



**MMSEA Section 111
MSP Mandatory Reporting
GHP USER GUIDE**

**Version 2.2
March 6, 2009**

MMSEA Section 111 GHP User Guide

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MMSEA Section 111 GHP User Guide

Table of Contents

1	SUMMARY OF VERSION 2.1 AND 2.2 UPDATES.....	6
2	INTRODUCTION	9
3	MMSEA SECTION 111 OVERVIEW	10
4	MEDICARE ENTITLEMENT, ELIGIBILITY AND ENROLLMENT.....	11
5	MSP OVERVIEW FOR GHP.....	13
6	THE GHP PROCESS	16
6.1	Overview	16
6.2	GHP Reporting Options	17
6.2.1	Basic Reporting Option.....	17
6.2.2	Expanded Reporting Option	19
7	GHP MANDATORY REPORTING REQUIREMENTS.....	21
7.1	General Reporting Requirements.....	21
7.1.1	Responsible Reporting Entities	21
7.1.1.1	Who Must Report	21
7.1.1.2	Use of Agents	21
7.1.2	Active Covered Individuals	21
7.1.2.1	Finder File Approach to Determining Whom to Report	24
7.1.3	Inactive Covered Individuals	24
7.1.4	File Format.....	25
7.1.5	Data Formatting Standards	25
7.1.6	Section 111 Registration.....	27
7.1.6.1	Overview	27
7.1.6.2	Registration and Account Setup Process	27
7.1.6.3	Former VDSA/VDEA Partner Account Setup	31
7.1.7	Differences Between VDSA/VDEA and Section 111 Files	32
7.1.8	File Submission Timeframes	33
7.2	MSP Input File Requirements	35
7.2.1	Overview	35
7.2.2	TIN Reference File	36
7.2.2.1	Special GHP Extension For Reporting Employer TINs	37
7.2.2.2	TIN Validation.....	38
7.2.3	Record Matching Criteria.....	39
7.2.3.1	Individuals	39
7.2.3.2	MSP Occurrences	40
7.2.4	Small Employer Exception (SEE)	40
7.2.4.1	Extension for Reporting on Pending SEE Requests	42

7.2.5	Initial MSP Input File Submission.....	43
7.2.6	Quarterly Update MSP Input File Submissions.....	43
7.2.6.1	Add, Delete, Update Transactions.....	44
7.2.7	MSP Input File Detailed Requirements.....	47
7.2.8	Special GHP Reporting Extension For Dependents.....	50
7.2.9	Processing Response Files.....	52
7.2.9.1	Disposition Codes.....	52
7.2.9.2	SP Error Codes.....	53
7.2.9.3	Rx Disposition and Rx Error Codes.....	55
7.2.9.4	Expanded Option Only - Part D Eligibility and Enrollment Data.....	58
7.2.9.5	File Level and Threshold Errors.....	58
7.2.9.6	Late Submission and Compliance Flags.....	59
7.2.9.7	Split Entitlement Indicator – Multiple Response Records.....	60
7.2.9.8	End Stage Renal Disease (ESRD).....	60
7.3	Query Only Input File Requirements.....	62
7.3.1	Overview.....	62
7.3.2	Query Only Input File Detailed Requirements.....	62
7.4	Non-MSP Input File Requirements.....	63
7.4.1	Overview.....	63
7.4.2	Action Types.....	64
7.4.2.1	N – Query Records.....	64
7.4.2.2	D – Supplemental Prescription Drug Coverage Records.....	64
7.4.2.3	S – RDS Retiree File Records.....	65
7.4.3	Record Matching Criteria.....	65
7.4.3.1	Individuals.....	65
7.4.3.2	Supplemental Prescription Drug Records.....	65
7.4.4	Initial Non-MSP Input File Submission.....	66
7.4.5	Update Non-MSP Input File Submissions.....	67
7.4.5.1	Add, Delete, Update Transactions.....	68
7.4.6	Detailed Non-MSP Input File Requirements.....	69
7.4.7	Processing Response Files.....	70
7.4.7.1	Part D Eligibility and Enrollment Data.....	71
7.4.7.2	Processing “D” Response Records.....	71
7.4.7.3	Processing “N” Response Records.....	72
7.4.7.4	Processing “S” Response Records.....	73
7.4.7.5	Non-MSP Input File Level and Threshold Errors.....	73
7.4.7.6	End Stage Renal Disease (ESRD).....	73
7.4.8	True-Out-of-Pocket (TrOOP) Facilitation RxBIN and PCN Codes.....	74
7.4.9	RDS Retiree File Submission.....	74
7.5	Testing the Section 111 Reporting Process.....	78
7.5.1	Overview of the Testing Process.....	78
7.5.2	General Testing Requirements.....	78
7.5.3	MSP Input File Testing.....	79
7.5.4	Non-MSP Input File Testing.....	80
7.5.5	Query Only File Testing.....	80
7.6	Summary of Steps to Register, Test and Submit Production Files.....	81
8	ELECTRONIC DATA EXCHANGE.....	83
8.1	File Transmission Methods.....	83
8.1.1	Connect:Direct (NDM via the AT&T Global Network System (AGNS)).....	83

