

MedAllocators Reporter MMSEA, SECTION 111 QUICK REFERENCE NGHP USER'S GUIDE

Pending Issues

Mass Torts is still under discussion. Also, CMS is reviewing additional examples submitted by the industry for possible inclusion in the upcoming User Guide Section for "Who is the Responsible Reporting Entity (RRE)".

Description of Injury/Illness Field

Until January 1, 2011, there is a "Description of Illness/Injury" field (field 57), which is a free form text description. A description of major body part injured (e.g., head, arm, leg, etc.) and cause of illness/injury should be included.

Total Payment Obligation to the Claimant (TPOC) Definition

TPOC refers to the dollar amount of a settlement, judgment, award, or other payment in addition to/apart from ongoing responsibility for medicals (ORM).

TPOC Date – If no court approval is required, it is the date that the payment obligation is established. Or, if there is a written agreement, it is the date that the obligation is signed. If court approval is required, it is the later date that the obligation is signed or the date of court approval. If there is no written agreement, it is the date of the payment, or the date of the first payment should there be multiple payments.

TPOC Amount – The dollar amount of the total payment obligation to the claimant is not required for the initial report of a claim reflecting ongoing responsibility for medicals. If there is a structured settlement, the amount is the total payout amount. 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 ORM (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 responsibility for ongoing medicals.

ORM: When and What to Report

The reference to "ongoing" is not related to "ongoing reporting" of claims, but rather the RRE's responsibility to pay medicals associated with the claim. This typically applies to no-fault and workers' compensation. 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. ORM 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. For claims where the injured party is a Medicare beneficiary and there has been a settlement, judgment, award, or other payment and the RRE has not assumed ORM, then only one Section 111 claim report is required. For claims where there is no settlement, no judgment, no award, or no other payments, but the insurer has assumed ORM for the injured party, then two reports under Section 111 are required. The first report occurs when the carrier assumes the ORM and the second when ORM terminates.



For certain states that require a workers' compensation claim be left open for ORM indefinitely, the second report may never be submitted. Records are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by RRE, etc. Consequently, it is possible that an RRE will submit more than one record for a particular individual in a particular quarter's submission window. 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 the purpose of the required reporting, 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. 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. Note: CMS is not bound by any allocation made by the parties even where a court has approved such an allocation. 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. The geographic location of the incident, illness, injury is not determinative of the RRE's reporting responsibility as Medicare beneficiaries who are injured or become ill outside of the United States often return to the U.S. for medical care.

When to Report Claims Involving Appeals

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

- If payment is being made, pending results of the appeal, then the ORM must be reported.
- If payment is not being made pending results of the appeals, then 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 carrier or claimant is appealing or further negotiating:

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

Special Exception Regarding Reporting Termination of ORM

Assumption of ORM typically occurs with respect to no-fault insurance 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 (i.e., a minor fully healed flesh wound in a state where workers' compensation requires life-time medicals). To address this situation, RREs may submit a termination date for ORM, if they have a signed statement from the injured individual's treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening of 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 in the ORM Termination Date (Field 99).



Special Reporting Extension for ORM and Special Qualified Reporting Exception for ORM Assumed Prior to July 1, 2009 Where Such ORM Continues as of July 1, 2009

Where ORM was assumed prior to July 1, 2009, and continues as of July 1, 2009, then the RRE must report this individual. As RREs may not have collected the necessary data elements for these individuals (such as the SSN), CMS is permitting RREs to delay reporting for these individuals until the RRE's assigned submission in the third calendar quarter (July – October) of 2010. This is to allow RREs time to determine the Medicare status. This extension does not apply to claims that are addressed/resolved (partially addressed/resolved) on or after July 1, 2009. 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.

Qualified Exception – A report terminating the ORM should not be submitted as long as the ORM is subject to reopening or an additional request for payment. CMS issued the following statement: *However, for ORM 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 [date of incident] DOI (as defined by CMS).* What this means is if a claim was closed/inactive prior to January 1, 2009, the RRE does not need to report that claims unless it is subsequently re-opened.

Definition of a Claim

For purposes of RRE submissions, the term *claim* is used to refer to the overall claim rather than a single claim for a particular medical item or service.

Multiple Defendants in a Settlement

Where there are multiple defendants involved in a settlement, an agreement to have one of the defendant's insurers issue any payment in obligation of a settlement, judgment, award or other does not shift RRE responsibility to the entity issuing the payment. All RREs involved in the settlement remain responsible for their own reporting.

