

## What is MMSEA Section 111?

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Section 111 of The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) institutes mandatory reporting requirements for group health, liability (including self-insurance), no-fault insurers and workers' compensation insurers/plans. Insurers **must** report certain prescribed claims information in regard to Medicare beneficiaries to the Secretary of Health and Human Services.

## What are the major responsibilities for insurance carriers and other primary payers?

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- Determine whether the claimant is a Medicare beneficiary
- Submit entitled claims to Medicare on a quarterly basis

## What are the penalties for non-compliance?

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Failure to comply may result in a \$1,000.00 fine per day, per claim.

## Who is responsible for reporting?

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The Responsible Reporting Entity (RRE) is the insurer or self-insured plan (please refer to the July 31, 2009 User Guide for definitions of RRE, insurer and self-insured plan), which can be viewed at the CMS dedicated MMSEA Web page: <https://www.cms.hhs.gov/MandatoryInsRep/>.

**Third-party administrators (TPAs) are never RREs.** CMS has confirmed that TPAs of any type have no reporting responsibilities for liability insurance (including self-insurance), no-fault insurance, or workers' compensation.

## What are the current Implementation Timeframes?

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| ■ Registration period                      | May 1, 2009 – September 30, 2009 |
| ■ Test and Production Query Files Accepted | July 1, 2009                     |
| ■ Claim Input File Testing Begins          | January 1, 2010                  |
| ■ Production Claim Input Files Accepted    | January 1, 2010                  |
| ■ First Live Production Files Due          | April 1, 2010 – June 30, 2010    |



## Can an RRE assign MMSEA reporting to their TPA or a vendor?

CMS will allow the use of agents for MMSEA Section 111 reporting. However, if an agent is designated, the RRE remains responsible and accountable for compliance. Where an entity reports on behalf of another entity required to report, it is doing so as an **agent** of the second entity. Therefore, if a TPA reports on behalf of an insurance carrier, they would be considered an agent. If a TPA who has been designated to report on behalf of an RRE would like to use an agent, CMS will allow this and has set up the system accordingly.

## How will the RRE submit data to CMS?

The data submission process will take place electronically with the Coordination of Benefits Contractor (COBC).

## What are the available File Transmission Methods?

- Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)
- Secure File Transfer Protocol (SFTP) – PMSI's method of file transmission
- RREs with large amounts of data—over 24,000 records submitted on a regular basis—may submit via Connect: Direct through the AT&T Global Network System.

## When do RREs need to register?

The registration period is May 1, 2009 – September 30, 2009. RREs must register on their own behalf. If an agent will be used for reporting, they should be designated during the registration process.

## How will RREs verify whether a claimant is a Medicare beneficiary for MMSEA Section 111 reporting purposes?

CMS has confirmed that they will provide a Query function to liability (including self-insurance), no-fault insurers and workers' compensation RREs. The Query function will be an electronic file-exchange process.

- The Query will be available for testing and submission of live files as of July 1, 2009. The Query will only be available once registration has been completed and the RRE has been moved to Testing status. Testing of Query files is not mandatory, but is recommended by CMS. **Each RRE ID can submit one query file per month.** The COBC will return a response file to the entity that submitted the file (either the RRE or the agent).



- The information required for the Query will be Social Security Number (SSN) or Health Insurance Claim Number (HICN), name (first initial and first six characters of the last name), date of birth (DOB) and gender. The SSN is **REQUIRED** to run the Query. If there is a match—**claimant is currently on Medicare or was on Medicare at some time**—with the above data, CMS will send back the HICN for that individual. The COBC will also supply updated values for the name, DOB and gender based on the information stored for that beneficiary on Medicare’s files.
- Query Response files will be returned within one week.

If the CMS response file indicates there is no match, this does not mean the claimant is not on Medicare. It just means there was no match based on the data provided (some data could be incorrect). The Query function is only as good as the data submitted.

- **Social Security entitlement information WILL NOT** be provided through the Query function.
- The Query function should be used to filter claims to determine which cases should be reported, as CMS only wants data on Medicare beneficiaries. CMS discourages “data dumping”—sending all claims without verifying Medicare status—and recommends utilization of the Query function.
- CMS confirmed that it is acceptable to report **ALL** cases where the claimant is age 65 or older rather than performing a Query on these files. This will not be considered “data dumping.”

## Will CMS advise the RRE if an SSN is incorrect?

As noted above, the Query function **WILL NOT** identify if a SSN is incorrect. CMS has made the decision that the only information to be returned on the Query file is the claimant’s Medicare status. Verification of Social Security status through the Social Security Administration will still be required for Medicare Secondary Payer (MSP) compliance purposes to determine the need for a Medicare Set-Aside (MSA) allocation, as CMS has no plans to offer any information other than Medicare-entitlement status.