8.1.2	Secure File Transfer Protocol (SFTP).....	84
8.1.3	Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)	86
9	QUERYING FOR MEDICARE COVERAGE INFORMATION.....	88
9.1	How to Obtain Medicare Coverage Information.....	88
9.1.1	File Transmission	88
9.1.2	Beneficiary Automated Status and Inquiry System (BASIS).....	89
10	DATA USE AGREEMENT.....	90
11	COB SECURE WEB SITE.....	91
12	CUSTOMER SERVICE AND REPORTING ASSISTANCE FOR SECTION	
111	91	
12.1	EDI Representative.....	92
12.2	Contact Protocol for the Section 111 Data Exchange.....	92
13	TRAINING AND EDUCATION.....	92
	APPENDIX A – MSP FILE SPECIFICATIONS	94
	APPENDIX B – QUERY ONLY HEW INPUT/OUTPUT FILE SPECIFICATIONS	
	121
	APPENDIX C – NON-MSP FILE SPECIFICATIONS	126
	APPENDIX D – DISPOSITION, ERROR AND COMPLIANCE CODES.....	146
	APPENDIX E – MMSEA SECTION 111 BASIS REQUEST ATTACHMENT ...	161
	APPENDIX F – MMSEA SECTION 111 STATUTORY LANGUAGE	163
	APPENDIX G – MMSEA SECTION 111 DEFINITIONS AND REPORTING	
	RESPONSIBILITIES.....	166

MMSEA Section 111 GHP User Guide

1 Summary of Version 2.1 and 2.2 Updates

The following updates have been made in Version 2.1 of the MMSEA Section 111 GHP User Guide:

- The definition of Active Covered Individuals and related reporting requirements were refined in Sections 7.1.2 and 7.1.2.1. Examples of Active Covered Individuals have been added.
- Section 7.1.6 has been replaced to reflect registration on the COB Secure Website (COBSW). Step by step instructions have been added and a list of data needed to complete registration and account setup has been included.
- Section 7.1.7 was updated to inform former VDSA/VDEA partners of the changes made to the Query Only File Layout that will now use the RRE ID rather than the combination of VDSA/VDEA ID and contractor number. Also see the changes made in Appendix B.
- References made to “Taft-Hartley multiple employer/multi-employer plans (plans using an “hours bank” arrangement)” were changed to “Taft-Hartley multiple employer/multi-employer plans (*or other* plans using an “hours bank” arrangement)” in Section 7.2.2 and Appendix A for Field 21 of the MSP Input File Detail Record and Field 2 of the TIN Reference File Detail Record. This change was made to include any plan that uses an hours bank arrangement rather than strictly Taft-Hartley plans.
- The last Note in Section 7.2.2 was updated regarding the submission of the Plan Sponsor TIN in the Employer TIN field when reporting on a multiple employer/multi-employer plan using an hours bank arrangement. For the time being, the TIN Indicator (Field 8) on the TIN Reference File record should be submitted with a value of ‘E’. A new TIN Indicator value will be added for Plan Sponsor TINs at a later date. Do NOT place a ‘(PS)’ at the end of the corresponding TIN Reference File Name (Field 2) on the TIN Reference File record as previously instructed. Field 2 should contain the corresponding Plan Sponsor name without any special connotation.
- Section 7.2.2.2 was updated to note that when validating the TIN, only the TIN will be used in this validation. The name and address do not have to match the name and address associated with the TIN by the IRS.
- Section 7.2.4.1 Extension for Reporting Pending SEE Requests has been added to include information posted as an alert on January 8, 2009 to www.cms.hhs.gov/MandatoryInsRep/Downloads/GHPSEEALERT010909.pdf.
- A paragraph, “Initial Reporting When Employer Size Reaches 20”, was added to Section 7.2.6.1.
- Section 7.2.7 was updated to state that CMS is providing an extension on reporting HRA information until 4th Quarter 2010 (files submitted in October – December 2010). Information for HRA coverage should NOT be reported until then. Further instructions will be provided at a later date.
- Section 7.2.7 was updated to add an exclusion for reporting coverage for stand-alone behavioral and mental healthcare benefits.

