25	C2 Representative Firm Name	70	439	508	Alpha-Numeric	Representative's firm name. If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces. Optional.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
26	C2 Representative TIN	9	509	517	Alpha-Numeric	<p>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).</p> <p>May contain only spaces and numbers. If no C2 Representative TIN is available, fill with spaces or all zeroes.</p> <p>If supplied, cannot = TIN (Field 72 of Claim Input file layout).</p> <p>If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces or all zeroes.</p> <p>Optional.</p>
27	C2 Representative Mailing Address Line 1	50	518	567	Alpha-Numeric	<p>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.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>If C2 Representative Indicator (Field 22) is equal to a space or C2 Representative State (Field 30) = "FC," must contain all spaces.</p> <p>Optional.</p>
28	C2 Representative Mailing Address Line 2	50	568	617	Alpha-Numeric	<p>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.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code. If supplied, must contain at least 2 alphanumeric characters.</p> <p>If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
29	C2 Representative City	30	618	647	Alpha-Numeric	<p>Mailing address city for the C2 representative named above.</p> <p>Field may contain only alphabetic, Space, Comma, &—'. @ # / ; : characters. No numeric characters allowed.</p> <p>If no US address is available, fill with spaces and supply "FC" in the corresponding State Code.</p> <p>If C2 Representative Indicator (Field 22) is equal to a space or C2 Representative State (Field 30) = "FC," must contain all spaces.</p> <p>Optional.</p>
30	C2 Representative State	2	648	649	Alphabetic	<p>US Postal abbreviation State Code for the C2 representative named above.</p> <p>See http://www.usps.com</p> <p>If no US address is available supply "FC." The District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses.</p> <p>If C2 Representative Indicator (Field 22) is equal to a space, must contain all spaces.</p> <p>Optional.</p>
31	C2 Representative Zip	5	650	654	Alpha-Numeric	<p>5-digit Zip Code for the C2 representative named above.</p> <p>If no US address is available, fill with zeroes and supply "FC" in the corresponding State Code.</p> <p>If C2 Representative Indicator (Field 22) is equal to a space or C2 Representative State (Field 30) = "FC," must contain all spaces or all zeroes.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
32	C2 Representative Zip+4	4	655	658	Alpha-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 or C2 Representative State (Field 30) = "FC," must contain all spaces or all zeroes. Optional.
33	C2 Representative Phone	10	659	668	Alpha-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. If C2 Representative Indicator (Field 22) is equal to a space or C2 Representative State (Field 30) = "FC," must contain all spaces or all zeroes. Optional.
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. Optional.
35	Reserved for Future Use	20	674	693	Alpha-Numeric	Fill with spaces.
36	Claimant 3 Relationship	1	694	694	Alphabetic	See Claimant 2 Information section for individual field specifications.
37	Claimant 3 TIN	9	695	703	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
38	Claimant 3 Last Name	40	704	743	Alphabetic	See Claimant 2 Information section for individual field specifications.
39	Claimant 3 First Name	30	744	773	Alphabetic	See Claimant 2 Information section for individual field specifications.
40	Claimant 3 Middle Initial	1	774	774	Alphabetic	See Claimant 2 Information section for individual field specifications.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
41	Claimant 3 Entity/Organization Name	71	704	774	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
42	Claimant 3 Mailing Address Line 1	50	775	824	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
43	Claimant 3 Mailing Address Line 2	50	825	874	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
44	Claimant 3 City	30	875	904	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
45	Claimant 3 State	2	905	906	Alphabetic	See Claimant 2 Information section for individual field specifications.
46	Claimant 3 Zip	5	907	911	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
47	Claimant 3 Zip+4	4	912	915	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
48	Claimant 3 Phone	10	916	925	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
49	Claimant 3 Phone Extension	5	926	930	Alpha-Numeric	See Claimant 2 Information section for individual field specifications.
50	Reserved for Future Use	20	931	950	Alpha-Numeric	Fill with spaces.
51	Claimant 3 (C3) Representative Indicator	1	951	951	Alphabetic	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
52	C3 Representative Last Name	40	952	991	Alphabetic	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
53	C3 Representative First Name	30	992	1021	Alphabetic	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
54	C3 Representative Firm Name	70	1022	1091	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
55	C3 Representative TIN	9	1092	1100	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
56	C3 Representative Mailing Address Line 1	50	1101	1150	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
57	C3 Representative Mailing Address Line 2	50	1151	1200	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
58	C3 Representative City	30	1201	1230	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
59	C3 Representative State	2	1231	1232	Alphabetic	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
60	C3 Representative Zip	5	1233	1237	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
61	C3 Representative Zip+4	4	1238	1241	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
62	C3 Representative Phone	10	1242	1251	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
63	C3 Representative Phone Extension	5	1252	1256	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications
64	Reserved for Future Use	20	1257	1276	Alpha-Numeric	Fill with spaces.
65	Claimant 4 Relationship	1	1277	1277	Alphabetic	See Claimant 2 Information section above for individual field specifications.
66	Claimant 4 TIN	9	1278	1286	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
67	Claimant 4 Last Name	40	1287	1326	Alphabetic	See Claimant 2 Information section above for individual field specifications.
68	Claimant 4 First Name	30	1327	1356	Alphabetic	See Claimant 2 Information section above for individual field specifications.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
69	Claimant 4 Middle Initial	1	1357	1357	Alphabetic	See Claimant 2 Information section above for individual field specifications.
70	Claimant 4 Entity/Organization Name	71	1287	1357	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
71	Claimant 4 Mailing Address Line 1	50	1358	1407	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
72	Claimant 4 Mailing Address Line 2	50	1408	1457	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
73	Claimant 4 City	30	1458	1487	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
74	Claimant 4 State	2	1488	1489	Alphabetic	See Claimant 2 Information section above for individual field specifications.
75	Claimant 4 Zip	5	1490	1494	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
76	Claimant 4 Zip+4	4	1495	1498	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
77	Claimant 4 Phone	10	1499	1508	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
78	Claimant 4 Phone Extension	5	1509	1513	Alpha-Numeric	See Claimant 2 Information section above for individual field specifications.
79	Reserved for Future Use	20	1514	1533	Alpha-Numeric	Fill with spaces.
80	Claimant 4 (C4) Representative Indicator	1	1534	1534	Alphabetic	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
81	C4 Representative Last Name	40	1535	1574	Alphabetic	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
82	C4 Representative First Name	30	1575	1604	Alphabetic	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
83	C4 Representative Firm Name	70	1605	1674	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
84	C4 Representative TIN	9	1675	1683	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
85	C4 Representative Mailing Address Line 1	50	1684	1733	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
86	C4 Representative Mailing Address Line 2	50	1734	1783	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
87	C4 Representative City	30	1784	1813	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
88	C4 Representative State	2	1814	1815	Alphabetic	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
89	C4 Representative Zip	5	1816	1820	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
90	C4 Representative Zip+4	4	1821	1824	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
91	C4 Representative Phone	10	1825	1834	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.
92	C4 Representative Phone Extension	5	1835	1839	Alpha-Numeric	See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
93	TPOC Date 2	8	1840	1847	Numeric Date	<p>Date of second (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). See Field 80 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.</p> <p>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) and less than or equal to the file submission date. Must be all zeroes if TPOC Amount 2 is all zeroes.</p>
94	TPOC Amount 2	11	1848	1858	Numeric	<p>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.</p> <p>See Field 81 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.</p> <p><i>Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as "0000100000."</i></p> <p>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.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
95	Funding Delayed Beyond TPOC Start Date 2	8	1859	1866	Numeric Date	<p>If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed.</p> <p>Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).</p> <p>Format: CCYYMMDD</p> <p>Fill with all zeroes if not applicable.</p>
96	TPOC Date 3	8	1867	1874	Numeric Date	<p>Date of third (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM).</p> <p>See Field 80 on the Claim Input Detail Record. Use this field only to report on an <i>additional</i> TPOC settlement, judgment, award or other payment.</p> <p>Must be non-zero if a non-zero value is submitted in TPOC Amount 3.</p> <p>Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record) and less than or equal to the file submission date. Must be all zeroes if TPOC Amount 3 is all zeroes.</p>
97	TPOC Amount 3	11	1875	1885	Numeric	<p>Third (additional) Total Payment Obligation to the Claimant (TPOC) amount</p> <p>See Field 81 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.</p> <p><i>Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as "00001000000."</i></p> <p>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.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
98	Funding Delayed Beyond TPOC Start Date 3	8	1886	1893	Numeric Date	<p>If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed.</p> <p>Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).</p> <p>Format: CCYYMMDD</p> <p>Fill with all zeroes if not applicable.</p>
99	TPOC Date 4	8	1894	1901	Numeric Date	<p>Date of fourth (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM).</p> <p>See Field 80 on the Claim Input Detail Record. Use this field only to report on an <i>additional</i> TPOC settlement, judgment, award or other payment.</p> <p>Must be non-zero if a non-zero value is submitted in TPOC Amount 4.</p> <p>Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record) and less than or equal to the file submission date. Must be all zeroes if TPOC Amount 4 is all zeroes.</p>
100	TPOC Amount 4	11	1902	1912	Numeric	<p>Fourth (additional) Total Payment Obligation to the Claimant (TPOC) amount</p> <p>See Field 81 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.</p> <p>Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as “0000100000.”</p> <p>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.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
101	Funding Delayed Beyond TPOC Start Date 4	8	1913	1920	Numeric Date	<p>If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed.</p> <p>Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).</p> <p>Format: CCYYMMDD</p> <p>Fill with all zeroes if not applicable.</p>
102	TPOC Date 5	8	1921	1928	Numeric Date	<p>Date of fifth (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM).</p> <p>See Field 80 on the Claim Input Detail Record. Use this field only to report on an additional TPOC settlement, judgment, award or other payment.</p> <p>Must be non-zero if a non-zero value is submitted in TPOC Amount 5.</p> <p>Must be greater than the CMS Date of Incident (Field 12 of the Claim Input File Detail Record) and less than or equal to the file submission date. Must be all zeroes if TPOC Amount 5 is all zeroes.</p> <p>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.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
103	TPOC Amount 5	11	1929	1939	Numeric	<p>Fifth (additional) Total Payment Obligation to the Claimant (TPOC) amount</p> <p>See Field 81 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.</p> <p>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.</p> <p>Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as “00001000000.”</p> <p>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.</p>
104	Funding Delayed Beyond TPOC Start Date 5	8	1940	1947	Numeric Date	<p>If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed.</p> <p>Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).</p> <p>Format: CCYYMMDD</p> <p>Fill with all zeroes if not applicable.</p>
105	Reserved for Future Use	273	1948	2220	Alpha-Numeric	Fill with spaces.

Claim Input File Trailer Record

Table A-6: 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	Alphabetic	Must be "NGCT" Required.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC 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	Alphabetic	Must be "NGHPCLM" Must be = Section 111 Reporting File Type (Field 3) of Claim Input File Header Record. Required.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the BCRC. 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." Must match total number of detail records in the file. 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 File Header Record

Table B-1: 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	Alphabetic	Must be "NGTH" Required.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Pad with leading zeroes. Required.
3	Section 111 Reporting File Type	7	14	20	Alphabetic	Must be "NGHPTIN" Required.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the BCRC. 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 File Detail Record

Table B-2: MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation TIN Reference File Detail Record – 2220 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alphabetic	Must be "NGTD" Required.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC assigned Section 111 Responsible Reporting Entity Identification Number (RRE ID). Pad with leading zeroes. Required.
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 52 of each Detail Claim Record. Used in conjunction with the Office Code/Site ID reported in Field 53 of the Detail Claim Record. Also known as the Employer Identification Number (EIN). Each TIN/Office Code combination reported in Fields 52 and 53 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.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
4	Office Code/Site ID	9	23	31	Alpha-Numeric	<p>RRE-defined 9-digit number to uniquely identify variations in insurer addresses/claim offices/Plan Contact Addresses as reported in Field 53 of each Detail Claim Record. Used in conjunction with the TIN reported in Field 52 of the Detail Claim record to uniquely specify different addresses associated with one TIN.</p> <p>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.</p> <p>Each TIN/Office Code combination reported in Fields 52 and 53 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.</p> <p>Required if Office Code/Site ID is supplied in Field 53 of the Claim Input File Detail Record.</p>
5	TIN/Office Code Mailing Name	70	32	101	Alpha-Numeric	<p>Name associated with the RRE reflected by the unique TIN and Office Code combination. If the RRE is using a recovery agent, do not enter the recovery agent's name here.</p> <p>This name will be used to address recovery-related correspondence (including demand notifications, if applicable) associated with matching claim reports to the RRE.</p> <p>This field must contain at least two characters. Limit field to no more than eight separate words in the first 40 characters for best results.</p> <p>Required.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
6	TIN/Office Code Mailing Address Line 1	50	102	151	Alpha-Numeric	<p>First line of the address associated with the unique TIN/Office Code combination reflected on this record.</p> <p>This mailing address should reflect where the RRE wishes to have all recovery-related correspondence directed for the TIN and Office Code combination. Note: If recovery agent information is submitted in Fields 16-22, the recovery agent will receive a copy of all recovery-related correspondence that is sent to the RRE.</p> <p>Must be a US address.</p> <p>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.</p> <p>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).</p> <p>If TIN/Office Code State (Field 9) = "FC," this field must be spaces.</p> <p>Required.</p>
7	TIN/Office Code Mailing Address Line 2	50	152	201	Alpha-Numeric	<p>Second line of the address associated with the unique TIN and Office Code combination reflected on this record.</p> <p>This mailing address should reflect where the RRE wishes to have all recovery related correspondence directed for the TIN and Office Code combination. Note: If recovery agent information is submitted in Fields 16-22, the recovery agent will receive a copy of all recovery-related correspondence that is sent to the RRE.</p> <p>Must be a US address.</p> <p>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.</p> <p>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).</p> <p>If TIN/Office Code State (Field 9) = "FC," this field must be spaces.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
8	TIN/Office Code City	30	202	231	Alpha-Numeric	<p>City of the address associated with the unique TIN and Office Code combination reflected on this record.</p> <p>This mailing address should reflect where the RRE wishes to have all recovery-related correspondence directed for the TIN and Office Code combination. Note: If recovery agent information is submitted in Fields 16-22, the recovery agent will receive a copy of all recovery-related correspondence that is sent to the RRE.</p> <p>Must be a US city.</p> <p>Field may contain only alphabetic, Space, Comma, &—' . @ # / ; : characters. No numeric characters allowed.</p> <p>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).</p> <p>If TIN/Office Code State (Field 9) = “FC,” this field must be spaces.</p> <p>Required.</p>
9	TIN/Office Code State	2	232	233	Alphabetic	<p>US Postal state abbreviation of the address associated with the unique TIN and Office Code combination reflected on this record.</p> <p>See http://www.usps.com</p> <p>The District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses.</p> <p>This mailing address should reflect where the RRE wishes to have all recovery-related correspondence directed for the TIN and Office Code combination. Note: If recovery agent information is submitted in Fields 16-22, the recovery agent will receive a copy of all recovery-related correspondence that is sent to the RRE.</p> <p>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.</p> <p>Required.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
10	TIN/Office Code Zip	5	234	238	Alpha-Numeric	5-digit ZIP Code of the address associated with the unique TIN and 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). If TIN/Office Code State (Field 9) = "FC," this field must be spaces. Required.
11	TIN/Office Code Zip+4	4	239	242	Alpha-Numeric	4-digit ZIP+4 code of the address associated with the unique TIN and Office Code combination reflected on this record. If not applicable fill with zeroes (0000) or spaces. If the RRE has registered as a foreign entity and no US address is available, fill with zeroes or spaces and supply "FC" in the TIN/Office Code State (Field 9). If TIN/Office Code State (Field 9) = "FC," this field can be filled with zeros or spaces.
12	Foreign RRE Address Line 1	32	243	274	Alpha-Numeric	First line of mailing address of a foreign RRE. Use <i>only if</i> RRE has no US address. Required if TIN/Office Code State (Field 9) = "FC."
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 <i>only if</i> 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.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
16	Recovery Agent Mailing Name	70	371	440	Alpha-Numeric	<p>Name to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces.</p> <p>If this field is used, it must contain at least two characters. Limit field to no more than eight separate words in the first 40 characters for best results.</p> <p>Optional.</p>
17	Recovery Agent Mailing Address Line 1	50	441	490	Alpha-Numeric	<p>Address line 1 to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces.</p> <p>Must be a US address.</p> <p>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.</p> <p>If Recovery Agent Mailing Name (Field 16) is submitted, this field is required.</p> <p>Optional.</p>
18	Recovery Agent Mailing Address Line 2	50	491	540	Alpha-Numeric	<p>Address line 2 to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces.</p> <p>Must be a US address.</p> <p>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.</p> <p>Optional.</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
19	Recovery Agent Mailing City	30	541	570	Alpha-Numeric	<p>City to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces. Must be a US city.</p> <p>Field may contain only alphabetic, space, comma, &, '-'. @ # / ; : characters. No numeric characters allowed.</p> <p>If Recovery Agent Mailing Name (Field 16) is submitted, this field is required.</p> <p>Optional.</p>
20	Recovery Agent Mailing State	2	571	572	Alphabetic	<p>US Postal state abbreviation to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces.</p> <p>See http://www.usps.com.</p> <p>The District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses.</p> <p>If Recovery Agent Mailing Name (Field 16) is submitted, this field is required.</p> <p>Optional.</p>
21	Recovery Agent Mailing Zip	5	573	577	Alpha-Numeric	<p>5-digit ZIP Code to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces.</p> <p>Must be a US ZIP Code.</p> <p>If Recovery Agent Mailing Name (Field 16) is submitted, this field is required.</p> <p>Optional.</p>
22	Recovery Agent Mailing Zip+4	4	578	581	Alpha-Numeric	<p>4-digit ZIP+4 to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces.</p> <p>If not applicable fill with zeroes (0000).</p>

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
23	TIN/Office Code Paperless Indicator	1	582	582	Alphabetic	<p>Indicates the paperless selection for the TIN/Office Code combination.</p> <p>Valid values:</p> <p>Y = the TIN/Office Code address is opting in to "Go Paperless" and will receive letter notification emails instead of mailed hard copies of NGHP recovery letters</p> <p>N = the TIN/Office Code address is opting out of "Go Paperless" and will receive hard copies of NGHP recovery letters</p> <p>Space = no change to the currently saved paperless selection</p> <p>Optional.</p> <p>Note: The TIN/Office Code address can only be opted in to "Go Paperless" when there is an active MSPRP account for the Recovery Agent TIN.</p>
24	Recovery Agent Paperless Indicator	1	583	583	Alphabetic	<p>Indicates the paperless selection for the Recovery Agent Address associated to the TIN/Office Code.</p> <p>Valid values:</p> <p>Y = the recovery agent address is opting in to "Go Paperless" and will receive letter notification emails instead of mailed hard copies of NGHP recovery letters</p> <p>N = the recovery agent address is opting out of "Go Paperless" and will receive hard copies of NGHP recovery letters</p> <p>Space = no change to the currently saved paperless selection</p> <p>Optional.</p> <p>Note: The recovery agent address can only be opted in to "Go Paperless" when there is an active MSPRP account for the Recovery Agent TIN.</p>
25	Recovery Agent TIN	9	584	592	Numeric	<p>Recovery Agent's Federal Tax Identification Number.</p> <p>Enter the 9-digit TIN for the recovery agent or fill with spaces.</p> <p>Required if Recovery Agent Paperless Indicator (Field 24) = 'Y'.</p>
26	Reserved for Future Use	1628	593	2220	Alpha-Numeric	Fill with spaces.

TIN Reference File Trailer Record

Table B-3: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference File Trailer Record – 2220 bytes

Field	Name	Size	Start Pos.	End Pos.	Date Type	Description
1	Record Identifier	4	1	4	Alphabetic	Must be "NGTT" Required.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC 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	Alphabetic	Must be "NGHPTIN" Required.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the BCRC. 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 "000005." Required.
6	Reserved for Future Use	2185	36	2220	Alpha-Numeric	Fill with spaces.

Appendix C: Claim Response File Layout

Claim Response File Header Record

Table C-1: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Header Record – 460 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alpha-Numeric	Contains value of "NGRH" BCRC supplied.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC 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	Alphabetic	Contains value of "NGHPRSP" BCRC supplied.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the RRE. Format: CCYYMMDD BCRC supplied.
5	Reserved for Future Use	432	29	460	Alpha-Numeric	Contains all spaces.

Claim Response File Detail Record

Fields 28-37:

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.

Fields 38-47:

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 BCRC. The RRE must review and correct compliance issues as applicable and resubmit the record as an update transaction on the next quarterly file submission.

Table C-2: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 460 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alphabetic	Contains value of "NGRD" BCRC 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 Medicare ID	12	21	32	Alpha-Numeric	Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) 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. If supplied by RRE on input record, the value will be returned as entered (i.e., either the last 5 digits of the SSN or full 9-digit SSN).
6	Submitted Injured Party Last Name	40	42	81	Alphabetic	As supplied by RRE on input record.
7	Submitted Injured Party First Name	30	82	111	Alphabetic	As supplied by RRE on input record.
8	Submitted Injured Party Middle Init	1	112	112	Alphabetic	As supplied by RRE on input record.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
9	Submitted Injured Party Gender	1	113	113	Numeric	As supplied by RRE on input record.
10	Submitted Injured Party DOB	8	114	121	Numeric Date	As supplied by RRE on input record.
11	Submitted Plan TIN	9	122	130	Numeric	As supplied by RRE on input record.
12	Submitted Plan Office Code/Site ID	9	131	139	Alpha-Numeric	As supplied by RRE on input record.
13	Submitted Policy Number	30	140	169	Alpha-Numeric	As supplied by RRE on input record.
14	Submitted Claim Number	30	170	199	Alpha-Numeric	As supplied by RRE on input record.
15	Reserved for Future Use	20	200	219	Alpha-Numeric	Filled with spaces.
16	Applied Injured Party Medicare ID	12	220	231	Alpha-Numeric	Current Medicare Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) of Injured Party if identified as a Medicare beneficiary based upon the information submitted. BCRC supplied.
17	Reserved for Future Use	9	232	240	Alpha-Numeric	Filled with spaces.
18	Applied Injured Party Last Name	40	241	280	Alphabetic	Injured Party Last Name, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. BCRC supplied.
19	Applied Injured Party First Name	30	281	310	Alphabetic	Injured Party First Name, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. BCRC supplied.
20	Applied Injured Party Middle Initial	1	311	311	Alphabetic	Injured Party Middle Initial, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. BCRC supplied.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
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. BCRC supplied. 1 – Male 2—Female
22	Applied Injured Party DOB	8	313	320	Numeric Date	Date of birth (DOB) of Injured Party, as stored on Medicare's files, if identified as a Medicare beneficiary based upon the information submitted. Format: CCYYMMDD BCRC 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 BCRC supplied.
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. BCRC supplied.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
25	Applied MSP Type Indicator	1	337	337	Alphabetic	Applied Medicare Secondary Payer (MSP) Type. D = No-Fault E = Workers' Compensation L = Liability As supplied by RRE on input record.
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 the Response File Disposition Codes Table for values. BCRC supplied.
28	Applied Error Code 1	5	360	364	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. See the Error Code Resolution Tables for values. BCRC supplied.
29	Applied Error Code 2	5	365	369	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. Provided only if at least 2 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.
30	Applied Error Code 3	5	370	374	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. Provided only if at least 3 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.
31	Applied Error Code 4	5	375	379	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. Provided only if at least 4 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.