## When will the data transfer process be tested?

CMS has advised that testing of the Claim Input File will take place from January 1, 2010 through March 31, 2010, with live file submission scheduled for the second quarter of 2010—April 1, 2010 through June 30, 2010. However, if the RRE completes testing early and wants to submit their first live production file prior to 4/1/09 that is acceptable. However, CMS cannot accept a live production file prior to January 1, 2010.

Test files will continue to be accepted and processed after production status has been attained.

Testing may continue up until the first Production Claim Input File is due.

All users associated with the RRE's account will be able to submit test files. Live data is not required for testing—the RRE should still go through the testing process even if they do not yet have all the required data.

Test files **must** be limited to no more than 100 records.

## When will an RRE be required to submit live data to CMS?

Live reporting will be required as of second quarter of 2010 (April 1, 2010 – June 30, 2010). However, if the RRE completes testing early, CMS can accept live files as of January 1, 2010, but no sooner.

Each RRE will receive a designated quarterly submission timeframe (7 day period) assigned by the COBC.

## What if multiple RREs are involved in the same case?

Multiple RREs involved in the same settlement are all responsible for their own reporting under each individual policy. This would apply when a workers' compensation (WC) case involves a WC carrier and a third-party liability carrier. This would also apply when there is no-fault and liability coverage on a case. The reporting process is claimant specific as well as policy specific.



## **Which claims need to be reported?**

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- All claims involving a Medicare beneficiary where a settlement, judgment, award or other payment is made as of July 1, 2009 or later for cases where there is ongoing responsibility for medical payment (ORM).
- All claims involving a Medicare beneficiary where ORM exists as of July 1, 2009 **regardless of the date of the initial acceptance of payment responsibility.**
  - **Note:** Medicare is providing a limited extension on reporting these cases until the RRE's assigned submission in the third calendar quarter to allow time to go back and determine Medicare status.
  - **If an RRE has information confirming the claimant is a Medicare beneficiary and the SSN or HICN is available, the record should be reported immediately.**
- All claims where a Total Payment Obligation to the Claimant (TPOC) has been made after January 1, 2010. (Lump Sum Settlements)
  - **CMS will accept TPOC dates prior to January 1, 2010.** Therefore RREs can collect and submit data for TPOCs from July 1, 2009 as originally intended if they choose to do so.

## **What is a total payment obligation to the claimant (TPOC)?**

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

## **What is the trigger for reporting ongoing responsibility for medicals (ORM)?**

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. CMS confirmed that medical payments do not actually have to be paid on the claim for ORM reporting to be required.



## Does the date of injury affect which cases need to be reported?

The date of incident does not affect the RRE's reporting responsibilities for workers' compensation. Since the program's inception, Medicare has been secondary to workers' compensation. Liability and no-fault insurance MSP provisions went into effect December 5, 1980. CMS has determined as a matter of policy that it will not recover under the MSP provisions with respect to liability insurance or no-fault settlements, judgments, or awards where the date of incident **as defined by CMS** was prior to **December 5, 1980 unless the claim involves exposure continuing on or after December 5, 1980.**

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

## What if a claimant is not a Medicare beneficiary at the time ongoing responsibility for medicals (ORM) is assumed? Does that claim need to be reported?

If an individual is not a Medicare beneficiary at the time responsibility for ongoing medicals is assumed, the RRE must monitor the status of that individual and report the case when the individual becomes a Medicare beneficiary. This would be done by continuing to Query the claimant on the RRE's monthly Query file.

- **Exception:** Responsibility for ongoing medicals has terminated before individual becomes a Medicare beneficiary.

## Do I have to report cases that are closed or currently inactive?

CMS has confirmed if the RRE still has ORM as of July 1, 2009—medicals were not irrevocably closed—those cases need to be reported. This includes:

- Medical-only claims
- Closed lost-time claims where the claimant returned to work and there was no settlement/final closure of medicals
- Cases settled but the statute does not allow closure of medical benefits (Massachusetts, New Hampshire, etc.)



If there is a statute of limitations on how long a carrier is responsible to provide ongoing medical treatment (i.e., if there is no treatment in the last five years, the claimant is barred from requesting further medical treatment), CMS will recognize that as a closure of ongoing medical responsibility and the case will not need to be reported. Likewise, if the policy limits are reached on a liability case, there is no further medical exposure and those cases would not be reported.