- Section 7.2.7 was updated to state that TRICARE coverage and Medicare Advantage plan coverage should not be reported on the MSP Input File.
- Section 7.2.7 was updated to indicate that when calculating the number of employees, RREs should use the total number of employees in an organizational structure (parent, subsidiaries and siblings) rather than just the number of employees in the particular subsidiary being reported on. In addition, in the case of a subsidiary of a foreign company, the employee count should reflect the number of employees worldwide for the entire organization.
- Sections 7.2.7 and 7.4.6 have been updated to add a recommendation that RREs utilize the Medicare HICN on input records whenever that data element for a covered individual is available.
- Section 7.3.1 was updated to state that the COBC is using the 4010A1 version of the X12 270/271. An upgrade to the X12 5010 is tentatively planned for a January 2011 date.
- Section 7.5 was replaced to reflect the testing process on the COBSW.
- Section 8.1.1 was updated to list the information your Account Manager must provide for the Connect:Direct file transmission method on the COBSW in order to complete the RRE account setup.
- Section 8.1.2 was replaced to reflect using the COBSW for the SFTP file transmission method.
- Section 8.1.3 was replaced to reflect using the COBSW for the HTTPS file transmission method.
- The language in the Section 111 data use agreement was modified and Section 10 has been updated accordingly.
- Section 11 was updated to reflect the implementation of the Section 111 application on the COBSW in April 2009.
- The “Customer Service Center” subsection of Section 12 was deleted as all Section 111 reporting assistance requests should be directed to your assigned EDI Representative.
- The description of the RxBIN Number (Field 27 of the MSP Input File Detail Record and Field 16 of the Non-MSP Input File Detail Record) has been updated in Appendix A and Appendix C to indicate that this field has a data type of numeric and must be a 6-digit number when required (based on coverage type codes). The RX02 error in Appendix D was also updated accordingly.
- The definition of the values for Field 19 Employee Coverage Election of the MSP Input File Detail Record was updated in Appendix A to state that a value of ‘2’ (subscriber and family) should also be used when the coverage election reflects subscriber and spouse.
- The record layout for the MSP Response File Trailer has been added to Appendix A. This trailer record was erroneously omitted on prior versions of the guide.
- The header and trailer record layouts for the Query Only File in Appendix B were modified to replace the former 4-byte Field 2 and 5-byte Field 3 (VDSA ID and Contractor Number) with one 9-byte field for the RRE ID. Fields on the header and trailer records were renumbered accordingly. This format is to be used for testing beginning April 1, 2009 and is required for production files as of July 1, 2009 and subsequent. This change does not affect former VDSA/VDEA partners who have converted to Section 111 RREs. These RREs may continue to use the previously published format which used VDSA/VDEA IDs.

- Appendix F from Version 2.0 (12/17/2008) was removed as it no longer applies to the HTTPS and SFTP file transmission methods on the COBSW. Appendix G from Version 2.0 was renamed as Appendix F.
- The Appendix H from Version 2.0 was replaced to include the entire, updated Attachment A to the PRA Supporting Statement. Appendix H from Version 2.0 was renamed as Appendix G.

The following updates have been made in Version 2.2 of the MMSEA Section 111 GHP User Guide:

- Section 7.1.7 has been updated to correct the statement about the new version of the Query Only Input File. This change does not affect former VDSA/VDEA partners who have converted to Section 111 RREs. These RREs may continue to use the previously published format which used VDSA/VDEA IDs or convert to using the new format with the RRE ID.
- Section 12 has been updated to provide the COBC EDI Department phone number to be used by those RREs who have not yet been assigned an EDI Representative.

2 Introduction

This guide provides information and instructions for the Medicare Secondary Payer (MSP) Group Health Plan (GHP) reporting requirements mandated by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173). An overview of Section 111 related legislation, MSP rules, and the GHP reporting process is followed by detailed instructions and process requirements. Complete explanations of entities that are required to report and how this reporting will be implemented are included in this guide. File specifications are located in appendices to this guide for easy reference.

This guide is for use by all Section 111 GHP responsible reporting entities.

Please note that CMS is implementing the Section 111 requirements in phases. As time passes and we gain experience with Section 111 reporting, the data exchange requirements will continue to be refined and new processes added when necessary. CMS will issue revised versions of the Section 111 GHP User Guide from time to time. Section 111 responsible reporting entities (RREs) will be notified when new versions are available. Please check the CMS Section 111 Web page often at www.cms.hhs.gov/MandatoryInsRep for the latest version of the guide and for other important information.

3 MMSEA Section 111 Overview

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111) adds mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Implementation dates are January 1, 2009, for GHP arrangement information and July 1, 2009, for information concerning liability insurance, no-fault insurance and workers' compensation.

The new provisions for GHP arrangements found at 42 U.S.C. 1395y(b)(7):

- Add reporting rules; do not eliminate any existing statutory provisions or regulations.
- Include penalties for noncompliance.
- Contain provisions for the Secretary to share information on Part A entitlement and enrollment under Part B.
- Include who must report: "an entity serving as an insurer or third party administrator for a group health plan...and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary."
- Include what must be reported: data elements determined by the Secretary.
- Specify that reporting must be done in a form and manner, including frequency, specified by the Secretary. GHP reporting will be done on a quarterly basis in an electronic format.