Field	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 BCRC in the submitted record. Provided only if at least 5 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.
33	Applied Error Code 6	5	385	389	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. Provided only if at least 6 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.
34	Applied Error Code 7	5	390	394	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. Provided only if at least 7 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.
35	Applied Error Code 8	5	395	399	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. Provided only if at least 8 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.
36	Applied Error Code 9	5	400	404	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. Provided only if at least 9 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.
37	Applied Error Code 10	5	405	409	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted record. Provided only if at least 10 errors were found. See the Error Code Resolution Tables for values. BCRC supplied.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
38	Applied Compliance Flag 1	2	410	411	Alpha-Numeric	Code indicating compliance issue found with record. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
39	Applied Compliance Flag 2	2	412	413	Alpha-Numeric	Code indicating compliance issue found with record. Populated if at least 2 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
40	Applied Compliance Flag 3	2	414	415	Alpha-Numeric	Code indicating compliance issue found with record. Populated if at least 3 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
41	Applied Compliance Flag 4	2	416	417	Alpha-Numeric	Code indicating compliance issue found with record. Populated if at least 4 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
42	Applied Compliance Flag 5	2	418	419	Alpha-Numeric	Code indicating compliance issue found with record. Populated if at least 5 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
43	Applied Compliance Flag 6	2	420	421	Alpha-Numeric	Code indicating compliance issue found with record. Populated if at least 6 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
44	Applied Compliance Flag 7	2	422	423	Alpha-Numeric	Code indicating compliance issue found with record. Populated if at least 7 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
45	Applied Compliance Flag 8	2	424	425	Alpha-Numeric	Code indicating compliance issue found with record. Populated if at least 8 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
46	Applied Compliance Flag 9	2	426	427	Alpha-Numeric	Code indicating compliance issue found with record. Populated if at least 9 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
47	Applied Compliance Flag 10	2	428	429	Alpha-Numeric	Code indicating compliance issue found with record. Populated if 10 issues were found. See Claim Response File Compliance Flag Code Table for values. BCRC supplied.
48	Reserved for Future Use	31	430	460	Alpha-Numeric	Filled with spaces.

Claim Response File Trailer Record

Table C-3: 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	Alphabetic	Contains value of "NGRT" BCRC supplied.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC 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	Alphabetic	Contains value of "NGHPRSP" BCRC supplied.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the RRE. Format: CCYYMMDD BCRC supplied.
5	File Record Count	7	29	35	Numeric	Number of detail response records contained within file (does not include header or trailer records). BCRC supplied.
6	Reserved for Future Use	425	36	460	Alpha-Numeric	Filled with spaces.

Appendix D: TIN Reference Response File Layout

TIN Reference Response File Header Record

Table D-1: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Header Record – 1000 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alphabetic	Contains value "NTRH" BCRC supplied.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC assigned Section 111 RRE ID. As supplied by RRE input record.
3	Section 111 Reporting File Type	7	14	20	Alphabetic	Contains value "NGHTNRP" BCRC supplied.
4	File Date	8	21	28	Numeric Date	Date TIN Reference Response File was transmitted to the RRE. Format: CCYYMMDD BCRC supplied.
5	Reserved for Future Use	972	29	1000	Alpha-Numeric	Contains all spaces.

TIN Reference Response File Detail Record

Table D-2: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Detail Record – 1000 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alphabetic	Contains value "NTRD"
2	Section 111 RRE ID	9	5	13	Numeric	BCRC 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	Alpha-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 code City	30	202	231	Alpha-Numeric	TIN/Office Code City as provided on input record.
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	Numeric	TIN/Office Code Zip code as provided on input record.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
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 TIN/Office Code Zip	5	375	379	Alpha-Numeric	TIN/Office Code Zip after 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.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
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 BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.
24	TIN Error Code 2	4	518	521	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.
25	TIN Error Code 3	4	522	525	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.
26	TIN Error Code 4	4	526	529	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.
27	TIN Error Code 5	4	530	533	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.
28	TIN Error Code 6	4	534	537	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.
29	TIN Error Code 7	4	538	541	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.

Field	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 BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.
31	TIN Error Code 9	4	546	549	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution Table for values.
32	TIN Error Code 10	4	550	553	Alpha-Numeric	Code associated with an error found by the BCRC in the submitted TIN Reference record. See the TIN Reference Response File Error Code Resolution 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 or Submitted TIN/Office Code State (Field 9) = “FC”
34	Recovery Agent Address Change Flag	1	555	555	Alpha-Numeric	Code indicating whether Recovery Agent Submitted Address (Fields 36-41) differs from the Recovery Agent Applied Address (Fields 42-47). Values: Y – address changed N – address did not change Space – record could not be validated
35	Submitted Recovery Agent Mailing Name	70	556	625	Alpha-Numeric	Recovery Agent Mailing Name as provided on input record.
36	Submitted Recovery Agent Mailing Address Line 1	50	626	675	Alpha-Numeric	Recovery Agent Mailing Address Line 1 as provided on input record.
37	Submitted Recovery Agent Mailing Address Line 2	50	676	725	Alpha-Numeric	Recovery Agent Mailing Address Line 2 as provided on input record.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
38	Submitted Recovery Agent City	30	726	755	Alpha-Numeric	Recovery Agent City as provided on input record.
39	Submitted Recovery Agent State	2	756	757	Alphabetic	Recovery Agent State as provided on input record.
40	Submitted Recovery Agent Zip	5	758	762	Numeric	Recovery Agent ZIP code as provided on input record.
41	Submitted Recovery Agent Zip+4	4	763	766	Alpha-Numeric	Recovery Agent ZIP+4 as provided on input record.
42	Applied Recovery Agent Mailing Address Line 1	50	767	816	Alpha-Numeric	Recovery Agent Address Line 1, after address validation is completed, will be used by Medicare for subsequent processing. Recovery Agent Address Change Flag (Field 34) will equal Y if the applied address in Fields 42–47 is different from the submitted address (Fields 36–41) and N if it is the same as the submitted address. Field 42 will contain spaces if the TIN record was rejected.
43	Applied Recovery Agent Mailing Address Line 2	50	817	866	Alpha-Numeric	Recovery Agent Mailing Address Line 2 after address validation is completed. See description for Field 42.
44	Applied Recovery Agent City	30	867	896	Alpha-Numeric	Recovery Agent City after address validation is completed. See description for Field 42.
45	Applied Recovery Agent State	2	897	898	Alphabetic	Recovery Agent State after address validation is completed. See description for Field 42.
46	Applied Recovery Agent Zip	5	899	903	Alpha-Numeric	Recovery Agent ZIP after address validation is completed. See description for Field 42.
47	Applied Recovery Agent Zip+4	4	904	907	Alpha-Numeric	Recovery Agent ZIP+4 after address validation is completed. See description for Field 42.

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
48	Submitted TIN/Office Code Paperless Indicator	1	908	908	Alphabetic	TIN/Office Code Paperless Indicator as provided on input record.
49	Applied TIN/Office Code Paperless Indicator	1	909	909	Alphabetic	TIN/Office Code Paperless Indicator after validation is completed.
50	Submitted Recovery Agent Paperless Indicator	1	910	910	Alphabetic	Recovery Agent Paperless Indicator as provided on input record.
51	Submitted Recovery Agent TIN	9	911	919	Numeric	Recovery Agent TIN as provided on the input record.
52	Applied Recovery Agent Paperless Indicator	1	920	920	Alphabetic	Recovery Agent Paperless Indicator after validation is complete.
53	Reserved for Future Use	80	921	1000	Alpha-Numeric	Filled with spaces.

TIN Reference Response File Trailer Record

Table D-3: MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference Response File Trailer Record – 1000 bytes

Field	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alphabetic	Contains value "NTRT" BCRC supplied.
2	Section 111 RRE ID	9	5	13	Numeric	BCRC 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	Alphabetic	Contains value "NGHTNRP" BCRC supplied.
4	File Date	8	21	28	Numeric Date	Date file was transmitted to the RRE. Format: CCYYMMDD BCRC 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). BCRC 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 BCRC to process the ASC X12 270/271. They reflect the flat file input and output for the current version of the HEW software.

Mainframe and Windows PC/Server-based versions of the HEW software are available. You may download the latest Windows version of the HEW software after logging on to the Section 111 COBSW at <https://www.cob.cms.hhs.gov/Section111/>. You may request a copy of the mainframe version from your EDI Representative or by contacting the EDI Department at 646-458-6740. See Appendix K for detailed steps on how to install and configure the HEW software.

Note: When using the HEW software, RREs should select the “COB” processing format for the Section 111 output file.

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 following link found on the NGHP page of the CMS website:

<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.html>. 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 – Version 5.0.0

Table E-1: Section 111 HEW Query Input File Header Record—200 bytes

Field	Name	Size	Displacement	Data Type	Description
1	Header Indicator	2	1-2	Alpha-Numeric	Must be: "H0" Required.
2	RRE ID	9	3-11	Numeric	"000010001," "000010002," etc. RRE ID number assigned by BCRC. Pad with leading zeroes. Required.
3	File Type	4	12-15	Alphabetic	"NGHQ" – NGHP Query. Required.
4	Cycle Date	8	16-23	Numeric Date	File date (CCYYMMDD). Required.
5	Filler	177	24-200	Alpha-Numeric	Unused Field. Fill with spaces.

HEW Query Input File Detail Record – Version 5.0.0

Table E-2: Section 111 HEW Query Input File Detail Record—200 bytes

Field	Name	Size	Displacement	Data Type	Description
1	Medicare ID	12	1-12	Alpha-Numeric	Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI). Optional.
2	Last Name	6	13-18	Alphabetic	First 6 characters of the surname of Individual/Injured Party. 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	Alphabetic	First Initial of Individual/Injured Party. 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	Numeric Date	Individual's Date of Birth (CCYYMMDD). Required.
5	Sex Code	1	28-28	Numeric	Individual's Gender: 0 = Unknown* 1 = Male 2 = Female Required. *If a value of "0" is submitted, the BCRC will change it to "1" for matching purposes.
6	SSN	9	29-37	Numeric	Social Security Number of the Individual/Injured Party. Required if Medicare ID not provided. If SSN is not provided, field must be zero filled.
7	RRE DCN 1	30	38-67	Alpha-Numeric	Primary identifier assigned to record by RRE for tracking. Will be returned on the corresponding response record. Optional.

Field	Name	Size	Displacement	Data Type	Description
8	RRE DCN 2	30	68-97	Alpha-Numeric	Secondary identifier assigned to record by RRE for tracking. Will be returned on the corresponding response record. Optional.
9	Filler	103	98-200	Alpha-Numeric	Unused. Fill with spaces.

HEW Query Input File Trailer Record – Version 5.0.0

Table E-3: Section 111 HEW Query Input File Trailer Record—200 bytes

Field	Name	Size	Displacement	Data Type	Description
1	Trailer Indicator	2	1-2	Alpha-Numeric	Must be: "T0" Required.
2	RRE ID	9	3-11	Numeric	"000010001," "000010002," etc. RRE ID number assigned by BCRC. Pad with leading zeroes. Must match RRE ID supplied on header record. Required.
3	File Type	4	12-15	Alphabetic	Must be "NGHQ" – NGHP Query. Required.
4	Cycle Date	8	16-23	Numeric Date	File date (CCYYMMDD). Required.
5	Record Count	9	24-32	Numeric	Number of individual query records in this file. Do not include the Header and Trailer Records in the Record Count. Right justify and pad with leading zeroes. A record count of 215 should be formatted as "000000215." Required.
6	Filler	168	33-200	Alpha-Numeric	Unused Field. Fill with spaces.

HEW Query Response File Record – Version 5.0.0

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

Table E-4: Section 111 HEW Query Response File Record—5608 bytes

Field	Name	Size	Displacement	Data Type	Description
1	Medicare ID	12	1-12	Alpha-Numeric	Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI). 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. BCRC supplied. If supplied on the input record and no beneficiary match is found, the value as supplied on the input will be returned.
2	Last Name	6	13-18	Alphabetic	Surname of Individual/Injured Party. Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted. If supplied on the input record and no beneficiary match is found, the value as supplied on the input will be returned.
3	First Initial	1	19-19	Alphabetic	First Initial of Individual/Injured Party. Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted. If supplied on the input record and no beneficiary match is found, the value as supplied on the input will be returned.

Field	Name	Size	Displacement	Data Type	Description
4	DOB	8	20-27	Numeric Date	Individual's Date of Birth (CCYYMMDD). Updated with Medicare information if the individual is identified as a Medicare beneficiary based upon the information submitted. If supplied on the input record and no beneficiary match is found, the value as supplied on the input will be returned.
5	Sex Code	1	28-28	Numeric	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 BCRC will change this value to "1" prior to matching. If supplied on the input record and no beneficiary match is found, the value as supplied on the input will be returned.
6	SSN	9	29-37	Alpha-Numeric	Social Security Number of the individual as submitted by the RRE on the input record. Note: If both a Medicare ID and an SSN were submitted on the input file CMS matches on the Medicare ID, and takes no action to validate or match on the SSN. If supplied on the input record and no beneficiary match is found, the value as supplied on the input will be returned.
7	Filler	62	38-99	Alpha-Numeric	Future Use
8	Disposition Code	2	100-101	Numeric	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. BCRC supplied.

Field	Name	Size	Displacement	Data Type	Description
9	CMS Document Control Number	15	102-116	Alpha-Numeric	Unique ID assigned to response record for tracking by the BCRC. BCRC supplied.
10	RRE DCN 1	30	117-146	Alpha-Numeric	Primary identifier assigned to record by RRE for tracking as submitted on the input record.
11	RRE DCN 2	30	147-176	Alpha-Numeric	Secondary identifier assigned to record by RRE for tracking as submitted on the input record.
12	Most Recent Medicare Part A Effective Date	8	177-184	Numeric Date	Individual's most recent Medicare Part A effective date. Format CCYYMMDD
13	Most Recent Medicare Part A Termination Date	8	185-192	Numeric Date	Individual's most recent Medicare Part A termination date. Format CCYYMMDD
14	Most Recent Medicare Part B Effective Date	8	193-200	Numeric Date	Individual's most recent Medicare Part B effective date. Format CCYYMMDD
15	Most Recent Medicare Part B Termination Date	8	201-208	Numeric Date	Individual's most recent Medicare Part B termination date. Format CCYYMMDD
16	Most Recent Medicare Part C Plan Contract Number	5	209-213	Alpha-Numeric	Individual's most recent Medicare Part C plan contract number.
17	Most Recent Medicare Part C Plan Enrollment Date	8	214-221	Numeric Date	Individual's most recent Medicare Part C plan enrollment date. Format CCYYMMDD
18	Most Recent Medicare Part C Plan Termination Date	8	222-229	Numeric Date	Individual's most recent Medicare Part C plan termination date. Format CCYYMMDD
19	Most Recent Medicare Part C Plan Contract Name	50	230-279	Alpha-Numeric	Individual's most recent Medicare Part C plan contract name.
20	Most Recent Medicare Part C Plan PBP Number	3	280-282	Alpha-Numeric	Individual's most recent Medicare Part C plan benefit package number.
21	Most Recent Medicare Part C Plan Contract Address 1	55	283-337	Alpha-Numeric	Individual's most recent Medicare Part C plan contract address 1.

Field	Name	Size	Displacement	Data Type	Description
22	Most Recent Medicare Part C Plan Contract Address 2	55	338-392	Alpha-Numeric	Individual's most recent Medicare Part C plan contract address 2.
23	Most Recent Medicare Part C Plan Contract Address City	30	393-422	Alpha-Numeric	Individual's most recent Medicare Part C plan contract address city.
24	Most Recent Medicare Part C Plan Contract Address State	2	423-424	Alpha-Numeric	Individual's most recent Medicare Part C plan contract address state.
25	Most Recent Medicare Part C Plan Contract Address Zip	9	425-433	Alpha-Numeric	Individual's most recent Medicare Part C plan contract address ZIP.
26	Previous Medicare Part C Plan Contract Number	5	434-438	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
27	Previous Medicare Part C Plan Enrollment Date	8	439-446	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
28	Previous Medicare Part C Plan Termination Date	8	447-454	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
29	Previous Medicare Part C Plan Contract Name	50	455-504	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
30	Previous Medicare Part C Plan PBP Number	3	505-507	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
31	Previous Medicare Part C Plan Contract Address 1	55	508-562	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
32	Previous Medicare Part C Plan Contract Address 2	55	563-617	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.

Field	Name	Size	Displacement	Data Type	Description
33	Previous Medicare Part C Plan Contract Address City	30	618-647	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
34	Previous Medicare Part C Plan Contract Address State	2	648-649	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
35	Previous Medicare Part C Plan Contract Address Zip	9	650-658	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
36	Previous Medicare Part C Plan Contract Number	5	659-663	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
37	Previous Medicare Part C Plan Enrollment Date	8	664-671	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
38	Previous Medicare Part C Plan Termination Date	8	672-679	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
39	Previous Medicare Part C Plan Contract Name	50	680-729	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
40	Previous Medicare Part C Plan PBP Number	3	730-732	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
41	Previous Medicare Part C Plan Contract Address 1	55	733-787	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
42	Previous Medicare Part C Plan Contract Address 2	55	788-842	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
43	Previous Medicare Part C Plan Contract Address City	30	843-872	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.

Field	Name	Size	Displacement	Data Type	Description
44	Previous Medicare Part C Plan Contract Address State	2	873-874	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
45	Previous Medicare Part C Plan Contract Address Zip	9	875-883	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
46	Previous Medicare Part C Plan Contract Number	5	884-888	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
47	Previous Medicare Part C Plan Enrollment Date	8	889-896	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
48	Previous Medicare Part C Plan Termination Date	8	897-904	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
49	Previous Medicare Part C Plan Contract Name	50	905-954	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
50	Previous Medicare Part C Plan PBP Number	3	955-957	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
51	Previous Medicare Part C Plan Contract Address 1	55	958-1012	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
52	Previous Medicare Part C Plan Contract Address 2	55	1013-1067	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
53	Previous Medicare Part C Plan Contract Address City	30	1068-1097	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
54	Previous Medicare Part C Plan Contract Address State	2	1098-1099	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.

Field	Name	Size	Displacement	Data Type	Description
55	Previous Medicare Part C Plan Contract Address Zip	9	1100-1108	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
56	Previous Medicare Part C Plan Contract Number	5	1109-1113	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
57	Previous Medicare Part C Plan Enrollment Date	8	1114-1121	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
58	Previous Medicare Part C Plan Termination Date	8	1122-1129	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
59	Previous Medicare Part C Plan Contract Name	50	1130-1179	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
60	Previous Medicare Part C Plan PBP Number	3	1180-1182	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
61	Previous Medicare Part C Plan Contract Address 1	55	1183-1237	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
62	Previous Medicare Part C Plan Contract Address 2	55	1238-1292	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
63	Previous Medicare Part C Plan Contract Address City	30	1293-1322	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
64	Previous Medicare Part C Plan Contract Address State	2	1323-1324	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
65	Previous Medicare Part C Plan Contract Address Zip	9	1325-1333	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.

Field	Name	Size	Displacement	Data Type	Description
66	Previous Medicare Part C Plan Contract Number	5	1334-1338	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
67	Previous Medicare Part C Plan Enrollment Date	8	1339-1346	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
68	Previous Medicare Part C Plan Termination Date	8	1347-1354	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
69	Previous Medicare Part C Plan Contract Name	50	1355-1404	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
70	Previous Medicare Part C Plan PBP Number	3	1405-1407	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
71	Previous Medicare Part C Plan Contract Address 1	55	1408-1462	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
72	Previous Medicare Part C Plan Contract Address 2	55	1463-1517	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
73	Previous Medicare Part C Plan Contract Address City	30	1518-1547	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
74	Previous Medicare Part C Plan Contract Address State	2	1548-1549	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
75	Previous Medicare Part C Plan Contract Address Zip	9	1550-1558	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
76	Previous Medicare Part C Plan Contract Number	5	1559-1563	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.

Field	Name	Size	Displacement	Data Type	Description
77	Previous Medicare Part C Plan Enrollment Date	8	1564-1571	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
78	Previous Medicare Part C Plan Termination Date	8	1572-1579	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
79	Previous Medicare Part C Plan Contract Name	50	1580-1629	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
80	Previous Medicare Part C Plan PBP Number	3	1630-1632	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
81	Previous Medicare Part C Plan Contract Address 1	55	1633-1687	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
82	Previous Medicare Part C Plan Contract Address 2	55	1688-1742	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
83	Previous Medicare Part C Plan Contract Address City	30	1743-1772	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
84	Previous Medicare Part C Plan Contract Address State	2	1773-1774	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
85	Previous Medicare Part C Plan Contract Address Zip	9	1775-1783	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
86	Previous Medicare Part C Plan Contract Number	5	1784-1788	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
87	Previous Medicare Part C Plan Enrollment Date	8	1789-1796	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
88	Previous Medicare Part C Plan Termination Date	8	1797-1804	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
89	Previous Medicare Part C Plan Contract Name	50	1805-1854	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
90	Previous Medicare Part C Plan PBP Number	3	1855-1857	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
91	Previous Medicare Part C Plan Contract Address 1	55	1858-1912	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
92	Previous Medicare Part C Plan Contract Address 2	55	1913-1967	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
93	Previous Medicare Part C Plan Contract Address City	30	1968-1997	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
94	Previous Medicare Part C Plan Contract Address State	2	1998-1999	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
95	Previous Medicare Part C Plan Contract Address Zip	9	2000-2008	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
96	Previous Medicare Part C Plan Contract Number	5	2009-2013	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
97	Previous Medicare Part C Plan Enrollment Date	8	2014-2021	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
98	Previous Medicare Part C Plan Termination Date	8	2022-2029	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
99	Previous Medicare Part C Plan Contract Name	50	2030-2079	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
100	Previous Medicare Part C Plan PBP Number	3	2080-2082	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
101	Previous Medicare Part C Plan Contract Address 1	55	2083-2137	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
102	Previous Medicare Part C Plan Contract Address 2	55	2138-2192	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
103	Previous Medicare Part C Plan Contract Address City	30	2193-2222	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
104	Previous Medicare Part C Plan Contract Address State	2	2223-2224	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
105	Previous Medicare Part C Plan Contract Address Zip	9	2225-2233	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
106	Previous Medicare Part C Plan Contract Number	5	2234-2238	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
107	Previous Medicare Part C Plan Enrollment Date	8	2239-2246	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
108	Previous Medicare Part C Plan Termination Date	8	2247-2254	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
109	Previous Medicare Part C Plan Contract Name	50	2255-2304	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.

Field	Name	Size	Displacement	Data Type	Description
110	Previous Medicare Part C Plan PBP Number	3	2305-2307	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
111	Previous Medicare Part C Plan Contract Address 1	55	2308-2362	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
112	Previous Medicare Part C Plan Contract Address 2	55	2363-2417	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
113	Previous Medicare Part C Plan Contract Address City	30	2418-2447	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
114	Previous Medicare Part C Plan Contract Address State	2	2448-2449	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
115	Previous Medicare Part C Plan Contract Address Zip	9	2450-2458	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
116	Previous Medicare Part C Plan Contract Number	5	2459-2463	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
117	Previous Medicare Part C Plan Enrollment Date	8	2464-2471	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
118	Previous Medicare Part C Plan Termination Date	8	2472-2479	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
119	Previous Medicare Part C Plan Contract Name	50	2480-2529	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
120	Previous Medicare Part C Plan PBP Number	3	2530-2532	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.

Field	Name	Size	Displacement	Data Type	Description
121	Previous Medicare Part C Plan Contract Address 1	55	2533-2587	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.
122	Previous Medicare Part C Plan Contract Address 2	55	2588-2642	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
123	Previous Medicare Part C Plan Contract Address City	30	2643-2672	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
124	Previous Medicare Part C Plan Contract Address State	2	2673-2674	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
125	Previous Medicare Part C Plan Contract Address Zip	9	2675-2683	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
126	Previous Medicare Part C Plan Contract Number	5	2684-2688	Alpha-Numeric	Individual's previous Medicare Part C plan contract number.
127	Previous Medicare Part C Plan Enrollment Date	8	2689-2696	Numeric Date	Individual's previous Medicare Part C plan enrollment date. Format CCYYMMDD
128	Previous Medicare Part C Plan Termination Date	8	2697-2704	Numeric Date	Individual's previous Medicare Part C plan termination date. Format CCYYMMDD
129	Previous Medicare Part C Plan Contract Name	50	2705-2754	Alpha-Numeric	Individual's previous Medicare Part C plan contract name.
130	Previous Medicare Part C Plan PBP Number	3	2755-2757	Alpha-Numeric	Individual's previous Medicare Part C plan benefit package number.
131	Previous Medicare Part C Plan Contract Address 1	55	2758-2812	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 1.