As noted above, CMS has indicated that cases where ORM exists as of July 1, 2009 should be reported and would include closed/inactive claims. However, CMS has indicated that on cases for which ORM was *“assumed prior to July 1, 2009, if the claim was actively closed or removed from current claims records prior to January 1, 2009, the RRE is not required to identify and report that ORM...if such a claim is later subject to reopening with further ORM, it must be reported with full information, including the original DOI (as defined by CMS).”*

**Based on this statement, if a claim was closed/inactive prior to January 1, 2009, the RRE does not need to report that claim unless it is subsequently re-opened.**

## When do you report claims involving appeals?

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If there is an assumption of ORM due to a judgment or award but the carrier is appealing the decision, and:

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

If there is a total payment obligation to the claimant (TPOC) date/amount due to a judgment, award, or other payment but the carrier or claimant is appealing or further negotiating, and:

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

## What about minor resolved injuries where medicals will not close?

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Assumption of ORM typically occurs with respect to no-fault insurance or workers' compensation. Because claims involve all levels of injury, the result can be the continuation of open ORM records even where, as a practical matter, there is no possibility of associated future treatment. (i.e., a



minor fully healed cut finger injury in a state where workers' compensation requires life-time medicals).

CMS has indicated that, in these instances, RREs may submit a termination date for ORM if they have a signed statement from the injured individual's treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to re-opening or there may be a claim for further payment.

If, in fact, there is a subsequent re-opening of the claim and further ORM, the RRE must report this as an update.

## How does an RRE report medical payment coverage (med pay) and personal injury protection (PIP) on the same policy?

Med Pay and PIP are both considered no-fault insurance by CMS.

RREs must combine PIP/Med Pay limits for one policy when they are separate coverages and being paid out on claims for the same injured party and same incident under a **single** policy. ORM should not be terminated until both the PIP and Med Pay limits are exhausted. If PIP and Med Pay are coverages under separate policies, separate records with the applicable no-fault policy limits for each should be reported.

## Are indemnity payments for lost time/wages reportable under Section 111?

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

## When is the Claim Input Auxiliary File used?

RREs only need to report the Auxiliary Record if they have more than one claimant, which will occur when the claimant is deceased, or if they have more than one distinct TPOC to report for the claim.

## Has CMS implemented any reporting thresholds?

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1. For **no-fault insurance**, there is **no low-dollar threshold** for reporting the assumption/establishment of ORM or for reporting the TPOC (i.e., a lump-sum settlement amount).
2. For **liability insurance**, there is **no low-dollar threshold** for reporting the **assumption/establishment** of ORM.
3. For **workers' compensation ORM**, claims meeting **all** of the following criteria are **excluded from reporting for file submissions due through December 31, 2011**:
  - a. Medicals only
  - b. The associated "lost time" for the worker is not more than the number of days permitted by the applicable workers' compensation law for a "medicals only" claim (or 7 calendar days if the applicable law has no such limit).
  - c. All payment(s) has/have been made directly to the medical provider
  - d. Total payment does not exceed \$750.00
4. For liability insurance and workers' compensation TPOCs, the following requirements and dollar thresholds apply:
  - RREs are not required to adhere to the TPOC thresholds for claims reported with ORM. RREs are only required to report a TPOC on a claim with ORM when it is over the TPOC threshold, but may report TPOCs under the threshold at the RRE's discretion.
  - RREs are only required to report TPOCs with dates of January 1, 2010 and subsequent. Therefore, only TPOCs with dates of January 1, 2010 and subsequent need to be included in the total for the threshold check. However, TPOCs with dates prior may be included at the RRE's discretion (the record will not be rejected). **The COBC will add all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.**
  - Where there are multiple TPOCs associated with the same claim record, the combined, cumulative TPOC amounts must be considered in determining whether or not the reporting threshold is met.
  - The threshold dollar and date ranges apply to the date when the threshold is met (the most recent TPOC Date). The COBC will use the most recent TPOC Date supplied on the claim report when checking the threshold ranges. Timeliness of reports will be determined based upon the applicable date for the TPOC which caused the threshold to be met (the last, latest, most recent TPOC Date reported on the claim record.)
  - For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the TPOC amount includes the total of these two figures which in turn is included in the total TPOC amount used for the threshold check.



## TPOC Threshold dates were updated in User Guide Version 2.0 (July 31, 2009) as follows:

- Claim reports where the last (most recent) TPOC Date is **January 1, 2010 through December 31, 2011**, with TPOC amounts totaling \$0.00- \$5,000.00 are exempt from reporting.
- Claim reports where the last (most recent) TPOC Date is **January 1, 2012 through December 31, 2012**, with TPOC amounts totaling \$0.00- \$2,000.00 are exempt from reporting.
- Claim reports where the last (most recent) TPOC Date is **January 1, 2013 through December 31, 2013**, with TPOC amounts totaling \$0.00- \$600.00 are exempt from reporting.
- No threshold applies to claims where the last (most recent) TPOC date is **January 1, 2014 and subsequent**.