Self-Insurance Pools (e.g., joint powers authority)

If the self-insurance pool is (1) 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 all three aforementioned characteristics are not applicable to the self-insurance pool, the participating self-insured entity is the responsible reporting entity.

State/Federal Established Assigned Claims Fund

RRE for a state-established "assigned claims fund" that 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 or a state/federal who assumes responsibility for situations where the employer fails to obtain insurance or to properly self-insure:

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.



RREs for Workers' Compensation

- Where the applicable law or plan authorizes an employer to purchase insurance from an insurance carrier and the employer does such, the insurance carrier is the RRE.
- Where the applicable law or plan authorizes an employer to self-insure and the employer does such, but independently of other employers, then the self-insuring employer is the RRE.
- Where the applicable law or plan authorizes employers to join with other employers in self-insurance pools, but any of the above-noted requirements are not satisfied, the participating employer is the RRE.
- Where the applicable law or plan establishes a state/federal agency with sole responsibility to resolve and pay claims, the established agency is the RRE.
- See above for rules regarding state/federal agencies.

Agents

- Agents must exchange separate files for each RRE ID that they represent.
- Agents must test each RRE ID file submission process separately.
- Agent representatives may be Account Managers and Account Designees for the RRE, but may not be named as the RRE's Authorized Representative.
- An agent may not mix data for multiple RRE IDs.

All communications regarding Medicare recovery will be directed to the RRE, not the agent.

Registration

Entities who are RREs for purposes of 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 claims to report. However, those who do not register initially because they have no expectation of any claims to report, must register in time to allow a full quarter for testing should they anticipate future situations where they have a reasonable expectation of a reporting requirement. Before beginning the registration process, an RRE must also determine how they will submit its Section 111 files to the COBC and how many Section 111 Reporter IDs (RRE IDs) will be needed. Only one Claim Input File may be submitted on a quarterly basis for each RRE ID. Due to corporate organization, claim system structures and agents that may be used for file submission, you may want to submit more than one Claim Input File to the COBC on a quarterly basis and therefore will need more than one RRE ID in order to do so. You may not set up a separate RRE ID for submission of the Query Input File only. You must submit a quarterly Claim Input File for every RRE ID you establish.

File Transmission Methods

- Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)
- Secure File Transfer Protocol (SFTP)
- 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.



File Submission Timeframe

A seven-day submission window is provided to account for the delay between file transmission and receipt-date determination. It is not intended to allow more time to submit. RREs and/or agents should be ready to transmit their files on the first day of the submission timeframe to be compliant with Section 111 reporting requirements. There is no submission timeframe associated with Query Input Files. Claim Input Files submitted within 14 calendar days before the start of a submission period are considered early submissions for that quarter. The file will be held until the start of the submission period.

Determination of Medicare Status

For matching an individual to determine if they are a Medicare beneficiary, the COBC uses:

- HICN or SSN
- First initial of the first name
- First 6 characters of the last name
- Date of birth (DOB)
- Gender

The COBC must find an **exact match on the SSN or HICN**. Then at least three out of the four remaining criteria must be matched exactly. If a match is found, the correct HICN will be returned by the COBC. This should be stored and used on future transactions. The COBC will also supply updated values for the name, date of birth and gender based on the information stored for that beneficiary on Medicare's files.

Response Files

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. RREs must take action on the information returned in the response file and be prepared to correct errors on the next quarterly submission. RRE Account Managers will receive e-mail notifications from the COBC when a file has been received and when response files are available. A record is considered accepted by the COBC if the corresponding response record is returned with a disposition code 01, 02, 03.

01 Disposition Code – Accepted as a claim where the injured party is a Medicare beneficiary and 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.

02 Disposition Code – Accepted as a claim where the injured party is a Medicare beneficiary during the time between the CMS Date of Incident and TPOC/Settlement Date and the RRE has indicated NO ongoing responsibility for medicals. The claim record does not need to be reported again unless updates are needed for material fields.

03 Disposition Code – Accepted as a claim where the injured party is a Medicare beneficiary, but the beneficiary's entitlement is outside the time period between the date of incident and TPOC/Settlement Date or the date ORM ended. As long as the injured party information submitted was completely correct and the claim does NOT represent ongoing responsibility for medicals, the case does not need to be submitted again.



If the claim represents ongoing responsibility for medicals, you must continue to monitor the status of the injured party as long as the claim remains open in order to determine if/when the injured party becomes entitled to Medicare. When the RRE determines that the injured party had become entitled to Medicare, then the record must be included on the next submission. However, monitoring of such individuals may cease before they become a Medicare beneficiary if the ORM is not subject to reopening/request for payment or if the standard for ORM termination set forth in the “Special Exception” section noted above is met.