Field	Name	Size	Displacement	Data Type	Description
132	Previous Medicare Part C Plan Contract Address 2	55	2813-2867	Alpha-Numeric	Individual's previous Medicare Part C plan contract address 2.
133	Previous Medicare Part C Plan Contract Address City	30	2868-2897	Alpha-Numeric	Individual's previous Medicare Part C plan contract address city.
134	Previous Medicare Part C Plan Contract Address State	2	2898-2899	Alpha-Numeric	Individual's previous Medicare Part C plan contract address state.
135	Previous Medicare Part C Plan Contract Address Zip	9	2900-2908	Alpha-Numeric	Individual's previous Medicare Part C plan contract address ZIP.
136	Most Recent Medicare Part D Plan Contract Number	5	2909-2913	Alpha-Numeric	Individual's most recent Medicare Part D contract number.
137	Most Recent Medicare Part D Plan Enrollment Date	8	2914-2921	Numeric Date	Individual's most recent Medicare Part D plan enrollment date. Format CCYYMMDD
138	Most Recent Medicare Part D Plan Termination Date	8	2922-2929	Numeric Date	Individual's most recent Medicare Part D plan termination date. Format CCYYMMDD
139	Most Recent Medicare Part D Plan Contract Name	50	2930-2979	Alpha-Numeric	Individual's most recent Medicare Part D plan contract name.
140	Most Recent Medicare Part D Plan PBP Number	3	2980-2982	Alpha-Numeric	Individual's most recent Medicare Part D plan benefit package number.
141	Most Recent Medicare Part D Plan Contract Address 1	55	2983-3037	Alpha-Numeric	Individual's most recent Medicare Part D plan contract address 1.
142	Most Recent Medicare Part D Plan Contract Address 2	55	3038-3092	Alpha-Numeric	Individual's most recent Medicare Part D plan contract address 2.

Field	Name	Size	Displacement	Data Type	Description
143	Most Recent Medicare Part D Plan Contract Address City	30	3093-3122	Alpha-Numeric	Individual's most recent Medicare Part D plan contract address city.
144	Most Recent Medicare Part D Plan Contract Address State	2	3123-3124	Alpha-Numeric	Individual's most recent Medicare Part D plan contract address state.
145	Most Recent Medicare Part D Plan Contract Address Zip	9	3125-3133	Alpha-Numeric	Individual's most recent Medicare Part D plan contract address ZIP.
146	Previous Medicare Part D Plan Contract Number	5	3134-3138	Alpha-Numeric	Individual's previous Medicare Part D contract number.
147	Previous Medicare Part D Plan Enrollment Date	8	3139-3146	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
148	Previous Medicare Part D Plan Termination Date	8	3147-3154	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
149	Previous Medicare Part D Plan Contract Name	50	3155-3204	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
150	Previous Medicare Part D Plan PBP Number	3	3205-3207	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
151	Previous Medicare Part D Plan Contract Address 1	55	3208-3262	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
152	Previous Medicare Part D Plan Contract Address 2	55	3263-3317	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
153	Previous Medicare Part D Plan Contract Address City	30	3318-3347	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.

Field	Name	Size	Displacement	Data Type	Description
154	Previous Medicare Part D Plan Contract Address State	2	3348-3349	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
155	Previous Medicare Part D Plan Contract Address Zip	9	3350-3358	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
156	Previous Medicare Part D Plan Contract Number	5	3359-3363	Alpha-Numeric	Individual's previous Medicare Part D contract number.
157	Previous Medicare Part D Plan Enrollment Date	8	3364-3371	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
158	Previous Medicare Part D Plan Termination Date	8	3372-3379	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
159	Previous Medicare Part D Plan Contract Name	50	3380-3429	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
160	Previous Medicare Part D Plan PBP Number	3	3430-3432	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
161	Previous Medicare Part D Plan Contract Address 1	55	3433-3487	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
162	Previous Medicare Part D Plan Contract Address 2	55	3488-3542	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
163	Previous Medicare Part D Plan Contract Address City	30	3543-3572	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
164	Previous Medicare Part D Plan Contract Address State	2	3573-3574	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.

Field	Name	Size	Displacement	Data Type	Description
165	Previous Medicare Part D Plan Contract Address Zip	9	3575-3583	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
166	Previous Medicare Part D Plan Contract Number	5	3584-3588	Alpha-Numeric	Individual's previous Medicare Part D contract number.
167	Previous Medicare Part D Plan Enrollment Date	8	3589-3596	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
168	Previous Medicare Part D Plan Termination Date	8	3597-3604	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
169	Previous Medicare Part D Plan Contract Name	50	3605-3654	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
170	Previous Medicare Part D Plan PBP Number	3	3655-3657	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
171	Previous Medicare Part D Plan Contract Address 1	55	3658-3712	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
172	Previous Medicare Part D Plan Contract Address 2	55	3713-3767	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
173	Previous Medicare Part D Plan Contract Address City	30	3768-3797	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
174	Previous Medicare Part D Plan Contract Address State	2	3798-3799	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
175	Previous Medicare Part D Plan Contract Address Zip	9	3800-3808	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.

Field	Name	Size	Displacement	Data Type	Description
176	Previous Medicare Part D Plan Contract Number	5	3809-3813	Alpha-Numeric	Individual's previous Medicare Part D contract number.
177	Previous Medicare Part D Plan Enrollment Date	8	3814-3821	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
178	Previous Medicare Part D Plan Termination Date	8	3822-3829	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
179	Previous Medicare Part D Plan Contract Name	50	3830-3879	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
180	Previous Medicare Part D Plan PBP Number	3	3880-3882	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
181	Previous Medicare Part D Plan Contract Address 1	55	3883-3937	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
182	Previous Medicare Part D Plan Contract Address 2	55	3938-3992	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
183	Previous Medicare Part D Plan Contract Address City	30	3993-4022	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
184	Previous Medicare Part D Plan Contract Address State	2	4023-4024	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
185	Previous Medicare Part D Plan Contract Address Zip	9	4025-4033	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
186	Previous Medicare Part D Plan Contract Number	5	4034-4038	Alpha-Numeric	Individual's previous Medicare Part D contract number.

Field	Name	Size	Displacement	Data Type	Description
187	Previous Medicare Part D Plan Enrollment Date	8	4039-4046	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
188	Previous Medicare Part D Plan Termination Date	8	4047-4054	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
189	Previous Medicare Part D Plan Contract Name	50	4055-4104	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
190	Previous Medicare Part D Plan PBP Number	3	4105-4107	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
191	Previous Medicare Part D Plan Contract Address 1	55	4108-4162	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
192	Previous Medicare Part D Plan Contract Address 2	55	4163-4217	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
193	Previous Medicare Part D Plan Contract Address City	30	4218-4247	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
194	Previous Medicare Part D Plan Contract Address State	2	4248-4249	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
195	Previous Medicare Part D Plan Contract Address Zip	9	4250-4258	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
196	Previous Medicare Part D Plan Contract Number	5	4259-4263	Alpha-Numeric	Individual's previous Medicare Part D contract number.
197	Previous Medicare Part D Plan Enrollment Date	8	4264-4271	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
198	Previous Medicare Part D Plan Termination Date	8	4272-4279	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
199	Previous Medicare Part D Plan Contract Name	50	4280-4329	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
200	Previous Medicare Part D Plan PBP Number	3	4330-4332	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
201	Previous Medicare Part D Plan Contract Address 1	55	4333-4387	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
202	Previous Medicare Part D Plan Contract Address 2	55	4388-4442	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
203	Previous Medicare Part D Plan Contract Address City	30	4443-4472	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
204	Previous Medicare Part D Plan Contract Address State	2	4473-4474	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
205	Previous Medicare Part D Plan Contract Address Zip	9	4475-4483	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
206	Previous Medicare Part D Plan Contract Number	5	4484-4488	Alpha-Numeric	Individual's previous Medicare Part D contract number.
207	Previous Medicare Part D Plan Enrollment Date	8	4489-4496	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
208	Previous Medicare Part D Plan Termination Date	8	4497-4504	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
209	Previous Medicare Part D Plan Contract Name	50	4505-4554	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
210	Previous Medicare Part D Plan PBP Number	3	4555-4557	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
211	Previous Medicare Part D Plan Contract Address 1	55	4558-4612	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
212	Previous Medicare Part D Plan Contract Address 2	55	4613-4667	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
213	Previous Medicare Part D Plan Contract Address City	30	4668-4697	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
214	Previous Medicare Part D Plan Contract Address State	2	4698-4699	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
215	Previous Medicare Part D Plan Contract Address Zip	9	4700-4708	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
216	Previous Medicare Part D Plan Contract Number	5	4709-4713	Alpha-Numeric	Individual's previous Medicare Part D contract number.
217	Previous Medicare Part D Plan Enrollment Date	8	4714-4721	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
218	Previous Medicare Part D Plan Termination Date	8	4722-4729	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
219	Previous Medicare Part D Plan Contract Name	50	4730-4779	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.

Field	Name	Size	Displacement	Data Type	Description
220	Previous Medicare Part D Plan PBP Number	3	4780-4782	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
221	Previous Medicare Part D Plan Contract Address 1	55	4783-4837	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
222	Previous Medicare Part D Plan Contract Address 2	55	4838-4892	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
223	Previous Medicare Part D Plan Contract Address City	30	4893-4922	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
224	Previous Medicare Part D Plan Contract Address State	2	4923-4924	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
225	Previous Medicare Part D Plan Contract Address Zip	9	4925-4933	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
226	Previous Medicare Part D Plan Contract Number	5	4934-4938	Alpha-Numeric	Individual's previous Medicare Part D contract number.
227	Previous Medicare Part D Plan Enrollment Date	8	4939-4946	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
228	Previous Medicare Part D Plan Termination Date	8	4947-4954	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
229	Previous Medicare Part D Plan Contract Name	50	4955-5004	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
230	Previous Medicare Part D Plan PBP Number	3	5005-5007	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.

Field	Name	Size	Displacement	Data Type	Description
231	Previous Medicare Part D Plan Contract Address 1	55	5008-5062	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
232	Previous Medicare Part D Plan Contract Address 2	55	5063-5117	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
233	Previous Medicare Part D Plan Contract Address City	30	5118-5147	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
234	Previous Medicare Part D Plan Contract Address State	2	5148-5149	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
235	Previous Medicare Part D Plan Contract Address Zip	9	5150-5158	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
236	Previous Medicare Part D Plan Contract Number	5	5159-5163	Alpha-Numeric	Individual's previous Medicare Part D contract number.
237	Previous Medicare Part D Plan Enrollment Date	8	5164-5171	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
238	Previous Medicare Part D Plan Termination Date	8	5172-5179	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
239	Previous Medicare Part D Plan Contract Name	50	5180-5229	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
240	Previous Medicare Part D Plan PBP Number	3	5230-5232	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
241	Previous Medicare Part D Plan Contract Address 1	55	5233-5287	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.

Field	Name	Size	Displacement	Data Type	Description
242	Previous Medicare Part D Plan Contract Address 2	55	5288-5342	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.
243	Previous Medicare Part D Plan Contract Address City	30	5343-5372	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
244	Previous Medicare Part D Plan Contract Address State	2	5373-5374	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
245	Previous Medicare Part D Plan Contract Address Zip	9	5375-5383	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.
246	Previous Medicare Part D Plan Contract Number	5	5384-5388	Alpha-Numeric	Individual's previous Medicare Part D contract number.
247	Previous Medicare Part D Plan Enrollment Date	8	5389-5396	Numeric Date	Individual's previous Medicare Part D plan enrollment date. Format CCYYMMDD
248	Previous Medicare Part D Plan Termination Date	8	5397-5404	Numeric Date	Individual's previous Medicare Part D plan termination date. Format CCYYMMDD
249	Previous Medicare Part D Plan Contract Name	50	5405-5454	Alpha-Numeric	Individual's previous Medicare Part D plan contract name.
250	Previous Medicare Part D Plan PBP Number	3	5455-5457	Alpha-Numeric	Individual's previous Medicare Part D plan benefit package number.
251	Previous Medicare Part D Plan Contract Address 1	55	5458-5512	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 1.
252	Previous Medicare Part D Plan Contract Address 2	55	5513-5567	Alpha-Numeric	Individual's previous Medicare Part D plan contract address 2.

Field	Name	Size	Displacement	Data Type	Description
253	Previous Medicare Part D Plan Contract Address City	30	5568-5597	Alpha-Numeric	Individual's previous Medicare Part D plan contract address city.
254	Previous Medicare Part D Plan Contract Address State	2	5698-5599	Alpha-Numeric	Individual's previous Medicare Part D plan contract address state.
255	Previous Medicare Part D Plan Contract Address Zip	9	5600-5608	Alpha-Numeric	Individual's previous Medicare Part D plan contract address ZIP.

Appendix F: NGHP Unsolicited Response File Layout

Note: As of July 2023, the following will be implemented:

This file is sent on the second Sunday of each month, and applies to ORM records the RRE uploaded in the last 12 months.

NGHP Unsolicited Response File Header Record

Table F-1: Section 111 NGHP Unsolicited MSP Response File Header Record - 600 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Header Type Code	4	1-4	Alpha-numeric	Contains a value of 'UNOH'.
2.	RRE ID	9	5-13	Numeric	Section 111 RRE ID.
3.	File Type	4	14-17	Alpha-numeric	Contains a value of 'USOL'.
4.	File Date	8	18-25	Numeric Date	Date file created by the BCRC. (CCYYMMDD format).
5.	Filler	575	26-600	Alpha-numeric	Not Used. Filled with spaces.

NGHP Unsolicited Response File Detail Record

Table F-2: NGHP Unsolicited Response File Detail Record – 600 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Transaction Type	4	1-4	Alpha-numeric	'USOL'
2.	Medicare ID	12	5-16	Alpha-numeric	Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]). Note: The Medicare ID is also known as the Medicare Number to CMS' Medicare beneficiaries.
3.	Beneficiary Surname	6	17-22	Text	First 6 characters of the beneficiary's last name.
4.	Beneficiary First Initial	1	23-23	Text	First letter of the beneficiary's first name.
5.	Beneficiary Date of Birth	8	24-31	Numeric Date	Date of birth of the beneficiary. (CCYYMMDD format).
6.	Beneficiary Sex Code	1	32-32	Alpha-numeric	Beneficiary gender code.
7.	Interested Party DCN	15	33-47	Alpha-numeric	Most recent Document Control Number successfully submitted by the interested party RRE on its MSP Input File. Use this field to assist in matching the Unsolicited MSP Response Detail Record to your previously submitted coverage records.
8.	Filler	2	48-49	Alpha-numeric	Not used. Filled with spaces.
9.	Last Transaction Type	1	50-50	Alpha-numeric	Last action performed on the MSP occurrence by the BCRC based on information from the entity identified in the Modifier Type Code and Modifier Name (Fields 29 and 30). Values: '0' = Update '1' = Delete
10.	Filler	2	51-52	Alpha-numeric	Not Used. Filled with spaces.
11.	Insurer's Name	32	53-84	Text	Name of the most current insurer/TPA Medicare has associated with the MSP occurrence.
12.	Insurer's Address 1	32	85-116	Alpha-numeric	Address Line 1 for the most current insurer/TPA Medicare has associated with the MSP occurrence.

Field	Name	Size	Displacement	Data	Description
13.	Insurer's Address 2	32	117-148	Alpha-numeric	Address Line 2 for the most current insurer/TPA Medicare has associated with the MSP occurrence.
14.	Insurer's City	15	149-163	Text	City for the most current insurer/TPA Medicare has associated with the MSP occurrence.
15.	Insurer's State	2	164-165	Alpha	State for the most current insurer/TPA Medicare has associated with the MSP occurrence.
16.	Insurer's Zip Code	9	166-174	Alpha-numeric	ZIP Code for the most current insurer/TPA Medicare has associated with the MSP occurrence.
17.	Filler	9	175-183	Alpha-numeric	Not used. Filled with spaces.
18.	MSP Effective Date	8	184-191	Numeric Date	Effective Date of the MSP occurrence posted on the Medicare CWF.
19.	MSP Termination Date	8	192-199	Numeric Date	End date of the MSP occurrence posted on the Medicare CWF. Note: All zeros if open-ended (i.e., if coverage is not terminated).
20.	Filler	39	200-238	Alpha-numeric	Not used. Filled with spaces.
21.	Attorney's Name	32	239-270	Text	Name of the most current attorney associated with the MSP occurrence.
22.	Attorney's Address 1	32	271-302	Alpha-numeric	Address Line 1 of the most current attorney associated with the MSP occurrence.
23.	Attorney's Address 2	32	303-334	Alpha-numeric	Address Line 2 of the most current attorney associated with the MSP occurrence.
24.	Attorney's City	15	335-349	Text	City of the most current attorney associated with the MSP occurrence.
25.	Attorney's State	2	350-351	Alpha	State code of the most current attorney associated with the MSP occurrence.
26.	Attorney's Zip Code	9	352-360	Alpha-numeric	ZIP Code of the most current attorney associated with the MSP occurrence.
27.	Group Insurance Policy/DOL	20	361-380	Alpha-numeric	Displays the group insurance policy number or date of loss.
28.	Filler	17	381-397	Alpha-numeric	Not used. Filled with spaces.
29.	Modifier Type Code	3	398-400	Alpha-numeric	Code identifying the type of entity that last changed the MSP occurrence.

Field	Name	Size	Displacement	Data	Description
30.	Modifier Name	32	401-432	Text	Modifier Name/Description of the last entity that changed the MSP occurrence.
31.	Change Reason Code	2	433-434	Alpha-numeric	Code identifying the reason for the last change to the MSP occurrence (if known).
32.	Last Update Applied Date	8	435-442	Numeric Date	Date the BCRC last changed the MSP occurrence. CCYYMMDD format.
33.	Filler	158	443-600	Alpha-numeric	Not used. Filled with spaces.

NGHP Unsolicited Response File Trailer Record

Table F-3: NGHP Unsolicited Response File Trailer Record – 600 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Type Code	4	1-4	Alpha-numeric	Contains a value of 'UNOT'.
2.	RRE ID	9	5-13	Numeric	Section 111 RRE ID.
3.	File Type	4	14-17	Alpha-numeric	Contains a value of 'USOL'.
4.	File Date	8	18-25	Numeric Date	Date file created by the BCRC (CCYYMMDD format).
5.	File Record Count	9	26-34	Numeric	Number of response detail records contained in this file. Does not include the header and trailer records in the count. Will contain a value of all zeros if there were no NGHP Unsolicited Response records to transmit to the RRE for the month.
6.	Filler	566	35-600	Alpha-numeric	Not used. Filled with spaces.

Appendix G: Disposition, Error, and Compliance Flag Codes

Response File Disposition Codes

Table G-1: Response File Disposition Codes

Disposition Codes	Description
01	<p>Claim Response File: Record accepted by the BCRC as an “Add,” “Delete” or “Update” record. RRE has indicated ongoing responsibility for medicals.</p> <p>TIN Reference Response File: TIN Record accepted.</p> <p>HEW Query Response File: For queries, the individual was identified as a Medicare beneficiary based upon the information submitted.</p>
02	<p>Claim Response File: Record accepted by the BCRC as an “Add,” “Delete” or “Update” record. RRE has indicated no ongoing responsibility for medicals.</p>
03	<p>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.</p> <p>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.</p> <p>For claims with no ongoing responsibility for medicals (no ORM), record does not need to be resubmitted unless subsequent TPOC Amounts must be reported.</p> <p>For claims with ongoing responsibility for medicals (ORM), RRE must continue to check the injured party’s Medicare status and report when the individual 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 the “Special Exception” section of the NGHP User Guide Chapter IV regarding reporting termination of ORM is met.</p>
DP	<p>Claim Response and Query Response Files:</p> <p>Multiple Medicare beneficiary records were identified based upon the data submitted. The DP (duplicate) disposition code will be returned if the the last 5 digits of the SSN submitted on the claim or query input files, when combined with matching criteria (first initial of the first name; the first six characters of the last name; date of birth; and gender), return multiple records.</p> <p>In instances where the RRE receives the DP code, they are instructed to take the following actions to remain in compliance with MMSEA Section 111 reporting requirements:</p> <ol style="list-style-type: none"> 1. Verify that the SSN, name, gender, and date of birth were entered accurately and re-submit. 2. Enter the full 9-digit SSN (if available) and re-submit. <p>If the system is still unable to locate a distinct match after re-submission, contact the BCRC at 1-855-798-2627. The RRE should provide the claim information to the customer service representative to file a self-report.</p>
SP	<p>Claim Response File: Record not accepted by the BCRC 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.</p>

Disposition Codes	Description
50	<p>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 be returned infrequently. RREs should expect to receive a very low volume of this disposition code. Records in the file that completed processing will be returned with an applicable disposition code.</p>
51	<p>Individual was not identified as a Medicare Beneficiary.</p> <p>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.</p> <p>For claims with ongoing responsibility for medicals (ORM), RRE must continue to check the injured party's Medicare status and report when he or 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 the "Special Exception" section of the NGHP User Guide Chapter IV regarding reporting termination of ORM is met.</p> <p>HEW Query Response File: For queries, the individual was not identified as a Medicare beneficiary based upon the information submitted.</p> <p>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 (HICN or MBI) 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.</p>
TN	<p>TIN Reference File: Detail Record rejected due to errors. Only returned on TIN Reference Response File.</p> <p>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.</p>

Claim Response File Compliance Flag Codes

Table G-2: Claim Response File Compliance Flag Codes

Compliance Code	Description
01	Most recent TPOC Date (or Funding Delayed Beyond TPOC Start Date, where applicable) submitted on an add record is more than 135 days older than the File Receipt Date .
02	Warning. As of October 1, 2015, ICD-10-CM diagnosis codes are required on all claim reports with a CMS DOI of October 1, 2015 and subsequent dates.
03	ORM Termination Date on an add or update record is more than 135 days older than the File Receipt Date .

Claim Response File Error Codes

Excel and text files containing the error codes, fields and corresponding descriptions are available at <https://www.cob.cms.hhs.gov/Section111/>. 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 Descriptions

In general, when you receive an error related to a Claim Input File Detail Record and/or a TIN Reference File Detail Record, the corrected record(s) needs to be resubmitted on your next Quarterly Claim Input File submission. If TIN Reference File records are not corrected, subsequently processed Claim Input File Detail Records with matching RRE TIN/Office Code will reject. Any Claim Input File Detail Record that rejects for TIN-related errors must be resubmitted with the corrected TIN Reference File Detail Record in order for it to correctly process.

Error codes are prefaced with two letters followed by two numbers. Error codes that begin with a “C” indicate that the error occurred in the Claim Input File. Error codes that begin with a “T” indicate that the error occurred in the TIN Reference File. See the table below:

Table G-3: Error Codes Descriptions

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

Error Code Resolution Tables

The Error Code Resolution Tables (Claim Response and TIN Reference Response) provide information on the error codes that you may receive on your Section 111 response file(s). Each table identifies the record and field that caused the error, identifies whether or not the field is required, provides the record layout field descriptions and provides some possible causes of the error.

NOTE: If you receive an error code that is not listed in this table, or you are not able to use this table to resolve your error, contact your EDI Representative for additional assistance.