RREs must adhere to these requirements when determining what claim information should be submitted. These thresholds do not act as a “safe harbor” with respect to any other obligation or responsibility of any individual or entity with respect to the Medicare Secondary Payer provisions. These thresholds are **interim** thresholds while CMS is implementing the Section 111 reporting process. CMS reserves the right to change these thresholds and will provide appropriate advance notification of any changes.

## How do I report Multiple Settlement/TPOC Amounts?

If an RRE negotiates separate, different settlements at different times, each settlement amount is to be reported and maintained ongoing in separate fields. Information pertaining to five TPOCs can be reported. The first will be reported on the Claim Input File Detail Record and TPOCs 2-5 will be reported on the Claim Input File Auxiliary Record.

The TPOC fields will be “positional” in the sense that the first TPOC should be reported on the Detail Record in Fields 100-102, the second TPOC Amount should be placed in the first available TPOC Date and Amount on the Auxiliary Record starting at Field 93. Additional TPOC dates and amounts should be placed in the next available fields in the Auxiliary record. Subsequent reports for the claim should maintain all previously reported data in its original position/field, except for fields being updated.

## How should a case involving deductibles or co-payments be reported?



CMS has stated that in the definition of liability self-insurance, deductibles and co-payments constitute liability self-insurance and require reporting by self-insured entities under MMSEA Section 111.

If there is a large deductible and the policyholder is going to pay up to the exhaustion of the deductible, this is considered a self-insured situation and should be reported by the policyholder. When the deductible is exhausted, the policyholder would report that coverage has ended. Then the carrier, as an RRE, would need to report their coverage responsibility. Each RRE would report their own respective coverage according to which entity is making the payments.

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

**CMS issued an alert dated July 31, 2009 which contained updated language regarding which entity is an RRE and included specific comments regarding deductible situations. The Alert called for RREs to review the draft language and encouraged any concerned RRE or other entity impacted by the proposed language to submit comments directly to CMS by August 16, 2009. It is important to note that the information provided in this recent alert is not yet finalized. CMS intends that upon completion of the comment period the suggested draft language, when final, will replace the existing Section 7.1 of the NGHP User Guide regarding “Who Must Report.”**

## Who is the RRE when there is a self-insurance pool (e.g., joint powers authority)?

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If the self-insurance pool (1) is a separate legal entity, (2) with full responsibility to resolve and pay claims using pool funds, (3) without involvement of the participating entity, **the self-insurance pool is the responsible reporting entity.**

If these three criteria are **not** applicable to the self-insurance pool, **the participating self-insured entity is the responsible reporting entity.**

## Who is the RRE when there is a state- or federal-established assigned claims fund?

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A state-established assigned claims fund provides benefits for individuals injured in an automobile accident that do not qualify for personal injury protection/medical payments protection from an automobile insurance carrier. Additionally, a state/federal fund can also assume responsibility for situations where an employer fails to obtain insurance or to properly self-insure. The RRE for these types of claims is as follows:



Where there is a state/federal agency that **resolves and pays the claims using state/federal funds or funds obtained from others for this purpose, the established agency is the RRE.**

Where there is a state/federal agency that **designates an authorized insurance carrier to resolve and pay the claims using state/federal-provided funds without state/federal agency review and/or approval, the designated carrier is the RRE.**

Where there is a state/federal agency that **designates an authorized insurance carrier to resolve and pay the claims using state/federal-provided funds but the state/federal agency retains review or approval authority, the state/federal agency is the RRE.**

## **When does a record need to be updated?**

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A record update should be processed when there are updates/changes to the following data elements:

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

## **When should a record be deleted?**

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A record should be deleted if it was done in error (i.e., should have never been reported). In addition, CMS has noted the following instances where a key field needs to be updated or where a file should be deleted and then resubmitted:

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



- Plan Insurance Type (Liability, No-Fault, Workers' Compensation (Field 71 of the Detail Record))
- ORM Indicator (Field 98 of the Detail Record)

## When and how will CMS fine for non-compliance?

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CMS has continually stated on conference calls that they are more interested in good quality data rather than passing out fines. CMS is expecting all RREs to register and test data according to the current timeline in place. Real data is not required for testing, so the RRE should register and begin testing as soon as possible. CMS has indicated that the first step in compliance with Section 111 is to follow the timeline. If RREs want to be in compliance, they need to register and test within the appointed timeframes and be prepared to do live reporting in the second quarter (April – June) of 2010. If the RRE is having any issues that impact their ability to be ready to report, they need to discuss these issues with the assigned Electronic Data Interchange Representative (EDI Rep).