NOTE: You must use the statutory language at 42 U.S.C. 1395y(b)(7) together with the "Definitions and Reporting Responsibilities" document published in conjunction with the Paperwork Reduction Act Federal Register Notice for Section 111 to determine if you are a "responsible reporting entity" for purposes of the Section 111 mandatory GHP reporting requirements. See Appendices G and H.

4 Medicare Entitlement, Eligibility and Enrollment

This section provides a general overview of Medicare entitlement, eligibility and enrollment. Please refer to www.cms.hhs.gov for more information on this topic.

Medicare is a health insurance program for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has:

Part A Hospital Insurance - Most people receive premium-free Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance, or HI) helps cover inpatient care in hospitals and skilled nursing facilities (but not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get 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 doctors' services and 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 - Throughout, Medicare has various coverage and payment rules which determine whether or not a particular item or service will be covered and reimbursed.

Section 111 states that CMS will share Medicare Part A entitlement and Part B enrollment information with GHP responsible reporting entities (RREs). Depending on your reporting option selected, CMS may also share Part D eligibility and enrollment information as well. In your response files you will get information about beneficiary eligibility and enrollment.

The distinction between an individual's benefit *eligibility* and benefit *enrollment* can be confusing. While it sometimes appears that the two terms are used interchangeably, for CMS they have very different and distinct meanings.

Once an individual is a Medicare beneficiary, he or she is then *eligible to participate* in Medicare's benefit programs, including Part D. Usually, the Medicare beneficiary can choose to participate, and if he or she does, the first day the beneficiary's participation is effective is *the date of enrollment* in the benefit program. For example, individuals who have aged into Medicare Part A are then eligible to enroll in Medicare Parts B and D, if they so choose. Once an application for enrollment is accepted, the beneficiary's effective date of enrollment is established.

In summary, an eligible Medicare beneficiary may participate in Medicare program benefits beginning on his or her date of enrollment in the benefit program. For beneficiaries who choose to participate in the Part B and D programs, the date of enrollment is, usually, the first day of the following month.

5 MSP Overview for GHP

Note: The following paragraphs provide only a very high level overview of the MSP provisions. Employers, insurers, third party administrators, group health plans, and other group health plan sponsors are always responsible for understanding when they are providing coverage primary to Medicare, and for paying appropriately. See 42 U.S.C. 1395y(b), and 42 C.F.R. Part 411, for the applicable statutory and regulatory provisions, and CMS manuals and Web pages for further detail.

Some people who have Medicare also have group health coverage. Often, employer-provided group health coverage must pay before Medicare does. In that case, Medicare is the secondary payer. Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation (including black lung benefits) or veterans' benefits. Since 1980, new laws have made Medicare the secondary payer for several additional categories of people. The additional categories of people for whom Medicare is the secondary payer are described below.

Medicare Secondary Payer

Medicare secondary payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first.

The terms "Medicare supplement" and "Medicare secondary payer" are sometimes confused. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the primary payer. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare program. Private "Medigap" insurance and Medicare secondary payer law and regulations are not the same.

Federal Medicare law takes precedence over conflicting State law and private contracts. Thus, for the categories of people described below, Medicare is secondary payer regardless of state law or plan provisions.

Who does MSP affect?

Medicare is now secondary payer to some group health plans (GHPs) or large group health plans (LGHPs) for services provided to the following groups of Medicare beneficiaries:

- The "working aged,"
- People with permanent kidney failure, and
- Certain disabled people.

Working Aged

The “working aged” are employed people age 65 or over and people age 65 or over with employed spouses of any age who have GHP coverage because of their or their spouse’s current employment status. In general, an individual has current employment status if the individual is an employee, the employer, or is associated with an employer in a business relationship.

Medicare is secondary payer to GHPs for the “working aged” where either:

- a single employer of 20 or more full and/or part-time employees is the sponsor of the GHP or contributor to the GHP,

or

- two or more employers are sponsors or contributors to a multi-employer/multiple employer plan, and a least one of them has 20 or more full and/or part-time employees.

When determining the “20 or more threshold,” employers (i.e., individual or wholly owned entities) with more than one company must follow the IRS aggregation rules. The relevant IRS codes can be found in 26 U.S.C. sections 52(a), 52(b), 414 (n) (2).

There is one MSP exception: A multi-employer/multiple employer GHP may request to exempt specific working aged people enrolled through an employer with fewer than 20 full and/or part-time employees. If CMS approves the request, Medicare would become primary payer for specifically identified working aged people enrolled through a specifically identified employer with fewer than 20 full or part-time employees. The GHP must be able to document its request and/or CMS approval of its request to exempt such individuals. See the Small Employer Exception section of this guide for more information.