Claim Response File Error Code Resolution Table

Table G-4: Claim Response File Error Code Resolution Table

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CB01	Claim Input File Detail Record	Record Identifier (Field 1)	Yes	Must be "NGCD."	Field 1 does not equal "NGCD."
CB01	Claim Input File Auxiliary Record	Record Identifier (Field 1)	Yes	Must be "NGCE."	Field 1 does not equal "NGCE." Field 1 on preceding record does not equal "NGCD"
CB01	Claim Input File Auxiliary Record	DCN (Field 2), Medicare ID (Field 3), SSN (Field 4), Injured Party Last Name (Field 5), and/or Injured Party First Name (Field 6)	Yes	Must match the values submitted in the corresponding field names on the preceding Claim Input File Detail Record.	The values in Field 2, 3, 4, 5, and/or 6 on the Claim Input File Auxiliary Record do not match the values submitted in the corresponding fields on the preceding Claim Input File Detail Record
CB02	Claim Input File Detail Record	DCN (Field 2)	Yes	Document Control Number (DCN) 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.	Field 2: <ul style="list-style-type: none"> • is space-filled; • is zero-filled; • contains parenthesis (); or • is not unique within the same Claim Input File submission
CB03	Claim Input File Detail Record	Action Type (Field 3)	Yes	Action to be performed. Valid values: 0 (zero) = Add; 1 = Delete; 2 = Update/Change Note: To change or correct TPOC information, use "2."	Field 3: <ul style="list-style-type: none"> • does not equal "0," "1," or "2"

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CB04	Claim Input File Detail Record	Injured Party Medicare ID (Field 4)	Yes, if Injured Party SSN (Field 5) is not submitted.	Health Insurance Claim Number of the Injured Party. Fill with spaces if unknown and SSN provided. Do not include dashes. May only contain digits 0 through 9, spaces, and/or letters. No special characters.	Field 4: <ul style="list-style-type: none"> contains dashes, hyphens or special characters; or is not left-justified
CB06	Claim Input File Detail Record	Injured Party Medicare ID (Field 4) and Injured Party SSN (Field 5)	Yes, either Field 4 or Field 5 must be submitted	See record layout field descriptions for Field 4 (Injured Party Medicare ID) and Field 5 (Injured Party SSN).	Field 4 and Field 5 were either zero-filled or space-filled
CB07	Claim Input File Detail Record	Injured Party Last Name (Field 6)	Yes	Surname of the injured party. Submit it 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.	Field 6: <ul style="list-style-type: none"> was space-filled contains values other than a space, letter, hyphen or an apostrophe; or Position (42) did not contain an alphabetic character
CB08	Claim Input File Detail Record	Injured Party First Name (Field 7)	Yes	First name of injured party. Submit it as it appears on the individual's Social Security or Medicare Insurance card. May only contain letters and spaces.	Field 7: <ul style="list-style-type: none"> was space-filled; contained non-alphabetic characters; or Position (82) did not contain an alphabetic character
CB09	Claim Input File Detail Record	Injured Party Middle Init (Field 8)	No	First letter of Injured Party middle name. Name should be submitted as it appears on the individual's Social Security or Medicare Insurance card. Fill with space if unknown.	Field 8: <ul style="list-style-type: none"> contained non-alphabetic characters; or was not space-filled
CB10	Claim Input File Detail Record	Injured Party Gender (Field 9)	Yes	Sex of the injured party. Valid values: 0 (zero) = Unknown; 1 = Male; or 2 = Female.	Field 9: does not equal "0," "1," or "2"

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CB11	Claim Input File Detail Record	Injured Party DOB (Field 10)	Yes	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.	Field 10: <ul style="list-style-type: none"> • contained non-numeric data; • was zero-filled; • was not a valid date (formatted CCYYMMDD); or • was not prior to the current date
CC01	Claim Input File Detail Record	Claimant 1 Relationship (Field 84)	No, but if entered, it will be edited.	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 = Claimant Information Not Supplied. (Fields 104 – 118 must contain default values according to Data Type, or all spaces)	Field 84 does not equal "E," "F," "O," "X," "Y," "Z," or space.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC02	Claim Input File Detail Record	Claimant 1 TIN (Field 85)	No, but if entered, it will be edited.	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 1. Optional.	Field 85: <ul style="list-style-type: none"> has non-numeric data or something other than spaces; matches the Claimant TIN submitted for another claimant listed on the Detail or Auxiliary Record; or is not space-filled or zero-filled when Field 84 = a space.
CC03	Claim Input File Detail Record	Claimant 1 Last Name (Field 86)	No, but if entered or Claimant 1 Relationship is not equal to a space, it will be edited.	Surname of Claimant 1. Embedded hyphens (dashes), apostrophes and spaces accepted. Optional.	Field 86: <ul style="list-style-type: none"> is all spaces and Field 84 = "E," "F," or "O;" position 1647 is not an alphabetic character when Field 84 = "E," "F," or "O;" or is not space-filled when Field 104 = a space
CC04	Claim Input File Detail Record	Claimant 1 First Name (Field 87)	No, but if entered or Claimant 1 Relationship is not equal to a space, it will be edited.	Given/First name of Claimant 1. May only contain letters and spaces. Optional.	Field 87: <ul style="list-style-type: none"> is all spaces and Field 84 = "E," "F," or "O;" position 1687 is not an alphabetic character when Field 84 = "E," "F," or "O;" or is not space-filled when Field 104 = a space
CC05	Claim Input File Detail Record	Claimant 1 Middle Initial (Field 88)	No	First letter of Claimant 1's middle name. Optional.	Field 88: <ul style="list-style-type: none"> does not equal a space when Field 84 = a space; or was not submitted as a letter <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC06	Claim Input File Detail Record	Claimant 1 Mailing Address 1 (Field 90)	No, but if entered, it will be edited.	First line of the mailing address for the claimant 1. 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. Optional.	Field 90: <ul style="list-style-type: none"> is not space-filled when Field 84 = a space; contains an invalid character such as a parenthesis; is not space-filled when Field 93 = "FC;" or is not at least 2 alphanumeric characters.
CC07	Claim Input File Detail Record	Claimant 1 Mailing Address 2 (Field 91)	No	Second line of the mailing address of the claimant 1. 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. Optional	Field 91: <ul style="list-style-type: none"> is not space-filled when Field 84 = a space; contains an invalid character such as a parenthesis; or is not space-filled when Field 93 = "FC"
CC08	Claim Input File Detail Record	Claimant 1 City (Field 92)	No	Mailing address city for the claimant 1. Optional.	Field 92: <ul style="list-style-type: none"> has numeric data; is not space-filled when Field 84 = a space; is space filled when Field 84 does not equal a space; contains an invalid character such as a parenthesis; is not space-filled when Field 93 = "FC;" or contains data other than alphabetic, space comma, &—, @#;:
CC09	Claim Input File Detail Record	Claimant 1 State (Field 93)	No	US Postal abbreviation State Code for the claimant 1. 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. Optional.	Field 93: <ul style="list-style-type: none"> is submitted with numeric data; is not space-filled when Field 84 = a space; or is space-filled when Field 84 does not equal a space

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC10	Claim Input File Detail Record	Claimant 1 Zip (Field 94)	No, but if entered, it will be edited.	5-digit Zip Code for the claimant 1. Optional.	Field 94: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 84 = a space; or is not zero-filled when Field 93 = "FC"
CC11	Claim Input File Detail Record	Claimant 1 Zip+4 (Field 95)	No	4-digit Zip+4 Code for claimant 1. If not applicable or unknown, fill with zeroes (0000). Optional.	Field 95: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 84 = a space; or is not zero-filled when Field 93 = "FC" <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>
CC12	Claim Input File Detail Record	Claimant 1 Phone (Field 96)	No, but if entered, it will be edited.	Telephone number of claimant 1. 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. Optional.	Field 96: <ul style="list-style-type: none"> is not zero-filled when Field 84 = a space; is not zero-filled when Field 93 = "FC;" or contains a non-numeric character <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>
CC13	Claim Input File Detail Record	Claimant 1 Phone Extension (Field 97)	No	Telephone extension number of the claimant 1. Fill with all spaces if unknown or not applicable. Optional.	Field 97: <ul style="list-style-type: none"> is not space-filled when Field 84 = a space; or contains an invalid character such as a parenthesis <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission. (Effective April 5, 2021)</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC14	Claim Input File Detail Record	Claimant 1 Entity / Organization Name (Field 89)	No, but if entered, it will be edited.	Name of Claimant 1 Entity/Organization. Redefines Fields 86-88 (is made up of the same bytes, is in the same location as Fields 86-88). Use either Field 89 or Fields 86-88 depending on the Relationship code submitted. Optional.	Field 89: <ul style="list-style-type: none"> • is not space-filled when Field 84 = a space; • is space-filled when Field 84 = "X," "Y," or "Z;" • contains an invalid character such as a parenthesis; or • is not at least 2 alphanumeric characters.
CC21	Claim Input File Auxiliary Record	Claimant 2 Relationship (Field 7)	No, but if entered, it will be edited.	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 = Claimant Information Not Supplied. (Fields 7 – 21 must contain default values according to Data Type, or all spaces) Optional.	Field 7 does not equal "E," "F," "O," "X," "Y," "Z," or space.

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CC22	Claim Input File Auxiliary Record	Claimant 2 TIN (Field 8)	No	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 2. Optional.	Field 8: <ul style="list-style-type: none"> has non-numeric data or something other than spaces; matches the Claimant TIN submitted for another claimant listed on the Detail or Auxiliary Record; or is not space-filled or zero-filled when Field 7 = a space.
CC23	Claim Input File Auxiliary Record	Claimant 2 Last Name (Field 9)	No, but if entered or Claimant 2 Relationship is not equal to a space, it will be edited.	Surname of Claimant 2. Embedded hyphens (dashes), apostrophes and spaces accepted. Optional.	Field 9: <ul style="list-style-type: none"> is all spaces and Field 7 = "E," "F," or "O;" position 121 is not an alphabetic character when Field 7 = "E," "F," or "O;" or is not space-filled when Field 7 = a space
CC24	Claim Input File Auxiliary Record	Claimant 2 First Name (Field 10)	No, but if entered or Claimant 2 Relationship is not equal to a space, it will be edited.	Given/First name of Claimant 2. May only contain letters and spaces. Optional.	Field 10: <ul style="list-style-type: none"> is all spaces and Field 7 = "E," "F," or "O;" position 161 is not an alphabetic character when Field 7 = "E," "F," or "O;" or is not space-filled when Field 7 = a space
CC25	Claim Input File Auxiliary Record	Claimant 2 Middle Initial (Field 11)	No	First letter of Claimant 2's middle name. Optional.	Field 11: <ul style="list-style-type: none"> is not a space when Field 7 = a space <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC26	Claim Input File Auxiliary Record	Claimant 2 Mailing Address 1 (Field 13)	No, but if entered, it will be edited.	First line of the mailing address for Claimant 2 . 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. Optional.	Field 13: <ul style="list-style-type: none"> is not space-filled when Field 7 = a space; is space filled when Field 7 does not equal a space; is not space-filled when Field 16 = “FC;” or contains an invalid character such as a parenthesis
CC27	Claim Input File Auxiliary Record	Claimant 2 Mailing Address 2 (Field 14)	No	Second line of the mailing address for Claimant 2. 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. Optional.	Field 14: <ul style="list-style-type: none"> is not space-filled when Field 7 = a space; contains an invalid character such as a parenthesis; or is not space-filled when Field 16 = “FC”
CC28	Claim Input File Auxiliary Record	Claimant 2 City (Field 15)	No	Mailing address city for Claimant 2. If no US address is available, fill with spaces and supply “FC” in the corresponding State Code. Optional.	Field 15: <ul style="list-style-type: none"> has numeric data; is not space-filled when Field 7 = a space; is space filled when Field 7 does not equal a space; contains an invalid character such as a parenthesis; is not space-filled when Field 16 = “FC” contains data other than alphabetic, space comma, &—‘ , @#;:
CC29	Claim Input File Auxiliary Record	Claimant 2 State (Field 16)	No	US Postal abbreviation State Code for Claimant 2. 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. Optional.	Field 16: <ul style="list-style-type: none"> has numeric data; is not space-filled when Field 7 = a space; or is space-filled when Field 7 does not equal a space

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC30	Claim Input File Auxiliary Record	Claimant 2 Zip (Field 17)	No, but if entered, it will be edited.	5-digit Zip Code for Claimant 2. If no US address is available, fill with zeroes and supply "FC" in the corresponding State Code. Optional.	Field 17: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 7 = a space; is not space-filled or zero-filled when Field 7 = a space; is not zero-filled when Field 16 = "FC;" or is space-filled when Field 7 does not equal a space
CC31	Claim Input File Auxiliary Record	Claimant 2 Zip+4 (Field 18)	No	4-digit Zip+4 Code for Claimant 2. If not applicable or unknown, fill with zeroes (0000). Optional.	Field 18: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 7 = a space; or is not zero-filled when Field 16 = "FC" <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>
CC32	Claim Input File Auxiliary Record	Claimant 2 Phone (Field 19)	No.	Telephone number of Claimant 2. 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. Optional..	Field 19: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 7 = a space; is space-filled when Field 7 does not equal a space; is not zero-filled when Field 16 = "FC;" or contains a non-numeric character <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC33	Claim Input File Auxiliary Record	Claimant 2 Phone Extension (Field 20)	No	Telephone extension number of Claimant 2. Fill with all spaces if unknown or not applicable. Optional.	Field 20: <ul style="list-style-type: none"> is not space-filled when Field 7 = a space; is not space-filled when Field 16 = "FC;" or contains an invalid character such as a parenthesis Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CC34	Claim Input File Auxiliary Record	Claimant 2 Entity / Organization Name (Field 12)	No, but if entered, it will be edited.	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. Optional..	Field 12: <ul style="list-style-type: none"> is not space-filled when Field 7 = a space; is space-filled when Field 7 is "X," "Y," or "Z;" or contains an invalid character such as a parenthesis
CC41	Claim Input File Auxiliary Record	Claimant 3 Relationship (Field 36)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 36 does not equal "E," "F," "O," "X," "Y," "Z," or space.
CC42	Claim Input File Auxiliary Record	Claimant 3 TIN (Field 37)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 37: <ul style="list-style-type: none"> has non-numeric data or something other than spaces; matches the Claimant TIN submitted for another claimant listed on the Detail or Auxiliary Record; is not space-filled or zero-filled when Field 36 = a space; or
CC43	Claim Input File Auxiliary Record	Claimant 3 Last Name (Field 38)	No, but if entered or Claimant 3 Relationship is not equal to a space, it will be edited.	See Claimant 2 Information section above for individual field description.	<ul style="list-style-type: none"> Field 38: is all spaces and Field 36 = "E," "F," or "O;" position 704 is not an alphabetic character when Field 36 = "E," "F," or "O;" or is not space-filled when Field 36 = a space

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC44	Claim Input File Auxiliary Record	Claimant 3 First Name (Field 39)	No, but if entered or Claimant 3 Relationship is not equal to a space, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 39: <ul style="list-style-type: none"> position 161 is not an alphabetic character when Field 36 = "E," "F," or "O;" is all spaces and Field 36 = "E," "F," or "O;" or is not space-filled when Field 36 = a space
CC45	Claim Input File Auxiliary Record	Claimant 3 Middle Initial (Field 40)	No	See Claimant 2 Information section above for individual field description.	Field 40: <p>does not a space when Field 36 = a space</p> <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>
CC46	Claim Input File Auxiliary Record	Claimant 3 Mailing Address 1 (Field 42)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 42: <ul style="list-style-type: none"> is not space-filled when Field 36 = a space; is space filled when Field 36 does not equal a space; is not space-filled when Field 45 = "FC;" or contains an invalid character such as a parenthesis
CC47	Claim Input File Auxiliary Record	Claimant 3 Mailing Address 2 (Field 43)	No	See Claimant 2 Information section above for individual field description.	Field 43: <ul style="list-style-type: none"> is not space-filled when Field 36 = a space; contains an invalid character such as a parenthesis; or is not space-filled when Field 45 = "FC"

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC48	Claim Input File Auxiliary Record	Claimant 3 City (Field 44)	No	See Claimant 2 Information section above for individual field description.	Field 44: <ul style="list-style-type: none"> has numeric data; is not space-filled when Field 36 = a space; is space filled when Field 36 does not equal a space; is not space-filled when Field 45 = "FC;" contains an invalid character such as a parenthesis; or contains data other than alphabetic, space comma, &—‘ , @#;:
CC49	Claim Input File Auxiliary Record	Claimant 3 State (Field 45)	No	See Claimant 2 Information section above for individual field description.	Field 45: <ul style="list-style-type: none"> has numeric data; is not space-filled when Field 36 = a space; or is space-filled when Field 36 does not equal a space
CC50	Claim Input File Auxiliary Record	Claimant 3 Zip (Field 46)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 46: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 36 = a space; is not space-filled or zero-filled when Field 36 = a space; is not zero-filled when Field 45 = "FC;" or is space-filled when Field 36 does not equal a space
CC51	Claim Input File Auxiliary Record	Claimant 3 Zip+4 (Field 47)	No	See Claimant 2 Information section above for individual field description.	Field 47: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 36 = a space; or is not zero-filled when Field 45 = "FC" <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC52	Claim Input File Auxiliary Record	Claimant 3 Phone (Field 48)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 48: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 36 = a space; is space-filled when Field 36 does not equal a space; is not zero-filled when Field 45 = "FC;" or contains a non-numeric character Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CC53	Claim Input File Auxiliary Record	Claimant 3 Phone Extension (Field 49)	No	See Claimant 2 Information section above for individual field description.	Field 49: <ul style="list-style-type: none"> is not space-filled when Field 36 = a space; is not space-filled when Field 45 = "FC;" or contains an invalid character such as a parenthesis Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CC54	Claim Input File Auxiliary Record	Claimant 3 Entity / Organization Name (Field 41)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 41: <ul style="list-style-type: none"> is not space-filled when Field 36 = a space; is space-filled when Field 36 is "X," "Y," or "Z;" or contains an invalid character such as a parenthesis
CC61	Claim Input File Auxiliary Record	Claimant 4 Relationship (Field 65)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 65 does not equal "E," "F," "O," "X," "Y," "Z," or space.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC62	Claim Input File Auxiliary Record	Claimant 4 TIN (Field 66)	No	See Claimant 2 Information section above for individual field description.	Field 66: <ul style="list-style-type: none"> has non-numeric data or something other than spaces; matches the Claimant TIN submitted for another claimant listed on the Detail or Auxiliary Record; is not space-filled or zero-filled when Field 65 = a space
CC63	Claim Input File Auxiliary Record	Claimant 4 Last Name (Field 67)	No, but if entered or Claimant 4 Relationship is not equal to a space, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 67: <ul style="list-style-type: none"> is all spaces and Field 65 = "E," "F," or "O;" position 1287 is not an alphabetic character when Field 65 = "E," "F," or "O;" or is not space-filled when Field 65 = a space
CC64	Claim Input File Auxiliary Record	Claimant 4 First Name (Field 68)	No, but if entered or Claimant 4 Relationship is not equal to a space, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 68: <ul style="list-style-type: none"> is all spaces and Field 65 = "E," "F," or "O;" position 161 is not an alphabetic character when Field 65 = "E," "F," or "O;" or is not space-filled when Field 65 = a space
CC65	Claim Input File Auxiliary Record	Claimant 4 Middle Initial (Field 69)	No but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 69: <ul style="list-style-type: none"> does not a space when Field 65 = a space <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC66	Claim Input File Auxiliary Record	Claimant 4 Mailing Address 1 (Field 71)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 71: <ul style="list-style-type: none"> • is not space-filled when Field 65 = a space; • is space filled when Field 65 does not equal a space; • is not space-filled when Field 74 = “FC;” or • contains an invalid character such as a parenthesis
CC67	Claim Input File Auxiliary Record	Claimant 4 Mailing Address 2 (Field 72)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 72: <ul style="list-style-type: none"> • is not space-filled when Field 65 = a space; • contains an invalid character such as a parenthesis; or • is not space-filled when Field 74 = “FC”
CC68	Claim Input File Auxiliary Record	Claimant 4 City (Field 73)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 73: <ul style="list-style-type: none"> • has numeric data; • is not space-filled when Field 65 = a space; • is space filled when Field 65 does not equal a space; • is not space-filled when Field 74 = “FC;” • contains an invalid character such as a parenthesis; or • contains data other than alphabetic, space comma, &—‘, @#;:
CC69	Claim Input File Auxiliary Record	Claimant 4 State (Field 74)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 74: <ul style="list-style-type: none"> • has numeric data; • is not space-filled when Field 65 = a space; or • is space-filled when Field 65 does not equal a space

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC70	Claim Input File Auxiliary Record	Claimant 4 Zip (Field 75)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 75: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 65 = a space; is not space-filled or zero-filled when Field 65 = a space; is not zero-filled when Field 74 = "FC;" or is space-filled when Field 65 does not equal a space
CC71	Claim Input File Auxiliary Record	Claimant 4 Zip+4 (Field 76)	No	See Claimant 2 Information section above for individual field description.	Field 76: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 65 = a space; or is not zero-filled when Field 74 = "FC" <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>
CC72	Claim Input File Auxiliary Record	Claimant 4 Phone (Field 77)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 77: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 65 = a space; is space-filled when Field 65 does not equal a space; is not zero-filled when Field 74 = "FC;" or contains a non-numeric character <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CC73	Claim Input File Auxiliary Record	Claimant 4 Phone Extension (Field 78)	No	See Claimant 2 Information section above for individual field description.	Field 78: <ul style="list-style-type: none"> • is not space-filled when Field 65 = a space; • is not space-filled when Field 74 = "FC;" or • contains an invalid character such as a parenthesis Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CC74	Claim Input File Auxiliary Record	Claimant 4 Entity / Organization Name (Field 70)	No, but if entered, it will be edited.	See Claimant 2 Information section above for individual field description.	Field 70: <ul style="list-style-type: none"> • is not space-filled when Field 65 = a space; • is space-filled when Field 65 is "X," "Y," or "Z;" or • contains an invalid character such as a parenthesis

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CI01	Claim Input File Detail Record	CMS Date of Incident (DOI):DOI as defined by CMS (Field 12)	Yes	<p>Date of Incident (DOI) <i>as defined by CMS:</i></p> <p>For an automobile wreck or other accident, the date of incident is the date of the accident.</p> <p>For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the <i>date of first exposure</i>.</p> <p>For claims involving ingestion (for example, a recalled drug), it is the <i>date of first ingestion</i>. For claims involving implants, it is the <i>date of the implant (or date of the first implant if there are multiple implants)</i>.</p> <p>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.</p> <p>Note: CMS’s 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.</p> <p>Must be numeric and a valid date prior to or equal to the current BCRC processing date. Field cannot contain spaces, alpha characters or all zeroes.</p>	<p>Field 12:</p> <ul style="list-style-type: none"> • contained non-numeric data; • was zero-filled; • was not a valid date formatted CCYYMMDD; or • was not prior to the current date

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CI02	Claim Input File Detail Record	Industry Date of Incident (DOI) (Field 13)	No	<p>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 <i>last</i> exposure, ingestion, or implantation.</p> <p>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.</p>	<p>Field 13:</p> <ul style="list-style-type: none"> • contained non-numeric data; • was not a valid date formatted CCYYMMDD; or • was not prior to the BCRC processing date; or • was not all zeroes if not used <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>
CI03	Claim Input File Detail Record	Alleged Cause of Injury, Incident, or Illness (Field 15)	No	<p>ICD-9-CM/ICD-10-CM External Cause of Injury Code "E Code" describing the alleged cause of injury/illness.</p> <p>Left justify. Do not include decimal point.</p>	<p>Field 15:</p> <ul style="list-style-type: none"> • included a decimal point; • was not left-justified; or • diagnosis code did not match a value on the list of valid ICD-9/ ICD-10 diagnosis codes <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CI03 (Cont)	Claim Input File Detail Record	Alleged Cause of Injury, Incident, or Illness (Field 15)	No	<p>See the NGHP User Guide Technical Information Chapter for complete information. ICD-9-CM diagnosis code must begin with the letter “E.” ICD-10-CM diagnosis code must begin with the letter “V,” “W,” “X,” or “Y.” Cannot report ICD-10 “Z” codes. These are excluded from Section 111 claim reports.</p> <p><i>Must NOT be on the list of Excluded ICD-9/ICD-10 Diagnosis Codes found on CMS.gov at https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists.</i></p> <p>Special default for liability reporting: If, and only if: 1) the ORM Indicator (Field 78) is N, the Plan Insurance Type (Field 51) 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 18.</p>	<p>Field 15:</p> <ul style="list-style-type: none"> included a decimal point; was not left-justified; or diagnosis code did not match a value on the list of valid ICD-9/ ICD-10 diagnosis codes <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CI04	Claim Input File Detail Record	State of Venue (Field 16)	Yes	<p>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</p> <p>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."</p> <p>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.</p> <p>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.</p>	<p>Field 16:</p> <ul style="list-style-type: none"> • does not equal "US" or "FC;" or • is not considered a valid US Postal state abbreviation

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CI05	Claim Input File Detail Record Detail Record	ICD Diagnosis Code 1 (Field 18)	Yes, if Action Type (Field 3) = 0 (Add) or if Action Type (Field 3) = 2 (Update)	ICD-9-CM or ICD-10-CM Diagnosis Code describing the alleged injury/illness. Special default for liability reporting: If, and only if: 1) the ORM Indicator (Field 78) is N, the Plan Insurance Type (Field 51) 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 18 then all remaining ICD Diagnosis Codes 2-19 must be filled with spaces.	Field 18: <ul style="list-style-type: none"> was space-filled (See the NGHP User Guide Technical Information Chapter for complete information.); <ul style="list-style-type: none"> ICD-9 began with the letter "V" or "E;" ICD-10 began with the letter "V," "W," "X," "Y," or "Z"; was not left-justified; included a decimal point; or was on the list of excluded ICD-9/ICD-10 Diagnosis Codes found on CMS.gov at https://www.cms.gov/mcdicare/coordination-benefits-recovery-overview/icd-code-lists
CI06	Claim Input File Detail Record	ICD Diagnosis Code 2 (Field 19)	No, unless multiple body parts are affected	See explanation for ICD Diagnosis Code 1 (Field 18). May include additional, valid ICD Diagnosis Code as specified in the requirements for Field 18.	See explanation for Error CI05.
CI07	Claim Input File Detail Record	ICD Diagnosis Code 3 (Field 20)	No, unless 3 or more body parts are affected	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	See explanation for Error CI05.
CI08	Claim Input File Detail Record	ICD Diagnosis Code 4 (Field 21)	No, unless 4 or more body parts are affected	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	See explanation for Error CI05.