The Claim Response File, which will be received from the COBC, contains 10 Compliance Flags that provide information on issues related to compliance.

**A record will NOT be rejected if one of the conditions to set the flags is found on the record.** However, the COBC will set the flags, track this information, and include it on compliance reports. The flags provide the RRE notice that the submitted record was not in compliance with Section 111 reporting requirements. These flags should be reviewed and corrections applied to internal systems/data used for Section 111 reporting.

## Can an agent servicing multiple RREs request the same quarterly reporting timeframe?

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CMS has indicated that they will attempt to accommodate specific requests by RREs or agents. This may include requesting the same reporting dates for multiple RREs or requesting one EDI Representative for multiple RREs for which an agent must report.

## How long will it take to receive a response from the COBC?

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The COBC will return a response file for each record indicating the results of processing. The response file is returned **within 45 days of file submission**.



## Can reporting be suspended?

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Yes, reporting can be suspended due to severe errors or a threshold error.

Files with severe errors will be suspended from processing. The EDI Rep should be contacted to resolve the situation. Files with severe errors will be deleted by the EDI Rep and a corrected file must be re-sent.

### Severe errors include:

- 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.

A file that exceeds the threshold checks will be suspended from further processing until the suspension is overridden by the EDI Representative. An e-mail will be sent to the Account Manager informing them of the suspension. The EDI Representative must be contacted to discuss/resolve file threshold errors.

### Threshold errors:

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



## When is an RRE required to submit ICD-9 codes?

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'Add' and 'Update' records on Claim Input Files submitted on or after January 1, 2011 must include International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes in the Detail Record Alleged Cause of Injury, Incident or Illness (field 15) and the ICD-9 Diagnosis Codes (fields 19-55).

To allow more time to incorporate the use of ICD-9 codes in the Section 111 reporting process, an interim requirement has been made available. If an RRE is unable to supply valid ICD-9 codes in the Cause of Injury and Diagnosis Code fields, the Description of Illness/Injury (field 57) may be used prior to January 1, 2011. It is a free-form, alphanumeric text field that must contain a description of the major body part(s) injured and cause of illness/injury.

## What ICD-9 codes are considered valid by CMS?

CMS publishes a list of valid ICD-9 diagnosis codes once per year at [www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06\\_codes.asp](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp).

CMS has determined that certain valid ICD-9 diagnosis codes do not provide enough information related to the cause and nature of an illness, incident or injury to be complete, useful, and/or adequate for Section 111 reporting. A list of these codes is provided in Appendix H of User Guide 2/0.

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

Prior to January 1, 2011, RREs must provide either:

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

**OR**

- Description of Illness/Injury (Field 57).

To be considered valid, the **Alleged Cause of Illness/Injury (field 15)** must begin with an 'E' (be an "E code") and be on the list of valid ICD-9 codes for Section 111 reporting (the E code supplied must **NOT** be on the list of Insufficient ICD-9 Diagnosis Codes provided in Appendix H).

Regardless of the submission date, if any number of **ICD-9 Diagnosis Codes** is provided (**fields 19-55**) at least one must NOT begin with 'E' or 'V' and NOT be on the list of Insufficient ICD-9 Diagnosis Codes. Additional ICD-9 Diagnosis Codes can (and should) be provided as long as they are on the list of valid codes.



Insufficient codes, as well as additional E codes, **will be accepted** in the Diagnosis Code fields **as long as one, valid, numeric ICD-9 Diagnosis is provided that is NOT on this list.**

If all requirements are not met, the record will be rejected.

CMS plans to implement the new ICD-10-CM diagnosis codes by October 2013. Complete instructions and requirements for the use of ICD-10 codes will be provided at a later date. At this time ICD-10 codes will not be accepted. Further information can be found at <http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf> and <http://www.cms.hhs.gov/ICD10/>.

## How does an RRE register if they do not have a United States address?

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CMS recognizes that in certain rare situations, the RRE may be an entity with no associated Federal Tax Identification Number (TIN), United States (US) address and/or US telephone number. In order to register and report under Section 111, a TIN and US address/telephone number are required.

RREs must provide a TIN and US address/phone if available. If none is available, contact the COBC EDI Department at **646.458.6740** who will refer the matter to CMS for resolution.