Verification of Medicare Status/Query

If the individual was not a Medicare beneficiary at the time that responsibility for ongoing medicals was assumed, then the RRE must monitor the status of that individual and report when that individual becomes a Medicare beneficiary unless responsibility for ongoing medicals has terminated before the individual becomes a Medicare beneficiary. **Note:** For an individual who is not initially identified as a Medicare beneficiary, status must be **determined** as of the date of the settlement, judgment, award, or other payment, if there is a TPOC and/or ORM. Use of the Query Input and Response Files is optional under Section 111 reporting to determine if the injured party is a Medicare beneficiary.

- A value of 01 indicates that the injured party submitted on the input record is/was a Medicare beneficiary and the record will contain the updated HICN, name, DOB and gender according to Medicare’s information.
- A value of 51 indicates that the information supplied on the query record could not be matched to a Medicare beneficiary.

The Query Input and Response Files are transmitted using the *ANSI X12 270/271* Entitlement Query transaction set (version 4010A1). If needed, the COBC will supply software (the HIPAA Eligibility Wrapper or HEW) to translate flat files to and from the X12 270/271 format.

Testing

If the RRE is using an agent to test, the agent must submit and pass the testing process on behalf of the RRE. Testing must be completed for each RRE ID. Testing of the Query Files is not required, but highly recommended. Test files **must** be limited to no more than 100 records. RREs must submit at least the following test files:

- One initial Claim Input File with at least 25 *add* (new) records.
- A second Claim Input File with at least 5 *updates* and 5 *deletes* for previously submitted records.
- A Tax Identification Number (TIN) Reference File with information for at least one TIN/Office Code combination. The Office Code may be left blank, if not used.



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RREs must process at least the following test response files sent back by the COBC:

- Two (2) corresponding Claim Response Files

RREs must successfully perform the following to pass the testing process:

- Post at least 25 new claims with *add* records in one file submission. These records must receive 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 the above requirements are met.

Note: RRE accounts that have been in a *testing* status for more than 30 calendar days will receive an e-mail indicating that the account may be at risk of failing Section 111 Mandatory Reporting compliancy.

Updating Records

The update function should be used to update the following fields:

- ICD-9 Diagnosis Codes 1-19 (starting at Field 19)
- Description of Illness/Injury (Field 57)
- TIN (Field 72)
- TPOC Date (Field 100)
- TPOC Amount (Field 101)
- Claimant 1 Information (Fields 104 – 115)

If one of the following key fields needs to be updated, a delete transaction should be performed along with a subsequent add record, which includes the corrected information:

- Injured Party SSN, HICN, Last Name, First Name, Date of Birth and Gender (Fields 4, 5, 6, 7, 9, and 10)
- CMS Date of Incident (Field 12)
- Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 71)
- ORM Indicator (Field 98)

Error Codes:

Appendix E (page 157 of the User Guide) lists all possible error codes. Some error codes received may be due to errors on the TIN Reference File. If there is an error in a TIN or an insurer name/address submitted an updated TIN Reference File with the corrected information must be included in the next quarterly submission.



Severe Errors:

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.

- 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.

Threshold Errors:

- 10% or more of the total records are delete transactions
- 20% or more of the total records failed with a disposition code of 'SP' (file is rejected due to errors in the data reported)
- More than one Claim Input File was submitted during your defined quarter

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

Compliance Flags

The Claim Response File contains 10 compliance flags in Fields 36 – 45, which provide information on issues related to compliance. *See Compliance Flag Code table on page 159 of the User Guide* If no compliance issue is found with the record, all the Compliance Flags on the response file record will be blank. These flags are different from error codes. Unlike an error code, a record will NOT be rejected if one of the conditions to set the flags is found on the record. 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. The records should be resubmitted with corrections on the next quarterly submission.

Contact Protocol for the Section 111 Data Exchange

If there is a program or technical problem involving Section 111 data exchange, the first person to contact is the EDI Representative at the COBC. If an EDI Representative is not yet assigned, call the COBC EDI Department at 646-458-6740. If further escalation is necessary, contact the COBC EDI Manager, Bill Ford, at 646-458-6613 or WFord@ghimedicare.com. The COBC Project Director, with overall responsibility for the COBC EDI Department, is Jim Brady, who can be reached at 646-458-6682 or JBrady@ghimedicare.com