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CI09	Claim Input File Detail Record	ICD Diagnosis Code 5 (Field 22)	No, unless 5 or more body parts are affected	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	See explanation for Error CI05.
CI10	Claim Input File Detail Record	ICD Diagnosis Code 6 (Field 23)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	See explanation for Error CI05.
CI11	Claim Input File Detail Record	ICD Diagnosis Code 7 (Field 24)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	See explanation for Error CI05.
CI12	Claim Input File Detail Record	ICD Diagnosis Code 8 (Field 25)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	See explanation for Error CI05.
CI13	Claim Input File Detail Record	ICD Diagnosis Code 9 (Field 26)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	See explanation for Error CI05.
CI14	Claim Input File Detail Record	ICD Diagnosis Code 10 (Field 27)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	See explanation for Error CI05.
CI15	Claim Input File Detail Record	ICD Diagnosis Code 11 (Field 28)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 28 was not a valid ICD Diagnosis Code per the field requirements.
CI16	Claim Input File Detail Record	ICD Diagnosis Code 12 (Field 29)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 29 was not a valid ICD Diagnosis Code per the field requirements.
CI17	Claim Input File Detail Record	ICD Diagnosis Code 13 (Field 30)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 30 was not a valid ICD Diagnosis Code per the field requirements.
CI18	Claim Input File Detail Record	ICD Diagnosis Code 14 (Field 31)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 31 was not a valid ICD Diagnosis Code per the field requirements.

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CI19	Claim Input File Detail Record	ICD Diagnosis Code 15 (Field 32)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 32 was not a valid ICD Diagnosis Code per the field requirements.
CI20	Claim Input File Detail Record	ICD Diagnosis Code 16 (Field 33)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 33 was not a valid ICD Diagnosis Code per the field requirements.
CI21	Claim Input File Detail Record	ICD Diagnosis Code 17 (Field 34)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 34 was not a valid ICD Diagnosis Code per the field requirements.
CI22	Claim Input File Detail Record	ICD Diagnosis Code 18 (Field 35)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 35 was not a valid ICD Diagnosis Code per the field requirements.
CI23	Claim Input File Detail Record	ICD Diagnosis Code 19 (Field 36)	No	See explanation for ICD Diagnosis Code 1 (Field 18). Provide if available/applicable.	Field 36 was not a valid ICD Diagnosis Code per the field requirements.
CI25	Claim Input File Detail Record	Alleged Cause of Injury, Incident, or Illness (Field 15)	No	See explanation for Alleged Cause of Injury, Incident, or Illness (Field 15)	Field 15 was not a valid Alleged Cause of Injury, Incident, or Illness Diagnosis Code per the field requirements, or The 'NOINJ' value was incorrectly submitted. When submitting the 'NOINJ' value, it must be submitted in Field 15 and Field 18 (ICD Diagnosis Code 1) and all other ICD Diagnosis Code fields must be blank. Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CI31	Claim Input File Detail Record	ICD Indicator (Field 17)	Yes	<p>Must be one of the following values:</p> <p>“0” – ICD-10-CM diagnosis codes</p> <p>“9” – ICD-9-CM diagnosis codes</p> <p>Space – ICD-9-CM diagnosis codes</p> <p>* Note: Claims submitted with a CMS DOI on or after October 1, 2015 that contain an ICD indicator of “9” or space will be rejected with a CI31 error.</p>	Field 17 did not equal “0,” “0” or Space.
CJ01	Claim Input File Detail Record	ORM Indicator (Field 78)	Yes	<p>Indication of whether there is ongoing responsibility for medicals (ORM). Fill with Y if there is ongoing responsibility for medicals. Valid values: Y – Yes, N – No.</p> <p>The Y value remains in this field even when an ORM Termination Date (Field 779) is submitted in this same record or a subsequent record.</p>	Field 78 contains a value other than a “Y” or “N.”

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CJ02	Claim Input File Detail Record	ORM Termination Date (Field 79)	No	<p>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. Format: CCYYMMDD</p> <p>ORM Termination Date is not applicable if claimant retains the ability to submit/apply for payment for additional medicals related to the claim. See the NGHP User Guide Technical Information Chapter IV (Sections 6.7 and 6.8) for information concerning exceptions regarding reporting ORM.</p> <p>When an ORM termination date is submitted, the ORM indicator in Field 78 must remain as "Y."</p> <p>Fill with zeroes if ORM Indicator = "N" or if a date for the termination of ORM has not been established.</p>	<p>Field 79:</p> <ul style="list-style-type: none"> • has non-numeric data or spaces; • is not zero-filled when Field 78 is N • ORM Indicator = "N" (Field 78) and ORM Termination Date (Field 79) provided (Add records); or • ORM Indicator = "Y" and ORM Termination Date is blank (the ORM Term Date must = 0 or a valid date) (Update records).

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CJ03	Claim Input File Detail Record	TPOC Date 1 (Field 80)	Yes, if ORM Indicator = N And TPOC Amount 1 is submitted	<p>Date of associated Total Payment Obligation to the Claimant (TPOC) without regard to <u>ongoing</u> responsibility for medicals (ORM).</p> <p>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.</p> <p>Format: CCYYMMDD</p> <p>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.</p> <p>Required for all other claim reports.</p> <p>Use the TPOC fields on the Auxiliary Record to report additional, separate TPOCs as required.</p>	<p>Field 80:</p> <ul style="list-style-type: none"> • has non-numeric data or spaces; • has a future date; • date submitted is less than or equal to the submitted CMS Date of Incident (Field 12); • date submitted is greater than the file submission date; • is not all zeros when Field 81 is all zeros; or • is all zeros when Field 81 is not all zeroes.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CJ04	Claim Input File Detail Record	TPOC Amount 1 (Field 81)	Yes, if ORM Indicator = N And TPOC Amount 1 is submitted	<p>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.</p> <p>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. (cont.)</p>	<p>Field 81:</p> <ul style="list-style-type: none"> • has non-numeric data or spaces; • is not all zeros when Field 80 is all zeros; or • is all zeros when Field 80 has a non-zero value

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CJ04 (cont.)	Claim Input File Detail Record	TPOC Amount 1 (Field 81)	Yes, if ORM Indicator = N And TPOC Amount 1 is submitted	<i>Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as "00001000000."</i> 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. Use the TPOC fields on the Auxiliary Record to report additional, separate TPOCs as required.	Field 81: <ul style="list-style-type: none"> • has non-numeric data or spaces; • is not all zeros when Field 80 is all zeros; or • is all zeros when Field 80 has a non-zero value
CJ05	Claim Input File Detail Record	Funding Delayed Beyond TPOC Start Date 1 (Field 82)	No	If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed. Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).	Field 82: <ul style="list-style-type: none"> • has non-numeric data or spaces; • was not submitted with all zeroes if not used; or • was not a valid date (formatted CCYYMMD)
CJ06	Claim Input File Detail Record	ORM Termination Date (Field 79)	No	See Field 79 description in the Claim Input File Detail Record.	Submitted ORM Termination Date (Field 79) is more than 75 years from the current date.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CJ07	Claim Input File Detail Record	TPOC Threshold	N/A	N/A	Add or Update Record: ORM Indicator = “N” and the cumulative total of all submitted TPOC Amounts is zero.
CP01	Claim Input File Detail Record	Plan Insurance Type (Field 51)	Yes	<p>Type of insurance coverage or line of business provided by the plan policy or self-insurance.</p> <p>Valid values: D=No-Fault E=Workers’ Compensation L = Liability</p> <p><i>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.</i></p> <p>“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.”</p>	Field 51 does not equal: “D,” “E,” or “L”

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CP02	Claim Input File Detail Record	TIN (Field 52)	Yes	<p>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.</p> <p>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.</p> <p>In the case of a foreign RRE without a valid IRS-assigned TIN, supply the pseudo-TIN created during Section 111 registration.</p> <p>Must have a corresponding entry with associated Office Code/Site ID on the TIN Reference File.</p>	<p>Field 52:</p> <ul style="list-style-type: none"> has non-numeric data.
CP03	Claim Input File Detail Record	Office Code/Site ID (Field 53)	No	<p>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.</p> <p>If only one address will be used per reported TIN, leave blank.</p> <p>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.</p>	<p>Field 53:</p> <ul style="list-style-type: none"> has letters or special characters; was not space-filled if not used; or was not right-justified and padded on the left with zeroes
CP04	Claim Input File Detail Record	Policy Number (Field 54)	Yes	<p>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 0s if you do not have or maintain a specific number reference.</p>	<p>Field 54:</p> <ul style="list-style-type: none"> was space-filled; or positions 1001-1003 were not submitted with data

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CP05	Claim Input File Detail Record	Claim Number (Field 55)	Yes	The unique claim identifier by which the primary plan identifies the claim. If liability self-insurance or workers' compensation self-insurance, fill with 0s if you do not have or maintain a claim number reference.	Field 55: <ul style="list-style-type: none"> was space-filled; or submitted data was not left-justified
CP06	Claim Input File Detail Record	Plan Contact Department Name (Field 56)	No	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.	Field 56: <ul style="list-style-type: none"> was not left-justified; or; was not space-filled if not used Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CP07	Claim Input File Detail Record	Plan Contact Last Name (Field 57)	No	Surname 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.	Field 57: <ul style="list-style-type: none"> position 1131 was not an alphabetic character when the rest of the field had data; was zero-filled; or contained data other than a letter, hyphen, apostrophe or space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CP08	Claim Input File Detail Record	Plan Contact First Name (Field 58)	No	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.	Field 58: <ul style="list-style-type: none"> position 1171 was not an alphabetic character when the remainder of the field had data; was zero-filled; or contained data other than letters or spaces Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CP09	Claim Input File Detail Record	Plan Contact Phone (Field 59)	No	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).	Field 59: <ul style="list-style-type: none"> has non-numeric data; was space-filled; or did not contain 10 numbers Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CP10	Claim Input File Detail Record	Plan Contact Phone Extension (Field 60)	No	Telephone extension number of individual that should be contacted at the Plan for claim-related communication.	Field 60: <ul style="list-style-type: none"> was not left-justified; contain parenthesis; position 1211 was a space, but other positions had data; or was not space-filled if not used Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CP11	Claim Input File Detail Record	No-Fault Insurance Limit (Field 61)	Yes if Plan Insurance Type (Field 51) = D	Dollar amount of limit on no-fault insurance. Specify dollars and cents with implied decimal. No formatting (no \$ or , or .) For example, a limit of \$10,500.00 should be coded as 00001050000. Note: the last two positions reflect cents. For example, an amount of 500 dollars and no cents must be submitted as "00000050000."	Field 61: <ul style="list-style-type: none"> has non-numeric data; was space-filled; was not filled all 9s when Field 51 = "D;" and Field 61 was not applicable; was zero-filled when Field 51 = "D;" or was not zero-filled when Field 51 = "E" or "L"
CP12	Claim Input File Detail Record	Exhaust Date for No-Fault Insurance Limit (Field 62)	Yes, if Plan Insurance Type (Field 51) = D and the Exhaust Date for No-Fault Insurance Limit has been reached	Date on which limit was reached or benefits exhausted for No-Fault Insurance Limit (Field 61). Format: CCYYMMDD If Plan Insurance Type (Field 51) 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 79).	Field 62: <ul style="list-style-type: none"> has non-numeric data; was space-filled; did not contain a valid date or all zeros; or was not zero-filled when Field 51 is "E" or "L"
CP13	Claim Input File Detail Record	No Fault Insurance Limit (Field 61)	Yes if Plan Insurance Type (Field 51) = D	Dollar amount of limit on no-fault insurance. Specify dollars and cents with implied decimal. No formatting (no \$ or , or .) For example, a limit of \$10,500.00 should be coded as 00001050000. Note: the last two positions reflect cents. For example, an amount of 500 dollars and no cents must be submitted as "00000050000."	Field 61: Dollar amount of No-Fault Insurance Limit (Field 61) is less than \$500.00. Error will not cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR01	Claim Input File Detail Record	Injured Party Representative Indicator (Field 64)	Yes, if the Injured Party has a representative.	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.	Field 64 does not equal “A,” “G,” “P,” “O,” or space
CR02	Claim Input File Detail Record	Representative Last Name (Field 65)	Yes, if Field 64 does not equal a space and Field 65 is space-filled	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.	Field 65: <ul style="list-style-type: none"> was not left-justified; position 1256 was not an alphabetic character; was zero-filled; or was not space filled when Field 64 = a space
CR03	Claim Input File Detail Record	Representative First Name (Field 66)	Yes, if Field 64 does not equal a space and Field 66 is space-filled	Given or first name of representative. Either Representative Last Name and First Name – or – Representative Firm Name is required if Injured Party has a representative.	Field 66: <ul style="list-style-type: none"> was not left-justified; position 1296 was not an alphabetic character; contained data other than letters or spaces; or was not space filled when Field 64 = a space
CR04	Claim Input File Detail Record	Representative Firm Name (Field 67)	Yes, if Field 64 does not equal a space and Fields 65 & 66 are space-filled	Representative’s firm name.	Field 67: <ul style="list-style-type: none"> was not space filled when Field 64 = a space; is not space-filled, but positions 1326 and 1327 are not alphanumeric characters; was not submitted when field 64 does not equal a space and field 64 and 66 were space-filled; or If supplied, it is not at least 2 alphanumeric characters.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR05	Claim Input File Detail Record	Representative TIN (Field 68)	No	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). If no Representative TIN is available, fill with spaces or all zeroes.	Field 68: <ul style="list-style-type: none"> has data other than numbers or spaces; or was not space-filled or zero-filled when Field 64 was a space
CR06	Claim Input File Detail Record	Representative Mailing Address Line 1 (Field 69)	Yes, if Field 64 does not equal a space	First line of the mailing address for the representative. 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.	Field 69: <ul style="list-style-type: none"> is not space-filled when Field 72 = "FC;" is not space filled when Field 64 = a space; or contains special characters other than , &—' . @ # / ; ;
CR07	Claim Input File Detail Record	Representative Mailing Address Line 2 (Field 70)	No	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.	Field 70: <ul style="list-style-type: none"> is not space-filled when Field 72 = "FC;" is not space filled when Field 64 = a space; or contains special characters other than , &—' . @ # / ; ;
CR08	Claim Input File Detail Record	Representative City (Field 71)	Yes, if Field 64 does not equal a space	If no US address is available, fill with spaces and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 71: <ul style="list-style-type: none"> is not space-filled when Field 72 = "FC;" is not space filled when Field 64 = a space; contains numeric data; or contains special characters other than , &—' . @ # / ; ;

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR09	Claim Input File Detail Record	Representative State (Field 72)	Yes, if Field 64 does not equal a space	US Postal abbreviation State Code for the representative. 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.	Field 72: <ul style="list-style-type: none"> is not space filled when Field 64 = a space; or contains numeric data
CR10	Claim Input File Detail Record	Representative Mail Zip Code (Field 73)	Yes, if Field 64 does not equal a space	5-digit Zip Code for the representative. If no US address is available, fill with zeroes and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 73: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 72 = "FC;," contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 64 = a space
CR11	Claim Input File Detail Record	Representative Mail Zip+4 (Field 74)	No	4-digit Zip+4 Code for the representative. If not applicable or unknown, fill with zeroes (0000).	Field 74: <ul style="list-style-type: none"> is not zero-filled when Field 72 = "FC;," contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 64 = a space <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR12	Claim Input File Detail Record	Representative Phone (Field 75)	Yes, if Field 64 does not equal a space	Telephone number of the representative. 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.	Field 75: <ul style="list-style-type: none"> is not zero-filled when Field 72 = "FC;" contains a non-numeric character; or is not space-filled or zero-filled when Field 84 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR13	Claim Input File Detail Record	Representative Phone Extension (Field 76)	No	Telephone extension number of representative. Fill with all spaces if unknown or not applicable.	Field 76: <ul style="list-style-type: none"> is not space-filled when Field 64 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR14	Claim Input File Detail Record	Representative Name/Firm Name (Field 65 & 66 / 67)	Yes, if Field 64 does not equal a space	See the description for the Representative Fields 65-67.	Field 64 does not equal a space, but data is not submitted in both Field 65 & 66 or is not submitted in Field 67. Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR21	Claim Input File Detail Record	Claimant 1 Representative Indicator (Field 99)	Yes, if the claimant is not the injured party.	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 64 – 76 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.	Field 99: <ul style="list-style-type: none"> • does not equal “A,” “G,” “P,” “O,” or space; or; • was populated, but Field 84 was space-filled.
CR22	Claim Input File Detail Record	Claimant 1 Representative Last Name (Field 100)	Yes, if Claimant 1 Representative Indicator (Field 99) does not equal a space and Field 101 is all spaces	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.	Field 100: <ul style="list-style-type: none"> • was not left-justified; • position 1895 was not an alphabetic character; • was zero-filled; or • was not space filled when Field 99 = a space
CR23	Claim Input File Detail Record	Claimant 1 Representative First Name (Field 101)	Yes, if Claimant 1 Representative Indicator (Field 99) does not equal a space and Field 101 is all spaces	Given or first name of representative. Either Representative Last Name and First Name – or – Representative Firm Name is required if Injured Party has a representative.	Field 101: <ul style="list-style-type: none"> • was not left-justified; • if submitted, does not contain at least 2 characters; • position 1935 was not an alphabetic character; • contained data other than letters or spaces; or • was not space filled when Field 99 = a space
CR24	Claim Input File Detail Record	Claimant 1 Representative Firm Name (Field 102)	Yes, if Claimant 1 Representative Indicator (Field 99) does not equal a space and Field 100 and Field 101 are all spaces	Representative’s firm name.	Field 102: <ul style="list-style-type: none"> • was not space filled when Field 99 = a space; • is not space-filled, but positions 1965 and 1966 are not alphanumeric characters; or • was not submitted when field 99 does not equal a space and field 100 and 101 were space-filled

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR25	Claim Input File Detail Record	Claimant 1 Representative TIN (Field 103)	No	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). If no Representative TIN is available, fill with spaces or all zeroes.	Field 103: <ul style="list-style-type: none"> has data other than numbers or spaces; was not space-filled or zero-filled when Field 99 was a space; or equals the TIN supplied in Field 52 on the Claim Input File.
CR26	Claim Input File Detail Record	Claimant 1 Representative Mailing Address 1 (Field 104)	Yes, if Claimant 1 Representative Indicator (Field 99) does not equal a space	First line of the mailing address for the representative. 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.	Field 104: <ul style="list-style-type: none"> is not space-filled when Field 107 = "FC;" is not space filled when Field 99 = a space; if submitted, does not contain at least two alphanumeric characters; or contains special characters other than , &—' . @ # / ; ;
CR27	Claim Input File Detail Record	Claimant 1 Representative Mailing Address 2 (Field 105)	No	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.	Field 105: <ul style="list-style-type: none"> is not space-filled when Field 107 = "FC;" is not space filled when Field 99 = a space; if submitted, does not contain at least two alphanumeric characters; or contains special characters other than , &—' . @ # / ; ;
CR28	Claim Input File Detail Record	Claimant 1 Representative Mailing City (Field 106)	Yes, if Claimant 1 Representative Indicator (Field 99) does not equal a space	If no US address is available, fill with spaces and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 106: <ul style="list-style-type: none"> is not space-filled when Field 107 = "FC;" is not space filled when Field 99 = a space; contains numeric data; or contains special characters other than , &—' . @ # / ; ;

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR29	Claim Input File Detail Record	Claimant 1 Representative State (Field 107)	Yes, if Claimant 1 Representative Indicator (Field 99) does not equal a space	US Postal abbreviation State Code for the Claimant 1 representative. 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.	Field 107: <ul style="list-style-type: none"> is not space filled when Field 99 = a space; or contains numeric data
CR30	Claim Input File Detail Record	Claimant 1 Representative Zip (Field 108)	Yes, if Claimant 1 Representative Indicator (Field 99) does not equal a space	5-digit Zip Code for the Claimant 1 representative. If no US address is available, fill with zeroes and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 108: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 107 = "FC;" contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 64 = a space
CR31	Claim Input File Detail Record	Claimant 1 Representative Zip+4 (Field 109)	No	4-digit Zip+4 Code for the Claimant 1 representative. If not applicable or unknown, fill with zeroes (0000).	Field 109: <ul style="list-style-type: none"> is not zero-filled when Field 107 = "FC;" contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 99 = a space <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR32	Claim Input File Detail Record	Claimant 1 Representative Phone (Field 110)	Yes, if Claimant 1 Representative Indicator (Field 99) does not equal a space	Telephone number of the Claimant 1 representative. 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.	Field 110: <ul style="list-style-type: none"> is not zero-filled when Field 127 = "FC;" contains a non-numeric character; or is not space-filled or zero-filled when Field 99 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR33	Claim Input File Detail Record	Claimant 1 Representative Phone Extension (Field 111)	No	Telephone extension number of the Claimant 1 representative. Fill with all spaces if unknown or not applicable.	Field 111: <ul style="list-style-type: none"> is not space-filled when Field 64 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR34	Claim Input File Detail Record	Claimant 1 Representative Name / Firm Name (Field 100 & 101 / Field 102)	Yes	See description for Field 100, 101, & 102.	Field 99 does not equal a space, but data is not submitted in both Field 100 & 101 or is not submitted in Field 102. Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR41	Claim Input File Auxiliary Record	Claimant 2 Representative Indicator (Field 22)	Yes, if the claimant is not the injured party.	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 64 – 76 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.	Field 22: <ul style="list-style-type: none"> has a value other than “A,” “G,” “P,” “O,” or space; or; Field 7 was space-filled.
CR42	Claim Input File Auxiliary Record	Claimant 2 Representative Last Name (Field 23)	Yes, if Claimant 2 Representative Indicator (Field 22) does not equal a space and Field 25 is all spaces	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.	Field 23: <ul style="list-style-type: none"> was not left-justified; has data, but position 369 was not an alphabetic character; was zero-filled; or was not space filled when Field 22 = a space
CR43	Claim Input File Auxiliary Record	Claimant 2 Representative First Name (Field 24)	Yes, if Claimant 2 Representative Indicator (Field 22) does not equal a space and Field 25 is all spaces	Given or first name of representative. Either Representative Last Name and First Name – or – Representative Firm Name is required if Injured Party has a representative.	Field 24: <ul style="list-style-type: none"> was not left-justified; position 409 was not an alphabetic character; contained data other than letters or spaces; or was not space filled when Field 22 = a space
CR44	Claim Input File Auxiliary Record	Claimant 2 Representative Firm Name (Field 25)	Yes, if Claimant 2 Representative Indicator (Field 22) does not equal a space and Field 23 and Field 24 are all spaces.	Representative’s firm name.	Field 25: <ul style="list-style-type: none"> was not space filled when Field 22 = a space; is not space-filled, but positions 439 and 440 are not alphanumeric characters; or was not submitted when field 22 does not equal a space and field 23 and 24 were space-filled