In some cases, CMS may allow the RRE to register under information for their US-based “managing agency company”, but an RRE should not do so unless CMS approval has been received.

## Can a foreign address be used for Section 111 reporting?

See above for information regarding registration and foreign addresses.

Contact information outside the US may not be provided in any address or telephone number field on Section 111 files. The RRE must supply a domestic, US address and telephone number for Claimant and Representative fields if possible. If none is available, a value of ‘FC’ should be input in the associated State Code field and default all other fields to spaces or zeroes as specified.

If US contact information is not supplied for a Claimant or Representative, the RRE may be contacted directly to supply additional information. Therefore, every effort should be made to supply US contact information.



## Who do I contact if I have problems with reporting?

If there is a program or technical problem involving Section 111 data exchange, the first person to contact is **your assigned EDI Representative at the COBC**. If an EDI Representative is not yet assigned, call the **COBC EDI Department at 646.458.6740**.

The escalation process for the EDI Department is as follows:

- If the EDI Representative does not respond to an inquiry or issue within **two business days**, the COBC EDI Department Supervisor, Jeremy Farquhar, may be contacted at 646-458-6614. Mr. Farquhar’s e-mail address is [JFarquhar@ehmedicare.com](mailto:JFarquhar@ehmedicare.com).
- If the EDI Supervisor or the supervisor’s designee does not respond to the inquiry or issue within **one business day**, the COBC EDI Department Manager, William Ford, may be contacted at 646-458-6613. Mr. Ford’s e-mail address is [WFord@ehmedicare.com](mailto:WFord@ehmedicare.com).
- If the EDI Manager does not respond to your inquiry or issue within one business day, the COBC Project Director, Jim Brady, who has overall responsibility for the COBC EDI Department and technical aspects of the Section 111 reporting process may be contacted. Mr. Brady can be reached at 646-458-6682. His e-mail address is [JBrady@ehmedicare.com](mailto:JBrady@ehmedicare.com). Mr. Brady should only be contacted after attempting to resolve your issue following the escalation protocol provided above.

## What kind of e-mail correspondence will I receive from CMS?

CMS has provided a list of e-mail notifications which will be sent by the COBC and has designated who the recipient of each e-mail will be (Authorized Representative, Account Manager or both, as well as Account Designees).

E-Mail Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	Sent after Account Setup step is complete on the COBSW. Included attachment with Profile Report.
Non-Receipt of Signed Profile Report	Authorized Representative, Account Manager	Generated 30 days after the Profile Report e-mail if a signed copy has not been received by the COBC. The Authorized Representative for the RRE ID must sign and return the Profile Report. If another copy is needed contact the



		assigned EDI Rep.
Successful File Receipt	Account Manager	Sent after an input file has been successfully received at the COBC. No action required.
Late File Submission	Authorized Representative, Account Manager	Sent 7 days after the end of the file submission period if no Claim Input File is received. Send the file immediately and contact the assigned EDI Rep.
Threshold Error	Account Manager	Sent when a Claim Input File has been suspended for a threshold error. Contact the assigned EDI Rep to resolve.
Severe Error	Account Manager	Sent when a Claim Input File has been suspended for a severe error. Contact the assigned EDI Rep to resolve.
Ready for Testing	Account Manager	Account Setup is complete and the signed Profile Report has been received by the COBC. The RRE may begin testing.
Ready for Production	Account Manager	Testing requirements have been met and production files will now be accepted for the RRE ID.
Successful File Processed	Account Manager	The COBC has completed processing on a Claim 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 them to the COBSW. If the Account Designee is a new user to the COBSW, the e-mail will contain a URL with a secure token link for the user to follow and 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.
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.

## Does MMSEA Section 111 have an impact on or change the Medicare Set Aside Process?

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No. CMS has made it clear that MMSEA Section 111 does not change or alter any legal obligation/requirements under the MSP statute. The MMSEA does not have a direct impact on the MSP. Therefore, insurers are still responsible for protecting Medicare's interest for both past (conditional payments/liens) and future (MSA) payments. MMSEA Section 111 does impose new claims reporting requirements on claims handlers, which are in addition to the necessity of protecting Medicare as a secondary payer under the MSP. The indirect impact is that CMS will now have a report outlining every case where Medicare should be protected as a secondary payer. **At any time in the future, CMS can select cases to audit for MSP compliance.**

## How does MMSEA Section 111 reporting affect claims handlers?

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Adjusters may need to adapt to system changes that will be necessary to capture all the data required for Section 111 reporting. Additional information may need to be obtained from claimants to comply with the data elements CMS requires to be reported. Expedited Medicare status will be important (through the Query function) to ensure timely reporting. Section 111 reporting brings a heightened awareness to Medicare conditional payments (liens). Adjusters should address potential Medicare conditional payments early in the claims process.