People with Permanent Kidney Failure

Medicare is secondary payer to GHPs during a 30-month coordination period for beneficiaries who have permanent kidney failure (End Stage Renal Disease or ESRD), and who have coverage under a GHP on any basis (current employment status is not required as the basis for coverage). The coordination of benefits period applies regardless of the number of full and/or part-time individuals employed by an employer and regardless of whether or not the employer belongs to a multi-employer/multiple employer GHP.

Disabled People

Medicare is the secondary payer for people under age 65 who have Medicare because of disability and who are covered under a LGHP based on the individual’s (or a family member’s) current employment status. In general, an individual has current employment status if the individual is an employee, the employer, or is associated with an employer in a business relationship. A LGHP provides health benefits to employees, former employees, the employer, business associates of the employer, or their families, where the employer has 100 or more full and/or part-time employees. Where an employer of

any size is part of a multi-employer/multiple employer GHP, Medicare is secondary for individuals who have Medicare because of a disability if one or more of the employers in the GHP has 100 or more full and/or part-time employees.

Making MSP Work

The entities under contract to pay Medicare claims ("Medicare contractors") are responsible for denying claims for primary benefits when Medicare is secondary payer. In making claims processing decisions, the Medicare contractors use information on the claim form and in CMS data systems in order to avoid making primary payments in error. Where CMS' systems indicate an MSP occurrence, Medicare will deny payment. In such cases, Medicare will not pay the claim as a primary payer and will return it to the claimant with instructions to bill the proper party.

Sometimes, after a Medicare claim is paid, CMS receives new information that indicates Medicare made a primary payment by mistake. Based on this new information, CMS takes action to recover the mistaken Medicare payment. CMS has a Medicare Secondary Payer Recovery Contractor (MSPRC) which is responsible for recovery actions. The MSPRC issues a demand letter for repayment to any or all the parties obligated to repay Medicare (the employer, insurer, third party administrator, plan, or other plan sponsor.) If the MSPRC does not receive repayment or a valid documented defense in response, it will refer the debt to the Department of the Treasury for the Treasury Offset Program and other cross-servicing activities pursuant to the Debt Collection Improvement Act of 1996. CMS may also refer debts to the Department of Justice for legal action if it determines that the required payment or a properly documented defense has not been provided. The law authorizes the Federal government to collect double damages from any party that is responsible for resolving the matter but which fails to do so.

Role of the Medicare Coordination of Benefits Contractor

The purposes of the Coordination of Benefits (COB) program are to identify the health benefits available to a Medicare beneficiary and to coordinate payment process to prevent mistaken payment of Medicare benefits. The CMS Coordination of Benefits Contractor (COBC) consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The COBC does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. Instead, the COBC updates the Medicare systems and databases used in the claims payment and recovery processes. The COBC has been directed by CMS to implement the MSP requirements of the MMSEA Section 111 legislation as part of its responsibilities to collect information in order for CMS to coordinate benefits for Medicare beneficiaries.

Where to Find MSP Regulations

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. See section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)). See 42 CFR Part 411 for the applicable regulations. Medicare has been secondary to workers' compensation benefits from the inception of the Medicare program in 1965.

6 The GHP Process

6.1 Overview

The purpose of the Section 111 GHP reporting process is to enable CMS to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 authorizes CMS and Section 111 GHP responsible reporting entities (RREs) to electronically exchange health insurance benefit entitlement information. The actual data exchange process will take place between the RREs and the CMS Coordination of Benefits Contractor (the COBC). The COBC will be managing the technical aspects of the Section 111 data exchange process for all Section 111 RREs.

On a quarterly basis, a responsible reporting entity must submit group health plan (GHP) entitlement information about employees and dependents to the COBC. In exchange, the COBC will provide the RRE with Medicare entitlement information for those individuals in a GHP that can be identified as Medicare beneficiaries. This mutual data exchange helps to assure that claims will be paid by the appropriate organization at first billing.

The Section 111 GHP reporting process includes an option to exchange prescription drug coverage information to coordinate benefits related to Medicare Part D. CMS is also allowing RREs, that are also participating in the Retiree Drug Subsidy (RDS) program or are reporting to RDS on behalf of a plan sponsor, to use the Section 111 GHP reporting process to submit subsidy enrollment (retiree) files to the RDS Center using the Section 111 GHP reporting process.