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR45	Claim Input File Auxiliary Record	Claimant 2 Representative TIN (Field 26)	No	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). If no Representative TIN is available, fill with spaces or all zeroes.	Field 26: <ul style="list-style-type: none"> has data other than numbers or spaces; was not space-filled or zero-filled when Field 22 was a space; or equals the TIN submitted in Field 52 of Claim Input File.
CR46	Claim Input File Auxiliary Record	Claimant 2 Representative Mailing Address 1 (Field 27)	Yes, if Claimant 2 Representative Indicator (Field 22) does not equal a space	First line of the mailing address for the Claimant 2 representative. 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.	Field 27: <ul style="list-style-type: none"> is not space-filled when Field 30 = "FC;" is not space filled when Field 22 = a space; or contains special characters other than , &—' . @ # / ; ;
CR47	Claim Input File Auxiliary Record	Claimant 2 Representative Mailing Address 2 (Field 28)	No	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.	Field 28: <ul style="list-style-type: none"> is not space-filled when Field 30 = "FC;" is not space filled when Field 22 = a space; or contains special characters other than , &—' . @ # / ; ;
CR48	Claim Input File Auxiliary Record	Claimant 2 Representative City (Field 29)	Yes, if Claimant 2 Representative Indicator (Field 22) does not equal a space	If no US address is available, fill with spaces and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 29: <ul style="list-style-type: none"> is not space-filled when Field 30 = "FC;" is not space filled when Field 22 = a space; contains numeric data; or contains special characters other than , &—' . @ # / ; ;

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR49	Claim Input File Auxiliary Record	Claimant 2 Representative State (Field 30)	Yes, if Claimant 2 Representative Indicator (Field 22) does not equal a space	US Postal abbreviation State Code for the Claimant 2 representative. 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.	Field 30: <ul style="list-style-type: none"> is not space filled when Field 22 = a space; or contains numeric data
CR50	Claim Input File Auxiliary Record	Claimant 2 Representative Zip (Field 31)	Yes, if Claimant 2 Representative Indicator (Field 22) does not equal a space	5-digit Zip Code for the Claimant 2 representative. If no US address is available, fill with zeroes and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 31: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 30 = "FC;" contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 22 = a space
CR51	Claim Input File Auxiliary Record	Claimant 2 Representative Zip+4 (Field 32)	No	4-digit Zip+4 Code for the Claimant 2 representative. If not applicable or unknown, fill with zeroes (0000).	Field 32: <ul style="list-style-type: none"> is not zero-filled when Field 30 = "FC;" contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 22 = a space <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR52	Claim Input File Auxiliary Record	Claimant 2 Representative Phone (Field 33)	Yes, if Claimant 2 Representative Indicator (Field 22) does not equal a space	Telephone number of the Claimant 2 representative. 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.	Field 33: <ul style="list-style-type: none"> is not zero-filled when Field 30 = "FC;" contains a non-numeric character; or is not space-filled or zero-filled when Field 22 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR53	Claim Input File Auxiliary Record	Claimant 2 Representative Phone Extension (Field 34)	No	Telephone extension number of the Claimant 2 representative. Fill with all spaces if unknown or not applicable.	Field 34: <ul style="list-style-type: none"> is not space-filled when Field 22 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR54	Claim Input File Auxiliary Record	Claimant 2 Representative Name / Firm Name (Field 23,24 & Field 25)	Yes	See the description for the Claimant 2 Representative Fields 23-25.	Field 22 does not equal a space, but data is not submitted in both Field 23 & 24 or is not submitted in Field 25. <ul style="list-style-type: none"> Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR61	Claim Input File Auxiliary Record	Claimant 3 Representative Indicator (Field 51)	Yes, if the claimant is not the injured party.	See Claimant 2 Information section above for field definition.	Field 51: <ul style="list-style-type: none"> has a value other than "A," "G," "P," "O," or space; or; was populated, but Field 36 was space-filled.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR62	Claim Input File Auxiliary Record	Claimant 3 Representative Last Name (Field 52)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space and Field 54 is all spaces	See Claimant 2 Information section above for field definition.	Field 52: <ul style="list-style-type: none"> was not left-justified; position 1895 was not an alphabetic character; was zero-filled; or was not space filled when Field 51 = a space
CR63	Claim Input File Auxiliary Record	Claimant 3 Representative First Name (Field 53)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space and Field 54 is all spaces	See Claimant 2 Information section above for field definition.	Field 53: <ul style="list-style-type: none"> was not left-justified; position 1935 was not an alphabetic character; contained data other than letters or spaces; or was not space filled when Field 51 = a space
CR64	Claim Input File Auxiliary Record	Claimant 3 Representative Firm Name (Field 54)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space and Field 52 and Field 53 are all spaces.	See Claimant 2 Information section above for field definition.	Field 54: <ul style="list-style-type: none"> was not space filled when Field 51 = a space; is not space-filled, but positions 1965 and 1966 are not alphanumeric characters; or was not submitted when field 51 does not equal a space and field 52 and 53 were space-filled
CR65	Claim Input File Auxiliary Record	Claimant 3 Representative TIN (Field 55)	No	See Claimant 2 Information section above for field definition.	Field 55: <ul style="list-style-type: none"> was not space-filled or zero-filled when Field 51 was a space; or has data other than numbers or spaces; or equals the TIN supplied in Field 52 on the Claim Input File.
CR66	Claim Input File Auxiliary Record	Claimant 3 Representative Mailing Address 1 (Field 56)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space	See Claimant 2 Information section above for field definition.	Field 56: <ul style="list-style-type: none"> is not space-filled when Field 59 = "FC;" is not space filled when Field 51 = a space; or contains special characters other than , &—' . @ # / : ;

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR67	Claim Input File Auxiliary Record	Claimant 3 Representative Mailing Address 2 (Field 57)	No	See Claimant 2 Information section above for field definition.	Field 57: <ul style="list-style-type: none"> is not space-filled when Field 59 = "FC;" is not space filled when Field 51 = a space; or contains special characters other than , &—' . @ # / ;
CR68	Claim Input File Auxiliary Record	Claimant 3 Representative City (Field 58)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space	If no US address is available, fill with spaces and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 58: <ul style="list-style-type: none"> is not space-filled when Field 59 = "FC;" contains special characters other than , &—' . @ # / ; is not space filled when Field 51 = a space; or contains numeric data
CR69	Claim Input File Auxiliary Record	Claimant 3 Representative State (Field 59)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space	US Postal abbreviation State Code for the Claimant 3 representative. 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.	Field 59: <ul style="list-style-type: none"> is not space filled when Field 51 = a space; or contains numeric data
CR70	Claim Input File Auxiliary Record	Claimant 3 Representative Zip (Field 60)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space	5-digit Zip Code for the Claimant 3 representative. If no US address is available, fill with zeroes and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 60: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 59 = "FC;" contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 51 = a space.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR71	Claim Input File Auxiliary Record	Claimant 3 Representative Zip+4 (Field 61)	No	4-digit Zip+4 Code for the Claimant 3 representative. If not applicable or unknown, fill with zeroes (0000).	Field 61: <ul style="list-style-type: none"> is not zero-filled when Field 59 = "FC;" contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 51 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR72	Claim Input File Auxiliary Record	Claimant 3 Representative Phone (Field 62)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space	Telephone number of the Claimant 3 representative. 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.	Field 62: <ul style="list-style-type: none"> is not zero-filled when Field 59 = "FC;" contains a non-numeric character; or is not space-filled or zero-filled when Field 51 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR73	Claim Input File Auxiliary Record	Claimant 3 Representative Phone Extension (Field 63)	No	Telephone extension number of the Claimant 3 representative. Fill with all spaces if unknown or not applicable.	Field 63: <ul style="list-style-type: none"> is not space-filled when Field 51 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR74	Claim Input File Auxiliary Record	Claimant 3 Representative Name / Firm Name (Fields 52, 53 & 54)	Yes, if Claimant 3 Representative Indicator (Field 51) does not equal a space	See the description for Claimant 3 Fields 52, 53 & 54.	Field 51 does not equal a space, but data is not submitted in both Field 52 & 53 or is not submitted in Field 54. Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR81	Claim Input File Auxiliary Record	Claimant 4 Representative Indicator (Field 80)	Yes, if the claimant is not the injured party.	See Claimant 2 Information section above for field definition.	Field 80: <ul style="list-style-type: none"> • has a value other than “A,” “G,” “P,” “O,” or space; or; • was populated, but Field 65 was space-filled.
CR82	Claim Input File Auxiliary Record	Claimant 4 Representative Last Name (Field 81)	Yes, if Claimant 4 Representative Indicator (Field 80) does not equal a space and Field 83 is all spaces	See Claimant 2 Information section above for field definition.	Field 81: <ul style="list-style-type: none"> • was not left-justified; • position 1895 was not an alphabetic character; • was zero-filled; or • was not space filled when Field 80 = a space
CR83	Claim Input File Auxiliary Record	Claimant 4 Representative First Name (Field 82)	Yes, if Claimant 4 Representative Indicator (Field 80) does not equal a space and Field 83 is all spaces	See Claimant 2 Information section above for field definition.	Field 82: <ul style="list-style-type: none"> • was not left-justified; • position 1935 was not an alphabetic character; • contained data other than letters or spaces; or • was not space filled when Field 80 = a space

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR84	Claim Input File Auxiliary Record	Claimant 4 Representative Firm Name (Field 83)	Yes, if Claimant 4 Representative Indicator (Field 80) does not equal a space and Field 81 and Field 82 are all spaces.	See Claimant 2 Information section above for field definition.	Field 83: <ul style="list-style-type: none"> was not space filled when Field 80 = a space; is not space-filled, but positions 1965 and 1966 are not alphanumeric characters; or was not submitted when field 80 does not equal a space and field 81 and 82 were space-filled
CR85	Claim Input File Auxiliary Record	Claimant 4 Representative TIN (Field 84)	No	See Claimant 2 Information section above for field definition.	Field 84: <ul style="list-style-type: none"> has data other than numbers or spaces; or was not space-filled or zero-filled when Field 80 was a space; or equals the TIN supplied in Field 52 on the Claim Input File.
CR86	Claim Input File Auxiliary Record	Claimant 4 Representative Mailing Address 1 (Field 85)	Yes, if Claimant 4 Representative Indicator (Field 80) does not equal a space	See Claimant 2 Information section above for field definition.	Field 85: <ul style="list-style-type: none"> is not space-filled when Field 59 = "FC;" is not space filled when Field 51 = a space; or contains special characters other than , &—' . @ # / ; ;
CR87	Claim Input File Auxiliary Record	Claimant 4 Representative Mailing Address 2 (Field 86)	No	See Claimant 2 Information section above for field definition.	Field 86: <ul style="list-style-type: none"> is not space-filled when Field 88 = "FC;" is not space filled when Field 80 = a space; or contains special characters other than , &—' . @ # / ; ;
CR88	Claim Input File Auxiliary Record	Claimant 4 Representative City (Field 87)	Yes, if Claimant 4 Representative Indicator (Field 80) does not equal a space	If no US address is available, fill with spaces and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 87: <ul style="list-style-type: none"> is not space-filled when Field 88 = "FC;" is not space filled when Field 80 = a space; contains numeric data; or contains special characters other than , &—' . @ # / ; ;

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR89	Claim Input File Auxiliary Record	Claimant 4 Representative State (Field 88)	Yes, if Claimant 4 Representative Indicator (Field 80) does not equal a space	US Postal abbreviation State Code for the Claimant 4 representative. 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.	Field 88: <ul style="list-style-type: none"> is not space filled when Field 80 = a space; or contains numeric data
CR90	Claim Input File Auxiliary Record	Claimant 4 Representative Zip (Field 89)	Yes, if Claimant 4 Representative Indicator (Field 80) does not equal a space	5-digit Zip Code for the Claimant 4 representative. If no US address is available, fill with zeroes and supply "FC" in the corresponding State Code. Required if Injured Party has a representative.	Field 89: <ul style="list-style-type: none"> is not space-filled or zero-filled when Field 88 = "FC;" contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 80 = a space
CR91	Claim Input File Auxiliary Record	Claimant 4 Representative Zip+4 (Field 90)	No	4-digit Zip+4 Code for the Claimant 4 representative. If not applicable or unknown, fill with zeroes (0000).	Field 90: <ul style="list-style-type: none"> is not zero-filled when Field 88 = "FC;" contains non-numeric data or spaces; or is not space-filled or zero-filled when Field 80 = a space <p>Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.</p>

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CR92	Claim Input File Auxiliary Record	Claimant 4 Representative Phone (Field 91)	Yes, if Claimant 4 Representative Indicator (Field 80) does not equal a space	Telephone number of the Claimant 4 representative. 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.	Field 91: <ul style="list-style-type: none"> is not zero-filled when Field 88 = "FC;" contains a non-numeric character; or is not space-filled or zero-filled when Field 80 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR93	Claim Input File Auxiliary Record	Claimant 4 Representative Phone Extension (Field 92)	No	Telephone extension number of the Claimant 4 representative. Fill with all spaces if unknown or not applicable.	Field 92: <ul style="list-style-type: none"> is not space-filled when Field 80 = a space Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
CR94	Claim Input File Auxiliary Record	Claimant 4 Representative Name / Firm Name (Field 81, 82 & 83)	Yes	See Field 81, 82, & 83 of the Claim Input File Auxiliary Record.	Field 80 does not equal a space, but data is not submitted in both Field 81 & 82 or is not submitted in Field 83. <ul style="list-style-type: none"> Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CS01	Claim Input File Detail Record	Self-Insured Indicator (Field 44)	Yes	<p>Indication of whether the reportable event involves self-insurance <u>as defined by CMS</u>. Valid values: Y = Yes N = No</p> <p>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 I. You must use this definition of self-insurance for purposes of this reporting.</p> <p>Used by CMS if Plan Insurance Type (Field 51) 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.</p>	<p>Field 44:</p> <ul style="list-style-type: none"> • does not equal “Y” or N when Field 51 is “E” or “L;” • does not equal “N” or space when Field 51 is “D;” or • does not equal “Y,” “N” or space
CS02	Claim Input File Detail Record	Self-Insured Type (Field 45)	Yes	<p>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</p>	<p>Field 45:</p> <ul style="list-style-type: none"> • does not equal “I,” or “O” when Field 44 = “Y;” • does not equal a space when Field 44 is “N” or a space; or • does not equal “I,” “O,” or space
CS03	Claim Input File Detail Record	Policyholder Last Name (Field 46)	Yes, if Self-Insured Type (Field 45) = “I”	Surname of policyholder or self-insured individual.	<p>Field 46:</p> <ul style="list-style-type: none"> • was not space-filled when Field 45 did not equal “I;” • Position (752) did not equal a letter when Field 45 has an “I;” • contained numeric data; or • contained data other than hyphens, apostrophes and spaces

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CS04	Claim Input File Detail Record	Policyholder First Name (Field 47)	Yes, if Self-Insured Type (Field 45) = "I"	Given/First name of policyholder or self-insured individual.	Field 47: <ul style="list-style-type: none"> position (792) did not equal a letter when Field 45 was submitted as an "I;" was not space-filled when Field 45 was "I;" or contained data other than letters or spaces
CS05	Claim Input File Detail Record	DBA Name (Field 48)	Yes, if Self-Insured Type (Field 45) = "O" and Legal Name (Field 49) = spaces	"Doing Business As" Name of self-insured organization/business.	Field 48: <ul style="list-style-type: none"> positions 822-823 were not submitted with data when Field 45 is "O" and Field 49 was space-filled; or was not space-filled when Field 45 = "I" or a space
CS06	Claim Input File Detail Record	Legal Name (Field 49)	Yes, if Self-Insured Type (Field 45) = "O" and DBA Name (Field 48) = spaces	Legal Name of self-insured organization/business. DBA Name or Legal Name is required for Self-Insured Type = "O."	Field 49: <ul style="list-style-type: none"> positions 892-893 were not submitted with data when Field 45 was "O" and Field 48 was space-filled; or was not space-filled when Field 45 = "I" or a space
CS07	Claim Input File Detail Record	DBA Name (Field 48) / Legal Name (Field 49)	Yes, either Field 48 or Field 49 must be submitted if the Self-Insured Type (Field 45) = "O"	See Field 48 and Field 49 of the Claim Input File Detail Record.	Field 48 and Field 49 were space-filled when Field 45 = "O."

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CT01	Claim Input File Auxiliary Record	TPOC Date 2 (Field 93)	Yes, if ORM Indicator = N and TPOC Amount 2 is submitted	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.	Field 93: <ul style="list-style-type: none"> has non-numeric data or spaces; has a future date; date submitted is less than or equal to the submitted CMS Date of Incident (Field 12); date submitted is greater than the file submission date; is not all zeros when Field 94 is all zeros; or is all zeros when Field 94 is not all zeroes
CT02	Claim Input File Auxiliary Record	TPOC Amount 2 (Field 94)	Yes, if ORM Indicator = N and TPOC Date 2 is submitted	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."	Field 94: <ul style="list-style-type: none"> has non-numeric data or spaces; is not all zeros when Field 100 is all zeros; or is all zeros when Field 100 has a non-zero value
CT03	Claim Input File Auxiliary Record	Funding Delayed Beyond TPOC Start Date 2 (Field 95)	No	If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed. Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).	Field 95: <ul style="list-style-type: none"> has non-numeric data or spaces; or was not submitted with all zeroes if not used); or was not a valid date (formatted CCYYMMDD)

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CT11	Claim Input File Auxiliary Record	TPOC Date 3 (Field 96)	Yes, if ORM Indicator = N and TPOC Amount 3 is submitted	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.	Field 96: <ul style="list-style-type: none"> has non-numeric data or spaces; has a future date; date submitted is less than or equal to the submitted CMS Date of Incident (Field 12); date submitted is greater than the file submission date; is not all zeros when Field 97 is all zeros; or is all zeros when Field 97 is not all zeroes
CT12	Claim Input File Auxiliary Record	TPOC Amount 3 (Field 97)	Yes, if ORM Indicator = N and TPOC Date 3 is submitted	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 “0000100000.” 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.	Field 97: <ul style="list-style-type: none"> has non-numeric data or spaces; is not all zeros when Field 96 is all zeros; or is all zeros when Field 96 has a non-zero value
CT13	Claim Input File Auxiliary Record	Funding Delayed Beyond TPOC Start Date 3 (Field 98)	No	If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed. Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).	Field 98: <ul style="list-style-type: none"> has non-numeric data or spaces; was not submitted with all zeroes if not used); or was not a valid date (formatted CCYYMMDD)

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CT21	Claim Input File Auxiliary Record	TPOC Date 4 (Field 99)	Yes, if ORM Indicator = N and TPOC Amount 4 is submitted	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.	Field 99: <ul style="list-style-type: none"> has non-numeric data or spaces; has a future date; date submitted is less than or equal to the submitted CMS Date of Incident (Field 12); date submitted is greater than the file submission date; is not all zeros when Field 100 is all zeros; or is all zeros when Field 100 is not all zeroes
CT22	Claim Input File Auxiliary Record	TPOC Amount 4 (Field 100)	Yes, if ORM Indicator = N and TPOC Date 4 is submitted	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 “0000100000.”	Field 100: <ul style="list-style-type: none"> has non-numeric data or spaces; is not all zeros when Field 99 is all zeros; or is all zeros when Field 99 has a non-zero value
CT23	Claim Input File Auxiliary Record	Funding Delayed Beyond TPOC Start Date 4 (Field 101)	No	If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed. Also see “Timeliness” of reporting in the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1).	Field 101: <ul style="list-style-type: none"> has non-numeric data or spaces; was not submitted with all zeroes if not used); or was not a valid date (formatted CCYYMMD)

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
CT31	Claim Input File Auxiliary Record	TPOC Date 5 (Field 102)	Yes, if ORM Indicator = N and TPOC Amount 5 is submitted	<p>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.</p> <p>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.</p> <p>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.</p>	<p>Field 102:</p> <ul style="list-style-type: none"> • has non-numeric data or spaces; • is not all zeros when Field 103 is all zeros; or • is all zeros when Field 103 has a non-zero value
CT32	Claim Input File Auxiliary Record	TPOC Amount 5 (Field 103)	Yes, if ORM Indicator = N and TPOC Date 5 is submitted	<p>Fifth (additional) Total Payment Obligation to the Claimant (TPOC) amount</p> <p>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.</p> <p>Note: the last two positions reflect cents. For example, an amount of 10,000 dollars and no cents must be submitted as “0000100000.”</p> <p>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.</p>	<p>Field 103:</p> <ul style="list-style-type: none"> • has non-numeric data or spaces; • is not all zeros when Field 102 is all zeros; or • is all zeros when Field 102 has a non-zero value

Error	Record	Field Name	Field	Record Layout Field	Possible Cause
CT33	Claim Input File Auxiliary Record	Funding Delayed Beyond TPOC Start Date 5 (Field 104)	No	If the TPOC was funded or disbursed after the settlement date (in TPOC Date field), provide date when the TPOC was funded or disbursed. Also see the NGHP User Guide Policy Guidance Chapter III (Section 6.5.1.2 - Timeliness of Reporting).	Field 104: <ul style="list-style-type: none"> has non-numeric data or spaces; was not submitted with all zeroes if not used); or was not a valid date (formatted CCYYMMDD)
SP31	Claim Input File Auxiliary Record	Action Type (Field 3)	Yes	Please see Field 3 in the Claim Input File Detail Record.	Record submitted with effective date greater than 90 days prior to Medicare entitlement. Injured Party matched to a Medicare beneficiary. No correction necessary by the RRE. Resubmit record in next quarterly file submission.
SP47 SP48 SP49	Claim Input File Detail Record	Action Type (Field 3)	Yes	Please see Field 3 in the Claim Input File Detail Record	No previously accepted record can be matched to the submitted delete. Delete failed.
SP50	Claim Input File Detail Record	Action Type (Field 3)	Yes	Please see Field 3 in the Claim Input File Detail Record	Transaction attempted to add/update/delete an ORM record locked by the BCRC. No changes are accepted via Section 111 reporting. Do NOT attempt to resubmit this record. See the NGHP User Guide Technical Information Chapter IV (Section 7.2).
SP55	Claim Input File Detail Record	Action Type (Field 3)	Yes	Please see Field 3 in the Claim Input File Detail Record	MSP Effective Date is less than the earliest beneficiary Part A or Part B Entitlement Date. MSP can only occur after the beneficiary becomes entitled to Medicare Part A or Medicare Part B. An MSP Effective Date that is an invalid date will also cause an SP55 error. No correction necessary - resubmit records with this error on your next file submission.

Error Code	Record	Field Name (Field No.)	Field Required	Record Layout Field Description	Possible Cause
TN99	Claim Input File Detail Record	TIN/Office Code (Field 52 & 53)	TIN (Field 52) is required	Please see Field 52 and Field 53 in the Claim Input File Detail Record	No matching, valid TIN Reference File Detail Record was found for the TIN/Office Code combination on the Claim Input File Detail Record. Review errors returned on the TIN Reference Response File. Resubmit corrected TIN Reference File record and/or Claim Input File record.