## How will the registration process work?

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At registration, an **Authorized Representative (AR)** will be assigned. This should be an individual who can legally bind the RRE to the requirements of MMSEA Section 111 reporting. This person will not be a user on the COBC secure Web site, but will sign the Data Use Agreement as well as designate and sign off on the Account Manager (AM).



At the time of registration, the AR will decide how many RRE ID numbers are needed (there is no limit to the number of RRE IDs that can be set up). The number of IDs needed will depend on how the RRE wants to set up the reporting process. If the RRE works with multiple TPAs who are using different agents for reporting, they will register for an RRE ID for each respective TPA/reporting agent. If an RRE has two different claims systems (i.e., workers' compensation versus liability) which would prevent the RRE from combining the information submitted, they should set up two RRE IDs so claims can be reported separately. If an RRE has several subsidiaries and wants to report those cases separately, they will register for multiple RRE IDs. Each RRE ID can send one data submission file per quarter and one query file per month.

The **Account Manager (AM)** will manage the day-to-day processing of the data transfer. Each RRE ID can have only one AM. The AM can be an employee of the RRE, a representative of the TPA or a representative of an agent.

**Account Designees (ADs)** are individuals designated by the AM to assist in the reporting process. ADs have the ability to upload, monitor and transfer files. ADs can be employees of the RRE, TPA or agent.

If an RRE wants to use their TPA to report, but the TPA wants to contract out to an agent to handle the reporting, this arrangement is allowed by CMS.

## What does the RRE need to do to prepare for the registration process?

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The registration process includes five phases:

- The RRE will determine the reporting structure. The RRE must determine how many RRE ID numbers will be required based on corporate structure, claim system structures and whether or not an agent will be utilized.
- The RRE will identify an Authorized Representative, Account Manager and other COBSW users (as necessary). The Authorized Representative must have the legal authority to bind the RRE to the terms of MMSEA Section 111 reporting. The Account Manager (PMSI Settlement Solutions) will oversee the MMSEA Section 111 Reporting Process.
- RRE registration will be done on the Section 111 COBSW and will be performed by the Authorized Representative.
- RRE account setup on the Section 111 COBSW is the second step for the online registration process and is performed by the Account Manager.



The Authorized Representative will return the signed RRE Profile Report to the COBC. The Profile Report summarizes the information provided during registration and provides important information needed for data file transmission.

## How does an RRE begin the registration process?

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The Authorized Representative will login to the COBSW at [www.Section111.cms.hhs.gov](http://www.Section111.cms.hhs.gov) and click on the “New Registration” button to begin the first step of the online registration process.

The RRE will then be prompted to enter RRE Account Information, which includes the following:

- Company EIN/TIN – The IRS assigned tax ID for the company associated with this Section 111 registration. If there is more than one EIN/TIN, the registration can be submitted with any one of the EIN/TIN IDs.
- Company Name – The company name associated with this Section 111 registration.
- Company Address – The corporate address associated with the EIN or TIN supplied.
- NAIC Number – The code assigned to the company by the National Association of Insurance Commissioners (NAIC). **If the RRE is not registered with the NAIC, this field should be filled with five zeros.** If there is more than one NAIC company code, the registration may be submitted with any one of the codes.
- Company Telephone Number – For the corporate office.
- Company Fax Number – For the corporate office.
- Reporter Type – Choose “Liability/No-Fault/Workers’ Compensation.”

The RRE will also enter information regarding any subsidiaries for which the RRE will be reporting under that specific RRE ID number, if necessary. Subsidiary information and corresponding TINs are not required for registration. Only one TIN is required to register the RRE. Subsequent information regarding subsidiaries and their respective TINs can be provided at the time of live reporting

The RRE will provide contact information for the Authorized Representative.

When a registration application is submitted, the RRE will be provided with their RRE ID number and EDI Representative information. Once the registration information is validated by the COBC, a letter will be sent via the U.S. Postal Service to the named Authorized Representative with a personal identification number (PIN).



The Authorized Representative must give this PIN to their Account Manager to use to complete the account setup step. When the Authorized Representative sends the PIN to the Account Manager the following information which is required for Account Setup should be provided:

- Lines of business reported under this RRE ID
- Estimate number of paid claims for the lines of business reported under this RREID

## How many RRE ID numbers should be used?

The number of RRE IDs utilized is completely up to the RRE and will depend on corporate organization, claim system structures and whether an agent will be used for reporting.