Section 111 RREs are required to register with the COBC and fully test the GHP data reporting exchange before submitting production files. You will be assigned a production file submission timeframe during which you are to submit your files on a quarterly basis. Once you are in a production mode, you will submit your initial file containing GHP coverage information for all individuals meeting the definition of an Active Covered Individual or Active Covered Individuals identified as Medicare beneficiaries through the query process. Subsequent quarterly file submissions are to contain only new or changed coverage information using add, delete and update transactions. These requirements are explained in later sections of this User Guide.

The data exchanged through the Section 111 GHP reporting process is arranged in six different record layouts. A responsible reporting entity (RRE) electronically transmits a data file to the COBC. The COBC processes the data in this *input file* by first editing the incoming data. Other insurance information for Medicare beneficiaries derived from the input file is posted on the Medicare Common Working File (CWF) and the Medicare Beneficiary Database (MBD) by the COBC for use by other Medicare contractors for claims processing and recovery efforts. When this processing is completed or the prescribed time for response file generation has elapsed, the COBC electronically transmits a *response file* back to the responsible reporting entity. The response file will include information on any errors found, disposition codes that indicate the results of processing, and Medicare entitlement/enrollment information as prescribed by the particular file format.

In only one instance – as part of the RDS file exchange process – will the COBC transmit a response file to an RRE without having first processed a specific input file. In ordinary circumstances it will always be an input file that will generate a response file.

6.2 GHP Reporting Options

Pursuant to Section 111, the Secretary has determined that GHP RREs are to provide CMS with information regarding hospital and medical GHP coverage they make available to Medicare beneficiaries. Section 111 also provides for CMS to share information regarding a beneficiary's Medicare Part A (hospital) entitlement, Part B (medical), and Part C (Medicare Advantage) coverage in return. However, CMS is very interested in coordinating benefits related to GHP prescription drug benefits and Medicare Part D (prescription drug) coverage for these same Medicare beneficiaries. As a result we have made two reporting options available – Basic and Expanded – in the Section 111 GHP reporting process.

The *Basic Reporting Option* reflects the minimum requirements you must adhere to in order to comply with Section 111. The *Expanded Reporting Option* includes the minimum requirements for Section 111 plus the exchange of prescription drug coverage information. If you select the Basic Reporting Option, CMS will return just Medicare Part A entitlement and Parts B and C enrollment information on your response files. RREs participating through the Expanded Reporting Option will also receive Medicare Part D eligibility and enrollment information. Most current users of the VDSA and VDEA program are already participating at the Section 111 Expanded Reporting Option level, and CMS encourages all RREs that are existing VDSA and VDEA partners to use the Section 111 Expanded Reporting Option.

The following sections explain each option in further detail. Complete explanations of the file types listed follow in later sections of this guide.

6.2.1 Basic Reporting Option

The Basic Reporting Option represents the minimum requirements you must adhere to for compliance with the Section 111 requirements. The Basic Reporting Option includes submission of the Medicare Secondary Payer (MSP) Input File for hospital and medical coverage of Active Covered Individuals and, optionally, the Query Only Input File, in the form of an ANSI X12 270/271 Entitlement Query file, along with the corresponding response files. The COBC will only return entitlement/enrollment information for Medicare Parts A, B and C with this option.

For GHP insurers that choose the Basic Reporting Option, CMS will be happy to accept reporting of prescription drug coverage that is in addition to your hospital and medical reporting. If you anticipate reporting such additional drug coverage on more than an occasional basis we recommend that you choose to report using the Expanded Reporting Option.

MMSEA Section 111 Basic GHP Reporting Option Files

File Type	Description
GHP MSP Input File	This is the data set transmitted from a MMSEA Section 111 responsible reporting entity (RRE) to the COBC that is used to report information regarding Active Covered Individuals.
GHP MSP Response File	This is the data set transmitted from the COBC to the MMSEA Section 111 RRE after the information supplied in the RRE's MSP Input File has been processed.
TIN Reference File	The TIN Reference File consists of a listing of each business entity's federal tax identification number (TIN) and the business mailing address that is linked to that particular TIN.
Query Only Input File	This is a query file used to obtain Medicare Part A entitlement and Parts B and C enrollment information of potential Medicare beneficiaries.
Query Only Response File	After the COBC has processed the Query Only Input File it will return the Query Only Response File with Medicare Parts A, B and C coverage information for individuals identified as Medicare beneficiaries.

6.2.2 Expanded Reporting Option

The Expanded Reporting Option is similar to the former VDSA/VDEA process. It includes submission of the MSP Input File for primary medical, hospital and prescription drug coverage for Active Covered Individuals, the Non-MSP File with supplemental prescription drug coverage records, Retiree Drug Subsidy (RDS) reporting and entitlement/enrollment query capability, and the optional Query Only Input File, in the form of an ANSI X12 270/271 Entitlement Query file. The COBC will provide response files with entitlement/enrollment information for Medicare Parts A, B, C and D with this option.