TIN Reference Response Error Code Resolution Table

Table G-5: TIN Reference Response Error Code Resolution Table

Error Code	Record	Field Name (Field Number)	Field Required	Record Layout Field Description	Possible Cause
TN01	TIN Reference File Detail Record	TIN (Field 3)	Yes	Invalid RRE TIN. TIN cannot be validated by the BCRC. If RRE ID is associated with a foreign entity with no TIN, must be formatted as 9999xxxx where "xxxx" is an RRE-defined number. 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.	Field 3: <ul style="list-style-type: none"> has non-numeric data or spaces; was not submitted with 9 digits; or TIN was not a valid, IRS-assigned TIN
TN02	TIN Reference File Detail Record	Office Code/Site ID (Field 4)	No	Invalid Office Code/Site ID. Must be equal to spaces or must be a 9-digit numeric code.	Field 4: <ul style="list-style-type: none"> was not submitted with 9 digits; or was not submitted with all spaces (if not used)
TN03	TIN Reference File Detail Record	TIN/Office Code Mailing Name (Field 5)	Yes	Invalid TIN/Office Code Name 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.	Field 5: <ul style="list-style-type: none"> has all spaces; was only submitted with one character; positions 70 & 71 were submitted as spaces; or has the names or special characters listed in the description for this error
TN04	TIN Reference File Detail Record	TIN/Office Code Mailing Address Line 1 (Field 6)	Yes	Invalid TIN/Office Code Mailing Address Line 1.	Field 6: <ul style="list-style-type: none"> is not space-filled when Field 9 = "FC;" is space-filled when Field 92 does not equal "FC;" or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote

Error Code	Record	Field Name (Field Number)	Field Required	Record Layout Field Description	Possible Cause
TN05	TIN Reference File Detail Record	TIN/Office Code Mailing Address Line 2 (Field 7)	No	Invalid TIN/Office Code Mailing Address Line 2.	Field 7: <ul style="list-style-type: none"> is not space-filled when Field 9 = "FC;" or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote
TN06	TIN Reference File Detail Record	TIN/Office Code City (Field 8)	Yes	Invalid TIN/Office Code City.	Field 8: <ul style="list-style-type: none"> is not space-filled when Field 9 = "FC;" or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote
TN07	TIN Reference File Detail Record	TIN/Office Code State (Field 9)	Yes	Invalid TIN/Office Code State.	Field 9: does not equal "FC" or a valid US postal state code
TN08	TIN Reference File Detail Record	TIN/Office Code Zip (Field 10)	Yes	Invalid TIN/Office Code Zip.	Field 10: <ul style="list-style-type: none"> is not 5 numeric digits when Field 9 does not equal "FC;" or is not all zeros or all spaces when Field 9 = "FC"
TN09	TIN Reference File Detail Record	TIN/Office Code Zip+4 (Field 11)	Yes	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."	Field 11: <ul style="list-style-type: none"> is not 4 numeric digits when Field 9 does not equal "FC;" or is not all zeros or all spaces when Field 9 = "FC"
TN10 – TN16	TIN Reference File Detail Record	N/A	N/A	N/A	N/A. These error codes are not currently used.
TN17	TIN Reference File Detail Record	Foreign RRE Address Line 1—4 (Fields 12, 13, 14, 15)	Yes	See the description for the TIN Reference File Detail Record (Fields 12-15).	Fields 12-15: <ul style="list-style-type: none"> are not space-filled when Field 9 does not equal "FC;" or are not submitted when Field 9 = "FC"

Error Code	Record	Field Name (Field Number)	Field Required	Record Layout Field Description	Possible Cause
TN18	TIN Reference File Detail Record	(Fields 6–11)	Yes, as applicable	See the description for the TIN Reference File Detail Record (Fields 6-11).	Fields 6-11: address was insufficient to determine a match to the postal database.
TN19	TIN Reference File Detail Record	(Fields 6–11)	Yes, as applicable	See the description for the TIN Reference File Detail Record (Fields 6-11).	Fields 6-11: address matches an undeliverable address
TN20	TIN Reference File Detail Record	(Fields 6–11)	Yes, as applicable	See the description for the TIN Reference File Detail Record (Fields 6-11).	Fields 6-11: apartment number was not found in the postal database or was not supplied for an address that requires apartment number
TN21	TIN Reference File Detail Record	(Fields 6–11)	Yes, as applicable	See the description for the TIN Reference File Detail Record (Fields 6-11).	Fields 6-11: house or box number was not found on the street
TN22	TIN Reference File Detail Record	(Fields 6–11)	Yes, as applicable	See the description for the TIN Reference File Detail Record (Fields 6-11).	Fields 6-11: street name not found in the postal database for the submitted ZIP code
TN23	TIN Reference File Detail Record	(Fields 6–11)	Yes, as applicable	See the description for the TIN Reference File Detail Record (Fields 6-11).	Fields 6-11: ZIP code not found in the postal database
TN24	TIN Reference Response File	Recovery Agent Mailing Name (Field 16)	No	Name to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces. If recovery agent name is entered, this field must contain at least two characters. Limit field to no more than eight separate words in the first 40 characters for best results.	Field 16: <ul style="list-style-type: none"> • does not contain at least 2 characters • one or both of the first 2 characters are blank • contains special characters other than space, comma, period, ampersand, dash, @, #, /, semicolon, colon, period, or single quote (').

Error Code	Record	Field Name (Field Number)	Field Required	Record Layout Field Description	Possible Cause
TN25	TIN Reference Response File	Recovery Agent Mailing Address Line 1 (Field 17)	Yes, if Field 16 is used	Address line 1 to be used on the recovery agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting recovery agent information, fill with spaces. 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 or apartment number if possible.	Field 17: <ul style="list-style-type: none"> contains characters other than alpha A-Z, numeric (0-9), space, or contains special characters other than space, comma, period, ampersand, dash, @, #, /, semicolon, colon, period, or single quote (') Recovery Agent Mailing Name is submitted and Recovery Agent Mailing Address 1 is missing Recovery Agent Mailing Address 1 is submitted and Recovery Agent Mailing Name is missing
TN26	TIN Reference Response File	Recovery Agent Mailing Address Line 2 (Field 18)	No	Address line 2 to be used on the Recovery Agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting Recovery Agent information, fill with spaces. 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.	Field 18: <ul style="list-style-type: none"> contains characters other than alphabetic, numeric, space, or special characters other than space, ampersand, dash, @, #, /, comma, semicolon, colon, period, or single quote (') Recovery Agent Mailing Address 2 is supplied and Recovery Agent Mailing Name is missing
TN27	TIN Reference Response File	Recovery Agent City (Field 19)	Yes, if Field 16 is used	City to be used on the Recovery Agent's copy of recovery-related correspondence reflected by the unique TIN/Office Code combination. If the RRE is not submitting Recovery Agent information, fill with spaces. Must be a US city. Field may contain only alphabetic, space, comma, &, '-'. @ # / ; : characters. No numeric characters allowed.	Field 19: <ul style="list-style-type: none"> contains characters other than alphabetic and special characters other than space, ampersand, dash, @, #, /, comma, semicolon, colon, period, or single quote (') Recovery Agent Mailing Name is submitted and Recovery Agent City is missing Recovery Agent City is submitted and Recovery Agent Mailing Name is missing

Error Code	Record	Field Name (Field Number)	Field Required	Record Layout Field Description	Possible Cause
TN28	TIN Reference Response File	Recovery Agent State (Field 20)	Yes, if Field 16 is used	US Postal state abbreviation to be used on the Recovery Agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting Recovery Agent information, fill with spaces. See http://www.usps.com . The District of Columbia, American Samoa, Guam, Puerto Rico, and the US Virgin Islands are considered to have US addresses.	Field 20: <ul style="list-style-type: none"> is not a valid US postal state code Recovery Agent Mailing Name is submitted and Recovery Agent State is missing Recovery Agent State is submitted and Recovery Agent Mailing Name is missing
TN29	TIN Reference Response File	Recovery Agent Zip (Field 21)	Yes, if Field 16 is used	5-digit ZIP Code to be used on the Recovery Agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting Recovery Agent information, fill with spaces. Must be a US ZIP Code.	Field 21: <ul style="list-style-type: none"> does not contain 5 numeric digits Recovery Agent Mailing Name is submitted and Recovery Agent Zip is missing Recovery Agent Zip is submitted and Recovery Agent Mailing Name is missing
TN30	TIN Reference Response File	Recovery Agent Zip+4 (Field 22)	No	4-digit ZIP+4 to be used on the Recovery Agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting Recovery Agent information, fill with spaces. If not applicable, fill with zeroes (0000).	Field 22 does not contain 4 numeric digits, all zeroes, or all spaces. Error will no longer cause record rejection, but the error code will continue to appear on the response file. Correct and resubmit on your next quarterly file submission.
TN31	TIN Reference Response File	Recovery Agent Address (Fields 16-22)	No	See TIN Reference File Detail Record description, fields 16–22.	Fields 16–22 are missing components needed to determine a unique match to the postal database
TN32	TIN Reference Response File	Recovery Agent Address (Fields 16-22)	No	See TIN Reference File Detail Record description, fields 16–22.	Fields 16–22 match an address to which mail is undeliverable, such as a vacant lot.
TN33	TIN Reference Response File	Recovery Agent Address (Fields 17-18)	Field 17 is required if Field 16 is used; Field 18 is optional.	See TIN Reference File Detail Record description, fields 17–18.	Fields 17 and 18 are missing an apartment number for an address that requires an apartment number.

Error Code	Record	Field Name (Field Number)	Field Required	Record Layout Field Description	Possible Cause
TN34	TIN Reference Response File	Recovery Agent Mailing Address (Field 17)	Yes, if Field 16 is used	Address line 1 to be used on the Recovery Agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting Recovery Agent information, fill with spaces. 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 or apartment number if possible.	Field 17: house number or box number supplied was not found on the street.
TN35	TIN Reference Response File	Recovery Agent Mailing Address (Field 17)	Yes, if Field 16 is used	Address line 1 to be used on the Recovery Agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting Recovery Agent information, fill with spaces. 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 or apartment number if possible.	Field 17: street name supplied was not found in the ZIP code.
TN36	TIN Reference Response File	Recovery Agent Zip (Field 21)	Yes, if Field 16 is used	5-digit ZIP code to be used on the Recovery Agent's copy of recovery-related correspondence reflected by the unique TIN and Office Code combination. If the RRE is not submitting Recovery Agent information, fill with spaces. Must be a US ZIP code.	Field 21: ZIP code supplied was not found in the postal database.

Error	Record	Field Name	Field	Record Layout	Possible Cause
TN37	TIN Reference File Detail Record	TIN/Office Code Paperless Indicator (Field 23)	No	<p>Indicates the paperless selection for the TIN/Office Code combination.</p> <p>Valid values:</p> <p>Y = the TIN/Office Code address is opting in to "Go Paperless" and will receive letter notification emails instead of mailed hard copies of NGHP recovery letters</p> <p>N = the TIN/Office Code address is opting out of "Go Paperless" and will receive hard copies of NGHP recovery letters</p> <p>Space = no change to the currently saved paperless selection</p> <p>Optional.</p> <p>Note: The TIN/Office Code address can only be opted in to "Go Paperless" when there is an active MSPRP account for the Recovery Agent TIN.</p>	<p>Field 23:</p> <ul style="list-style-type: none"> • is not "Y," "N," or space • is "N" and TIN/Office Code Address has never opted in to paperless (i.e., existing TIN/Office Code Paperless Indicator is space-filled).
TN38	TIN Reference File Detail Record	TIN/Office Code Paperless Indicator (Field 23)	No	<p>Indicates the paperless selection for the TIN/Office Code combination.</p> <p>Valid values:</p> <p>Y = the TIN/Office Code address is opting in to "Go Paperless" and will receive letter notification emails instead of mailed hard copies of NGHP recovery letters</p> <p>N = the TIN/Office Code address is opting out of "Go Paperless" and will receive hard copies of NGHP recovery letters</p> <p>Space = no change to the currently saved paperless selection</p> <p>Optional.</p> <p>Note: The TIN/Office Code address can only be opted in to "Go Paperless" when there is an active MSPRP account for the Recovery Agent TIN.</p>	<p>Field 23:</p> <ul style="list-style-type: none"> • is "Y" and there is not an established active MSPRP account for the insurer's TIN (field 3).

Error	Record	Field Name	Field	Record Layout	Possible Cause
TN39	TIN Reference File Detail Record	Recovery Agent Paperless Indicator (Field 24)	No	<p>Indicates the paperless selection for the Recovery Agent Address associated to the TIN/Office Code.</p> <p>Valid values:</p> <p>Y = the recovery agent address is opting in to "Go Paperless" and will receive letter notification emails instead of mailed hard copies of NGHP recovery letters</p> <p>N = the recovery agent address is opting out of "Go Paperless" and will receive hard copies of NGHP recovery letters</p> <p>Space = no change to the currently saved paperless selection</p> <p>Optional.</p> <p>Note: The recovery agent address can only be opted in to "Go Paperless" when there is an active MSPRP account for the Recovery Agent TIN.</p>	<p>Field 24:</p> <ul style="list-style-type: none"> is not "Y," "N," or space. is "N" and the recovery agent address was never opted in to paperless (i.e., existing "Recovery Agent Paperless Indicator" is space-filled).
TN40	TIN Reference File Detail Record	Recovery Agent TIN (Field 25)	Yes, if Field 24 is Y	<p>Recovery Agent's Federal Tax Identification Number.</p> <p>Enter the 9-digit TIN for the recovery agent or fill with spaces.</p> <p>Required if Recovery Agent Paperless Indicator (Field 24) = 'Y'.</p>	<p>There is not an established active MSPRP account for the recovery agent TIN (Field 25)</p>

Appendix H: 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

1. 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:

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.

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

- (E) 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.
- (F) 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.
- (G) 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).
- (H) 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.
- (I) 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.
 - (J) 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.
 - (K) SHARING OF INFORMATION- The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.
 - (L) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.
2. 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.
 3. 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 I: 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. § 1395v(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's 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 J: Excluded and No-Fault Excluded Diagnosis Codes

The ICD-9 and ICD-10 excluded lists of codes for all plan types, and the excluded lists for No-Fault Plan Type D are now located on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists>.

About Excluded Diagnosis Codes

The excluded ICD-9 and ICD-10 lists for plan types E, L, and D contain ICD-10 diagnosis codes that are not accepted by CMS for Section 111 reporting and are to be excluded from all claim report records.

None of these excluded codes may be submitted in Field 15 Alleged Cause of Injury, Incident, or Illness or the ICD Diagnosis Code 1-19 (Fields 18-36) on the Claim Input File Detail Record. If an ICD-9 diagnosis code is submitted in Field 15, it must be a code starting with the letter “E.” If an ICD-10 diagnosis code is submitted in Field 15, it must be a code starting with the letter “V,” “W,” “X,” or “Y” that is **not** on this list. Diagnosis codes that begin with “V,” “W,” “X,” or “Y” can **only be used** in Field 15.

If an ICD-9 diagnosis code is submitted in the ICD Diagnosis Codes 1-19, it cannot start with the letter “E,” and it cannot start with the letter “V.” If an ICD-10 diagnosis code is submitted in the ICD Diagnosis Codes 1-19, it cannot start with the letter “V,” “W,” “X,” “Y,” or “Z,” and it cannot be a code on the excluded list.

All ICD-10 codes beginning with “Z” and all ICD-9 Diagnosis Codes beginning with the letter “V” are considered inadmissible for Section 111 reporting and should be excluded from diagnosis code fields 18-36.

Note: To find out the corresponding ICD-9 code for any ICD-10 code, go online and select an ICD-10-to-ICD-9 conversion tool.

On add and update record submissions, ICD Diagnosis Codes submitted in Fields 18-36 must be valid, that is, the submitted ICD Diagnosis Code **MUST**:

- Exactly match an ICD-10 or ICD-9 diagnosis code that CMS has deemed to be valid;
- Be left justified and any remaining unused bytes filled with spaces to the right;
- Include any leading and trailing zeros only if they appear that way on the list of valid ICD diagnosis codes;
- Not include a decimal; and
- Cannot be one of the diagnosis codes found on the Excluded ICD-10/ICD-9 code lists.

Appendix K: HEW Installation and Configuration

About the Latest HEW Software

As of December 2021, the latest release of HEW version 5.0.0 is available to download. This HEW version should be used for unwrapping production 271 files, and you should discontinue use of the previous versions of the HEW software.

As part of the PAID Act, the HEW application was modified to accept new information in an NGHP 271 X12 file, which then converts and includes the new data it in the fixed-length S111 Query Response flat file.

Changes for Version 5.0.0

- Prior versions of HEW only had one input/output directory for all the format types. In this release, the directories have been created separately (Figure K-8) so you can configure and the query file paths individually.
- The log file used to be overwritten every time HEW was run. With this version, the log file is never overwritten. New entries are appended to the end of the file.
- This version (not previous versions) can now be automated (see Command Line Process for details).

Installation

The following describes the steps for installing and configuring the latest HEW software on the Windows platform. For a detailed description of the HEW software see NGHP Chapter IV.

1. To download the program, log in to the Section 111 application at <https://www.cob.cms.hhs.gov/Section111/>
2. Select the **HEW Software Download** from the *Reference Materials* menu to download the .exe file to your desktop.
3. Click the HEW .exe file to begin the automatic installer, following the screen prompts (Figure K-1).

Note: It is important to select the correct install option (Figure K-2). If in doubt, select *Everyone*.

4. Click **Next** to confirm the installation (Figure K-3).
5. Click **Close** to exit (Figure K-4).

An icon for the HEW application is installed on your desktop and in the Windows menu (Figure K-5).

Figure K-1: Welcome to HEW Setup Wizard

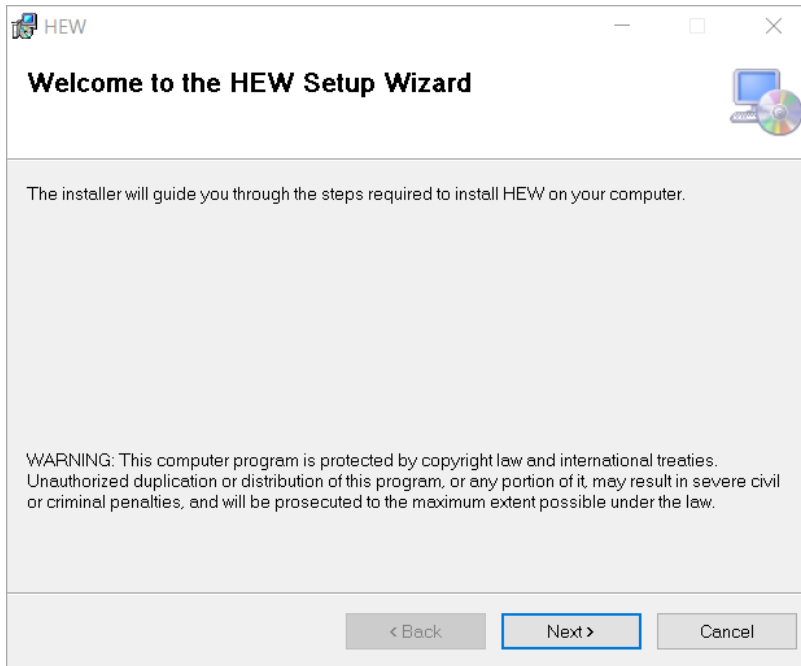


Figure K-2: Select Installation Folder

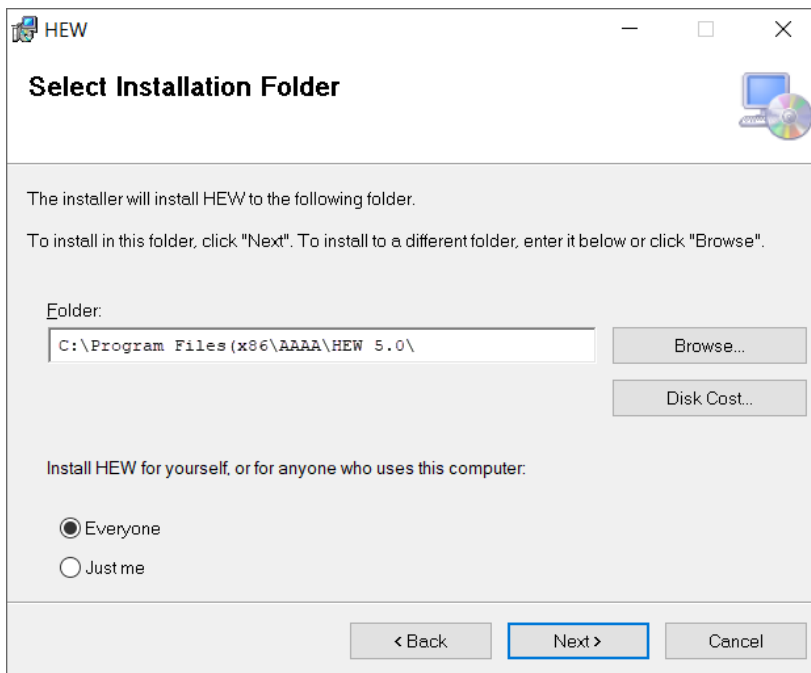


Figure K-3: Confirm Installation

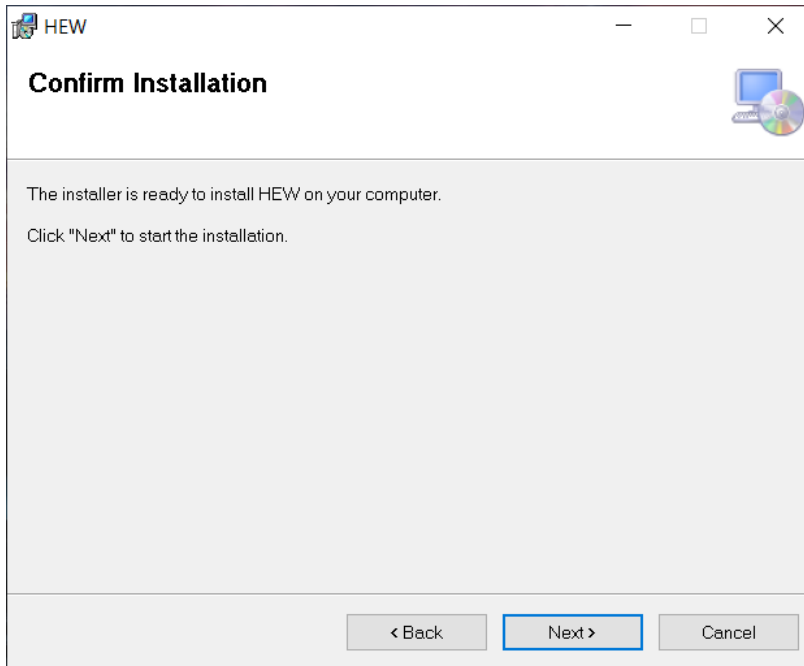


Figure K-4: Installation Complete

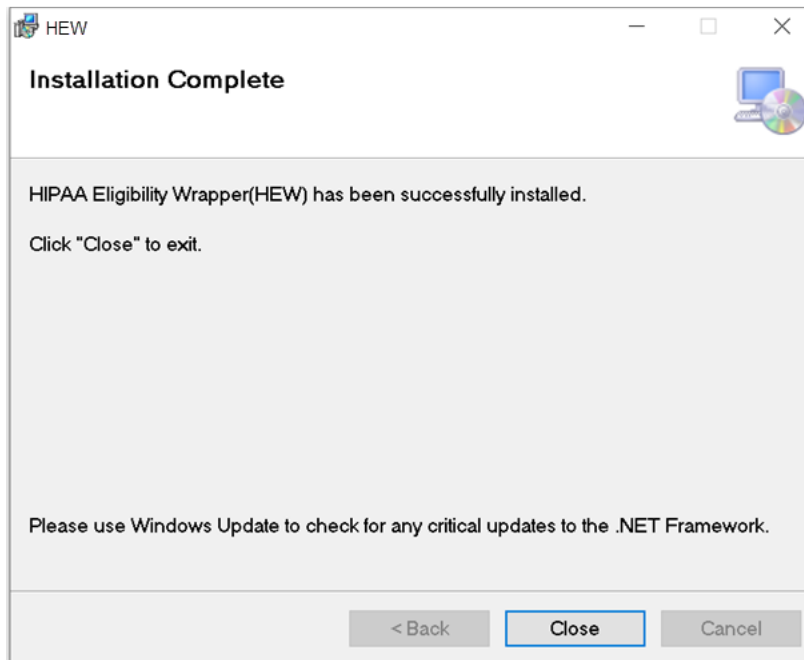


Figure K-5: Desktop Icons (Old and New)

	HEW	236 KB
		1/9/2020
	HEW	1.48 MB
		4/2/2021

Settings

Once you launch HEW, you can then specify your application settings. To open the *Settings* menu:

1. Click the HEW application icon to launch the program.
2. Click the **Settings** icon or select *Settings* from the *File* menu.