- If an RRE will use one agent to report liability cases and another agent to report workers' compensation cases, the RRE must register on the COBSW twice to obtain two RRE IDs, which will be used by each agent respectively.
- If an RRE has two or more subsidiary companies that handle different regions of the country, different lines of business or use different data systems, the RRE may decide it is not feasible to combine all the cases into one report. The RRE must register to obtain as many separate RRE IDs as necessary.
- If an RRE has two or more subsidiary companies, but wishes to send only one quarterly file, they may register for only one RRE ID.
- The RRE may assign one agent to submit the quarterly Claim Input Files and another agent to submit the Query files.

Only one Claim Input File can be submitted per RRE ID each quarter. Only one Query File can be submitted per month.

## Can an RRE register for multiple RRE IDs at one time?

No. A separate registration will be required for each RRE ID.

## **If an RRE is using multiple reporting agents can they have one RRE ID?**

No. If multiple reporting agents will be utilized, the RRE must register for separate RRE IDs. Only one file can be submitted on a quarterly basis per RRE ID.



## What is the Account Manager's responsibility during the registration process?

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The Account Manager completes the second step in the online registration process. The RRE's Account Manager, on or after May 1, 2009, must go to [www.Section111.cms.hhs.gov](http://www.Section111.cms.hhs.gov) with the PIN and RRE ID provided by the Authorized Representative and click on the "Account Setup" button.

The Account Manager will:

- Enter the RRE ID and associated PIN
- Enter Account Manager personal information including name, job title, address, phone, fax numbers and e-mail address
- Create a Login ID and password for the COBSW
- Enter information regarding the lines of business covered by that RRE ID. This information should be provided by the Authorized Representative at the same time the PIN is sent to the Account Manager.
- 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). This information should also be provided by the Authorized Representative at the same time the PIN is sent to the Account Manager.
- Verify if an agent will report on the RRE's behalf. If so, provide company name, contact name, address, phone, fax, numbers, e-mail address and EIN/TIN.
- Select a file transmission method

Once the Account Manager has successfully obtained a COBSW Login ID, he/she may log into the application and invite Account Designees to register for Login IDs.

## Can I register for additional RRE ID or change RRE information after September 30, 2009?

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The registration process will remain available indefinitely and an RRE may do the following after registration:

- Alter their reporting structure
- Request one or more additional RRE IDs if changes in business operations require changes in data reporting requirements



- Disable an RRE ID which is no longer needed by contacting the assigned EDI Representative

## **Can I have more than one Account Manager for each RRE ID?**

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No. Each RRE ID can have only one Account Manager. Additional users can be added to the COBSW for that RRE ID as Account Designees.

## **Can the Authorized Representative also be the Account Manager or an Account Designee?**

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No. The Authorized Representative from the RRE cannot be a user of the COBSW.

## **Why is the RRE required to give an estimated number of paid claims?**

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The estimated number of paid claims is required by CMS for planning purposes to estimate the volume of claims that will be reported per RRE. The RRE should report the estimated number of annual paid claims for the lines of business reported under this RRE ID. This is an estimate only to be used for CMS planning purposes and will not be verified and/or validated.

## **When can the RRE begin testing?**

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Once the COBC has received the signed Profile Report (which will be provided to the Authorized Representative via e-mail), they will change the RRE ID account to a “testing” status. Testing for the Query can commence on or after July 1, 2009 for registered RREs. Claim Input File testing may commence during the timeframe noted by CMS (January 1, 2010 – March 31, 2010). The COBC will send an e-mail to the Authorized Representative and the Account Manager indicating testing may begin.

## **What are the duties of Account Designees?**

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The Account Manager must invite other individuals to be associated with the RRE’s account as Account Designees. Account Designees assist the Account Manager with the reporting process. Account Designees may be RRE employees or agents. Account Designees can be associated with multiple RRE accounts, but only by an Account Manager invitation for each RRE ID.



## **How many Account Designees can be assigned to an RRE ID?**

There is no limit to the number of Account Designees associated with one RRE ID.

## **What will “users” on the COBSW be able to do?**

- Register on the COBSW and obtain a Login ID
- Be associated with multiple RRE IDs
- Upload and download files (HTTPS) or use his/her Login ID and Password to transmit files (SFTP), depending on the file transfer method chosen
- Review file transmission history, status and file statistics
- Change his/her personal information

The Account Manager will be able to perform the following additional functions:

- Complete the account setup tasks
- Invite other users to register on the COBSW and function as Account Designees
- Manage the RRE’s profile including selection of a file transfer method
- Remove an Account Designee’s association to an account
- Change account contact information (e.g., address, phone, etc.)