The Expanded Reporting Option represents the minimum you must adhere to for compliance to the Section 111 requirements plus the exchange of prescription drug coverage information. If you choose the Expanded Reporting Option, you must provide CMS with information about drug coverage for Medicare beneficiaries on a regular basis in the form of primary drug coverage on the MSP Input File, or supplemental drug coverage records or RDS retiree file records on the Non-MSP Input File.

If you maintain a Coordination of Benefits Agreement (COBA) with CMS for the purposes of receiving claims paid by Medicare for secondary payment by your plan, then you may submit supplemental prescription drug information using the COBA Drug Coverage Eligibility (E02) records and remain compliant with the requirements of the Section 111 Expanded Reporting Option. Note that we ask for this information during the Section 111 registration process. The COBC will track your COBA submissions accordingly.

MMSEA Section 111 Expanded GHP Reporting Option Files

File Type	Description
GHP MSP Input File	This is the data set transmitted from a MMSEA Section 111 responsible reporting entity (RRE) to the COBC that is used to report information regarding Active Covered Individuals.
GHP MSP Response File	This is the data set transmitted from the COBC to the MMSEA Section 111 RRE after the information supplied in the RRE's MSP Input File has been processed.
TIN Reference File	The TIN Reference File consists of a listing of each business entity's federal tax identification number (TIN) and the business mailing address that is linked to that particular TIN.
GHP Non-MSP Input File	This is the data set transmitted from a MMSEA Section 111 RRE to the

File Type	Description
	COBC that is used to report information regarding the drug insurance coverage information of Inactive (e.g. not employed, retired) Covered Individuals.
GHP Non-MSP Response File	This is the data set transmitted from the COBC to the MMSEA Section 111 RRE after the information supplied in the Non-MSP Input File has been processed.
Query Only Input File	This is a query file used to obtain Medicare Part A entitlement and Parts B and C enrollment information of potential Medicare beneficiaries.
Query Only Response File	After the COBC has processed the Query Only Input File it will return the Query Only Response File with Medicare Parts A, B and C coverage information for individuals identified as Medicare beneficiaries.

7 GHP Mandatory Reporting Requirements

7.1 General Reporting Requirements

7.1.1 Responsible Reporting Entities

7.1.1.1 Who Must Report

A GHP organization that must report under Section 111 is defined as “an entity serving as an insurer or third party administrator for a group health plan...and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary.” These organizations are referred to as Section 111 GHP responsible reporting entities, or RREs. You must use the definitions given in Appendix G when determining whether or not you are a responsible reporting entity under this provision.

7.1.1.2 Use of Agents

See the discussion of “agents” with respect to GHP reporting in Appendix G.

GHP 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 COBC on behalf of the RRE. Information on the use of agents is required as part of the Section 111 registration process. The RRE remains solely responsible and accountable for adhering to the requirements of the Section 111 program and for the accuracy of data submitted.

7.1.2 Active Covered Individuals

Section 111 GHP RREs are required to report information for Medicare beneficiaries who have GHP coverage which is primary to Medicare and Medicare is the secondary payer on the MSP Input File. Since an RRE may not know whether a covered individual is a Medicare beneficiary, CMS is providing two approaches for RREs to determine whom to report for Section 111. The first involves reporting on individuals defined as “Active Covered Individuals”. The second involves using a “finder file” to query on an individual’s Medicare entitlement and enrollment to determine whether an individual should be included in the MSP Input File. The finder file method is described in Section 7.1.2.1.

NOTE: Under no circumstances should these two reporting options be construed as requiring RREs to report on individuals who are not Medicare beneficiaries. Instead these two options, properly executed, allow RREs to identify and report on all individuals who have Medicare and for whom Medicare is the secondary payer of benefits, as required by the Section 111 legislation.

The definition of an Active Covered Individual is set forth below. Active Covered Individuals are to be reported on the RRE's Section 111 MSP Input File. In many cases, the GHP coverage being reported will be primary to Medicare. When an RRE uses this reporting method, the COBC will determine whether the Active Covered Individual is a Medicare beneficiary based upon the information submitted and whether the GHP coverage reported is primary to Medicare. The results of that determination are provided back to the RRE on the MSP Response File. The phrase "current employment status" in the definition below refers to the subscriber's employment status. This includes employees who may be in a temporary disability status. It does NOT include a subscriber who is a retiree covered by an employer's retirement plan. Note that the part of the definition related to individuals with ESRD does not depend on the current employment status of the subscriber. However, except in certain circumstances where the retiree has ESRD, individuals covered by a retiree plan would never be considered Active Covered Individuals and should NOT be reported to CMS as Active Covered Individuals on the MSP File. Please refer to the MSP Overview for GHP section of this guide for further information on MSP rules.