The *HEW Settings* menu appears (Figure K-8).

Figure K-6: Menus and Icons

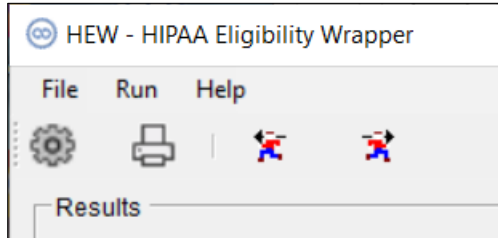


Table K-1: Menus and Icons

Item	Description
Menus	Options include:
File	Settings, Print, and Exit
Run	271 Inbound and 270 Outbound
Help	Contents (Help) and About (Version, Copyright, and Warning)
Icons	Functions:
Settings	Opens the <i>Settings</i> menu
Print	Prints results shown in <i>Results</i> panel
Run 271 Inbound	Runs the 271 Inbound query
Run 270 Outbound	Runs the 270 Outbound query

Figure K-7: File Settings

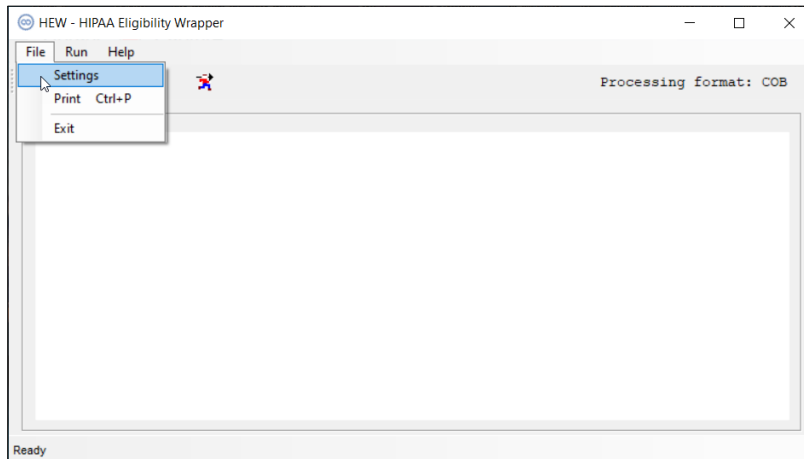
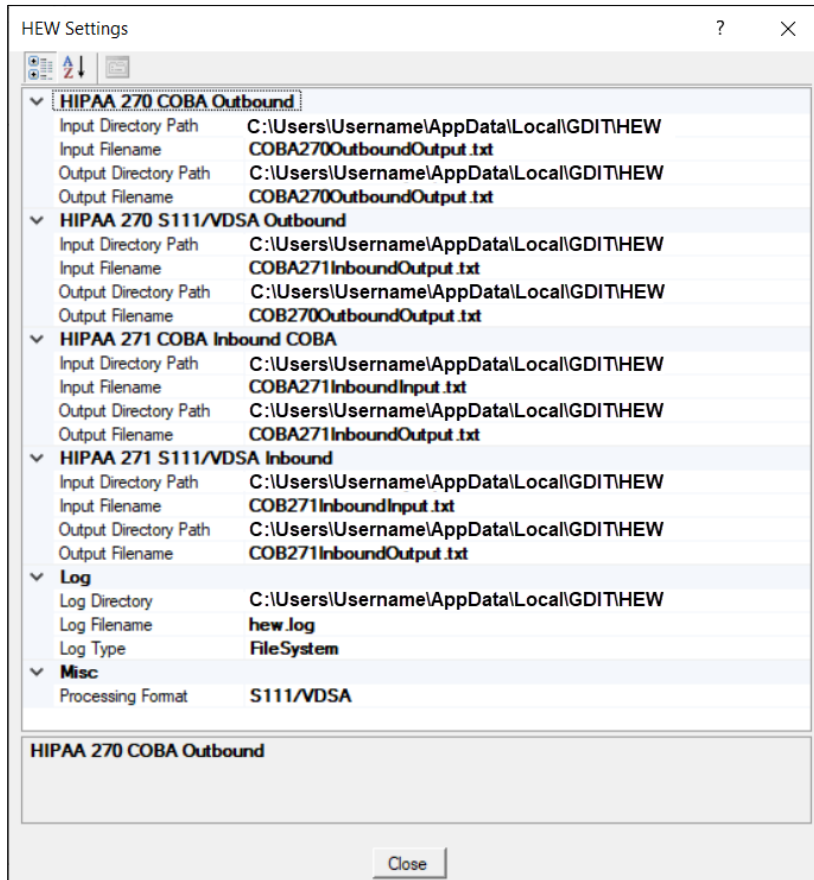


Figure K-8: HEW Settings



Changing Settings

From the *Settings* menu, you can change the defaults for the input and output directory paths, log type, and processing format.

- To change the destination of a selected directory, click an **Input Directory Path**, **Output Directory Path**, or **Log Directory** and then click the three-dot menu icon (...) to select a different folder location (Figure K-9).
- To change the processing format (i.e., S111/VDSA or COBA), double-click **Processing Format** under **Misc.** and select a different format from the drop-down menu (Figure K-10).
- To change the log type (Event Viewer, File System, or Both), double-click **Log Type** and select a different log type from the drop-down menu (Figure K-11).

Notes:

The directories can be located anywhere and mapped to any drive. However, if you plan to use the command line mode and you specify a network location, make sure the drive is mapped or available **before** executing the application.

If you select the log type *Event Viewer* or *Both* option, you will be prompted to verify that you would like to create a new Event Viewer source. Click **Yes** and follow the remaining screen prompts.

Figure K-9: Changing Directory Path

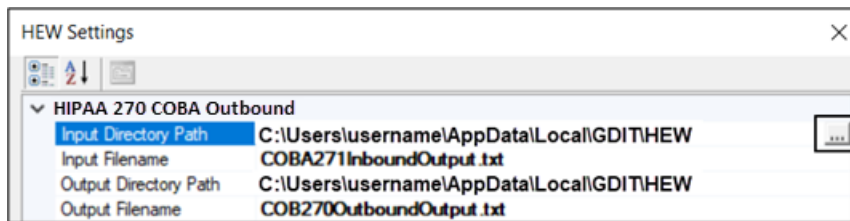


Figure K-10: Changing Processing Format

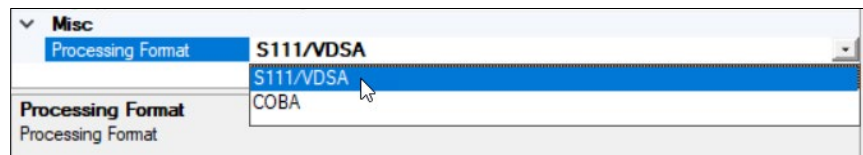
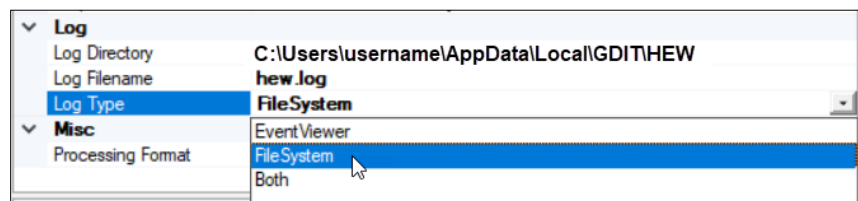


Figure K-11: Changing Log Type



Running Reports

Once you have mapped your drives, and have configured your settings (or have accepted the defaults), you can run your queries any time. Clicking the **Run 271 Inbound** button, for example, will display the input file results and location corresponding to the settings specified in the *Settings* menu. To cancel the processing, click **Stop**.

Pre-Processing Input Files

For Inbound files, the input files are pre-processed to ensure the file is properly formatted (i.e., each line is exactly 80 characters). If errors are detected, processing stops and the issues found are listed (Figure K-13).

For files that complete processing successfully, the last line of the results includes the command line argument options that can be used to automate the process just completed (Figure K-14).

Figure K-12: In Process Inbound 271 S111/VDSA Query (Example)

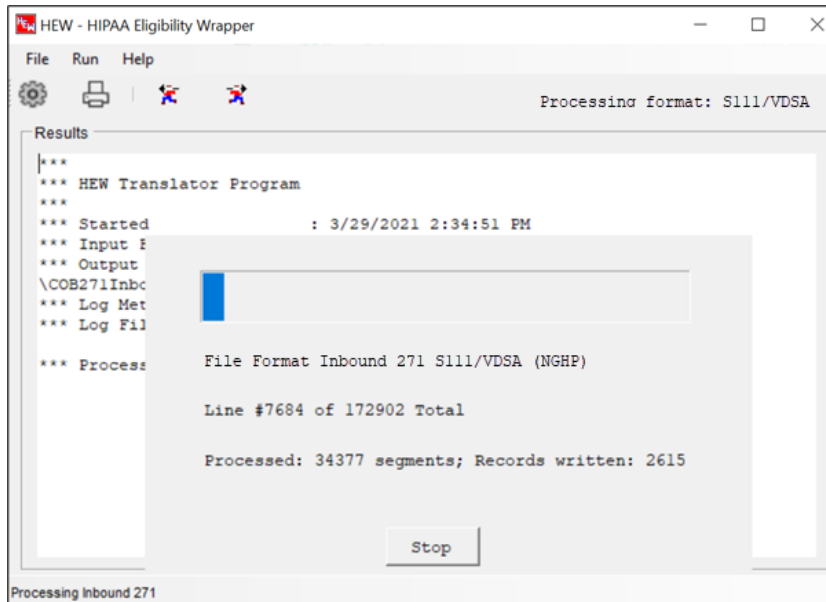


Figure K-13: Pre-Processing Errors (Example)

```

HEW - HIPAA Eligibility Wrapper
Processing format: S111/VDSA

Results
Error      : The input file is not in valid X12 format.  Ensure each line
is 80 characters long.
File: C:\bit9prog\dev\HET-DATA\File Examples\COBA\X12 271 File for Inbound
Process\COBA271x12.txt
Current Record:
Line #5702
Line: 5632893-AAA*Y**75*C-DMG*D8*19360401*F-SE*22847*0001-GE*1*0001-IEA*1*
000000001-
Length: 78
Line #75874
Line: 76511*76510*21*1-NM1*P5*2*****PI*000000508-H
Length: 45
Line #82324
Line: *PI*000000508-HL*83382*83381*22*0~TRN*1*211110000029236*9000000508-NM1
*IL*1*VAN
Length: 79
Line #118445
Line: *356*D8*20131201-MSG*ENTREAS=A~SE*445406*0001-GE*1*0001-IEA*1*000000001
~
Length: 72

```

Figure K-14: Completed Inbound 271 S111/VDSA Query (Example)

```

HEW - HIPAA Eligibility Wrapper
Processing format: S111/VDSA

Results
|***
*** HEW Translator Program
***
*** Started          : 3/29/2021 2:34:51 PM
*** Input File: C:\bit9prog\dev\HET-DATA\resp6027.txt
*** Output File: C:\Users\username\AppData\Local\GDIT\HEW
\COB271InboundOutput.txt
*** Log Method: Both
*** Log File: C:\Users\username\AppData\Local\GDIT\HEW\hew.log

*** Processing Inbound 271 S111/VDSA Records (NGHP)
*** File Format      : Inbound 271 S111/VDSA Records (NGHP)
*** Total Segments Read : 776175
*** Total Records Written : 59097
*** Ended           : 3/29/2021 2:39:16 PM
*** Elapsed Run Time  : 4 minutes 24 seconds
***
*** Finished: 3/29/2021 2:39:16 PM
-----
*** Command Line Args:
HEW-CmdLine.exe -i -n -filein "C:\bit9prog\dev\HET-DATA\resp6027.txt" -fileout
"C:\Users\username\AppData\Local\GDIT\COB271InboundOutput.txt" -
processtype "COB"

```

Error Files

In addition to pre-processing inbound files to check formats, if other errors occur during processing, an error file is created. The name of the file is the same as the input with the extension of .ERR and is stored in a sub-directory of the input file location and is named ERRORS. The format of the file is JavaScript Object Notation (JSON) and contains 4 fields per error record.

- FIELD 1: “ErrId” - Unique numeric identifier (sequential) for each error record
- FIELD 2: “Segment” - The complete record segment in which the error occurred
- FIELD 3: “ErrSegment” - The part of the Segment in FIELD 2 that caused the error
- FIELD 4: “ErrMsg” - The error message that was generated during processing

If errors occur, the processing will continue but will not output a results file. Instead, the errors will be displayed in the results screen in red text (Figure K-16) and logged in the error file.

Figure K-15: Error File (Example)

```
{
  "$schema": "json-schemaErrors.json#",
  "InputFilename": "NGHP271x12.txt",
  "allerrors": [
    {
      "ErrId": 1,
      "Segment": "HL*70129**20*1~N031",
      "ErrSegment": "N031",
      "ErrMsg": "Incorrect/Unknown Segment"
    },
    {
      "ErrId": 2,
      "Segment":
"HL*132183*132182*22*0~TRN*1*211120000159380*9000030783~NM1*IL*1*GIERCE*K~REF
*IG*448986892~REF*NQ*250011171926302~AAA*Y**75*C~DMG*D8*1952032079*21*1",
      "ErrSegment": "DMG*D8*1952032079*21",
      "ErrMsg": "DMG03 - GenderCode must be 1 character. 21"
    }
  ]
}
```

Figure K-16: Results File with Processing Errors (Example)

```

File Run Help
Processing format: S111/VDSA

Results
***
*** HEW Translator Program
***
*** Started           : 4/27/2021 1:06:54 PM
*** Input File: C:\bit9prog\dev\HET-DATA\NGHP271x12.txt
*** Output File: C:\bit9prog\dev\HET-DATA\NGHP271x12-OUT.txt
*** Log Method: FileSystem
*** Log File: C:\bit9prog\dev\HET-DATA\hew.log
*** Processing Inbound 271 S111/VDSA Records(GHP)
Error           : Incorrect/Unknown Segment
Current Record: HL*70129**20*1~N031
Segment - N031

Error           : DMG03 - GenderCode must be 1 character. 21
Current Record: DMG*D8*1962032079*21*1
Segment - DMG*D8*1962032079*21

*** File Format       : Inbound 271 S111/VDSA Records(GHP)
*** Total Segments Read  : 3482869
*** Total Records Written : 312886
*** Ended              : 4/27/2021 1:07:56 PM
*** Elapsed Run Time    : 1 minutes 1 seconds
***
*** Finished: 4/27/2021 1:07:56 PM
-----
*** Command Line Args:
"C:\Users\todd.bannar\OneDrive - GDIT\Documents\Visual Studio
Projects\HEW2\HEW\bin\Debug\HEW-CmdLine.exe" -i -filein "C:
\bit9prog\dev\HET-DATA\NGHP271x12.txt" -fileout "C:\bit9prog\dev
\HET-DATA\NGHP271x12-OUT.txt" -processtype "S111VDSA"
|
*** Errors occurred while processing. ***
Therefore, no output file was created. The error details were
logged and can be viewed here:
C:\bit9prog\dev\HET-DATA\ERRORS\NGHP271x12.ERR

```

Command Line Process

To launch HEW from a command line interface, open a command prompt and enter HEW-CmdLine.exe. Then enter “-h” to view the command line argument options.

Figure K-17: Command Line Mode and Options

```

Administrator: Command Prompt
C:\WINDOWS\system32>"C:\Program Files (x86)\GDIT\HEW\HEW-CmdLine.exe" -h
Command Line options:
-i           : Process Inbound Transactions; -i and -o cannot be specified together
-o           : Process Outbound Transactions; -i and -o cannot be specified together
-filein      : Input file, including full path enclosed in double quotes "fullpathname to file"
-fileout     : Output file, including full path enclosed in double quotes "fullpathname to file"
-processtype : Either S111/VDSA or COBA enclosed in double quotes "S111/VDSA" or "COBA"

The only required parameter is either -i or -o. If the other options are not specified, the values in User Settings are
used.
Ensure that the account/process running this task has access to data files directories.
Current Account: UserName

C:\WINDOWS\system32>

```


About Process Automation

For version 5.0.0, but not previous ones, the Command Line process can be automated by using the Windows(10) Task Scheduler. Keep the following points in mind when attempting to automate:

- By default, the data and error files are stored in the user's APPDATA directory:
C:\Users\username\AppData\Local\GDIT\HEW
- If the default file to process in the configuration file does not contain a path, then it looks in the default data directory listed above.
- Regardless of where you install the software, make sure that you are pointing to the HEW-CommandLine.exe file.

The user or process running the Command Line process must have **full rights** to the directories listed above. If the process runs from the application or user interface but not the command line, try running the Command Line process with administrative privileges. Right-click the Command Line file and select Run as administrator. If an error does occur while running it via the command line, any errors should be written to the log file located in the default directory listed above (Figure K-15). If the log file does not contain any errors, but the file was not processed, it may mean the account from which you are running the command line does not have read/write permission to that directory. You can always open a command prompt with administrative rights, navigate to the directory and type in: `hew.exe -on` at the command prompt to see if there are any messages.

Command Line Examples:

Inbound 271 S111/VDSA

```
HEW-CommandLine.exe -i -filein "C:\bit9prog\dev\HET-DATA\Test.txt" -fileout  
"C:\Users\username\AppData\Local\GDIT\HEW\COB271InboundOutput.txt" -processtype  
"S111/VDSA"
```

Inbound 271 COBA

```
HEW-CommandLine.exe -i -filein "C:\bit9prog\dev\HET-DATA\Test.txt" -fileout  
"C:\Users\username\AppData\Local\GDIT\HEW\COBA271InboundOutput.txt" -processtype  
"COBA"
```

Outbound 270 S111/VDSA

```
HEW-CommandLine.exe -o -filein "C:\bit9prog\dev\HET-DATA\Test.txt" -fileout  
"C:\Users\username\AppData\Local\GDIT\HEW\COB270OutboundOutput.txt" -processtype  
"S111/VDSA"
```

Outbound 270 COBA

```
HEW-CommandLine.exe -o -filein "C:\bit9prog\dev\HET-DATA\Test.txt" -fileout  
"C:\Users\username\AppData\Local\GDIT\HEW\COBA270OutboundOutput.txt" -  
processtype "COBA"
```

Appendix L: Acronyms

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

Table L-1: Acronyms

Acronym	Description
ANSI	American National Standards Institute
ASCII	American Standard Code for Information Interchange
BCRC	Benefits Coordination & Recovery Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits Program
COBA	Coordination of Benefits Agreement
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COBSW	COB Secure Website
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

Acronym	Description
HTTPS	Hypertext Transfer Protocol over Secure Socket Layer
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IACS UID	Individuals Authorized Access to CMS Computer Services User Identification Number
IRS	Internal Revenue Service
LGHPs	Large Group Health Plans
MBD	Medicare Beneficiary Database
MBI	Medicare Beneficiary Identifier
MMSEA	Medicare, Medicaid and SCHIP Extension Act of 2007
MSP	Medicare Secondary Payer
NAIC	National Association of Insurance Commissioners
NDM	Network Data Mover (now known as Connect:Direct)
NCPDP	National Council For 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
PBP	Plan Benefit Package
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

Acronym	Description
TrOOP	True Out of Pocket
TrOOP Rx BIN/Rx PCN	TrOOP specific drug payment codes
URL	Uniform Resource Locator (website address)
VAN	Value Added Network
VDEA	Voluntary Data Exchange Agreement
VDSA	Voluntary Data Sharing Agreement
VTAM	Virtual Telecommunications Access Method

Appendix M: Alerts

Recent Alerts related to Non-GHP (Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation) Section 111 reporting are posted on, and may be downloaded from, the Section 111 website: <https://go.cms.gov/mirnghp>. To view older Alerts, click on the **Archive** link on the left-hand side of the page or <https://go.cms.gov/MIRNGHPArchive>.

Appendix N: Previous Version Changes

Version 7.0

Chapter I

The expiration date for the OMB Control Number of the Paperwork Reduction Act (PRA) Disclosure Statement (before the Table of Contents) has been updated to 01/31/2025.

Chapter III

As of January 1, 2022, the threshold for physical trauma-based liability insurance settlements will remain at \$750. CMS will maintain the \$750 threshold for no-fault insurance and workers' compensation settlements, where the no-fault insurer or workers' compensation entity does not otherwise have ongoing responsibility for medicals (Sections 6.4.2, 6.4.3, and 6.4.4).

Chapter IV

The information on recovery agents has been clarified to emphasize that such agents need written authorizations to pursue any post-demand actions (Section 6.3.1).

Recovery agents may now view the Open Debt Report on the MSPRP, if the agent has an active MSPRP account with a TIN matching one submitted on the RRE's TIN Reference File (Section 6.3.1.2).

ORM Termination Date field number 79 was corrected for the Event Table (Section 6.6.4).

Chapter V

The CP13 soft edit policy limit amount has decreased from \$1000 to \$500 (Appendix F).

For the TIN Reference File, the Go Paperless Indicator is no longer required when submitting the Recovery Agent TIN (Field 25) (Appendix G).

Chapters I, IV, and V

As of July 2023, the following change will be made:

To inform RREs when another source has updated their submitted ORM records, RREs may now opt in via the Section 111 Coordination of Benefits Secure Website (COBSW) application to receive a monthly NGHP Unsolicited Response File. This will provide key information about updates to records originally submitted in the last 12 months, and allow RREs to either update their own internal data or contact the BCRC for a correction (Appendix F).

Note: The fields *Relationship Code*, *Policy Holder's First Name*, *Policy Holder's Last Name*, and *Policy Holder's SSN* will not be used in the NGHP Unsolicited Response File layout. They have been replaced with filler in the layout description (Appendix F) [January 30, 2023].

Version 6.9

Chapter IV

The Section 111 excluded ICD-10 diagnosis codes for All Types (E, L, D) and for No-Fault Plan Insurance Type D have been removed from this guide (previously Appendices I and J). Excel spreadsheets of the ICD-9/ICD-10 excluded and valid codes for FY 2023 are now available for

download on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists> (Section 6.2.5).

Chapter V

The Section 111 excluded ICD-10 diagnosis codes for All Types (E, L, D) and for No-Fault Plan Insurance Type D have been removed from this guide (previously Appendices I and J). Excel spreadsheets of the ICD-9/ICD-10 excluded and valid codes for FY 2023 are now available for download on CMS.gov at <https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists> (Appendix A, Appendix F, and Appendix I).

The SP31 error code has been restored. RREs will receive this error code when submitting records with effective dates greater than 90 days prior to Medicare entitlement (Appendix F).

Version 6.8

Chapter V

Field 79 (ORM Termination Date) has been updated and the possible causes for error codes CJ02 and CJ06 have been clarified. Also, error code TN40 has been corrected (Appendix A) (Table A-3) and Appendix F (Table F-4)).