For purposes of reporting, an Active Covered Individual is defined as someone who may be Medicare eligible and currently is employed, or the spouse or other family member of a worker who is covered by the employed individual's GHP and who may be eligible for Medicare and for whom Medicare would be a secondary payer for these individuals. On the MSP Input File, CMS is requiring an RRE using the Active Covered Individual definition to report for Section 111 to include all of the individuals covered by the GHP for whom, if they had Medicare, Medicare would be a secondary payer of their GHP benefits. The COBC will determine if the Active Covered Individual is a Medicare beneficiary based upon the information submitted and whether the GHP coverage overlaps Medicare coverage. The results of this determination are then provided to the submitter on the returned MSP Response File.

For purposes of Section 111 reporting, Active Covered Individuals are further defined to include:

- Effective January 1, 2009 through December 31, 2010, all individuals covered in a GHP age 55 through age 64 who have coverage based on their own or a family member's current employment status. Effective January 1, 2011 and subsequent, all individuals covered in a GHP age 45 through 64 who have coverage based on their own or a family member's current employment status.
- All individuals covered in a GHP age 65 and older who have coverage based upon their own or a spouse's current employment status.
- All individuals covered in a GHP who have been receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member's current employment status.
- All individuals covered in a GHP who are under age 55 (age 45 effective January 1, 2011), are known to be entitled to Medicare, and have coverage in the plan based on their own or a family member's current employment status. When reporting on individuals under age 45, you must submit their Medicare Health Insurance Claim Number (HICN).

With one exception, coverage through COBRA is not considered GHP coverage. Therefore, an individual covered by a COBRA plan is not considered an Active Covered Individual and should not be reported on the MSP Input File. The exception involves active dialysis treatment or kidney transplant. If the COBRA covered individual is receiving dialysis or has had a kidney transplant, the individual is considered an Active Covered Individual for reporting purposes.

Additional Notes on Active Covered Individuals:

1. If an employer has less than 20 full and/or part-time employees as defined in 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170, and the employer is not part of a multi-employer/multiple employer GHP, then the covered individuals under that plan do not have to be reported under Section 111 unless a covered individual is receiving dialysis or has had a kidney transplant (ESRD).
2. The fact that an employer has less than 20 full and/or part-time employees is **NOT** a basis for excluding such employees from the Section 111 GHP reporting process if the employer is part of a multi-employer/multiple employer GHP. Please also refer to the section of this User Guide discussing the Small Employer Exception.
3. The size of the employer is not relevant with respect to reporting for individuals who have been receiving kidney dialysis or have received a kidney transplant (ESRD).
4. The MSP provisions for the disabled apply to all employers in a multi-employer/multiple employer GHP if one or more of the employers has 100 or more full and/or part-time employees.
5. The age threshold of 55 described above will be lowered to 45 for all MSP Input Files submitted January 1, 2011 and subsequent.

Examples of Active Covered Individuals:

1. A subscriber age 55 is an employee of a company with more than 19 employees. His wife age 56 is also covered by the plan. In this case, both the subscriber and his spouse are Active Covered Individuals due to their age. Coverage information should be submitted on the MSP Input file for each on separate reporting records.
2. A subscriber age 44 is an employee of a company with more than 19 employees. His wife age 56 and his son age 10 are also covered by the plan. In this case, only the spouse qualifies as an Active Covered Individual since she is over the age threshold. Only the spouse's GHP coverage information should be submitted on the MSP Input File.
3. A subscriber age 44 is an employee of a company with any number of employees. His son age 10 is also covered by the plan. His son is known to have ESRD and be entitled to Medicare. In this case, the son is an Active Covered Individual but the subscriber is not. GHP coverage information for the son should be submitted on the MSP Input File. Since the son is under 45, his Medicare HICN must be included.
4. A subscriber is a retiree and she and her husband are covered by the GHP through her retirement plan. Neither is known to have ESRD. Neither is considered an Active Covered Individual since the subscriber is not currently employed. No information should be sent on these individuals on the MSP Input File.

5. A subscriber is an employee of a company with more than 19 employees and he and his wife are both 67. His wife is not covered by the GHP. Only the subscriber is an Active Covered Individual since his wife is not covered by the plan. Only information on the subscriber will be sent on the MSP Input File.
6. A subscriber age 66 is an employee of a company with less than 20 employees. The subscriber is not known to have ESRD and not known to be a Medicare beneficiary. The employer is NOT part of a multi-employer GHP. Technically, the subscriber fits the definition of an Active Covered Individual. However, since the employer has less than 20 employees and is not part of a multi-employer GHP, this individual does not have to be reported on the MSP Input File. Alternatively, a record for him could be submitted but the COBC will determine that the coverage is not primary to Medicare due to the employer's size.

7.1.2.1 Finder File Approach to Determining Whom to Report

As second approach to determine which individuals to report, CMS is making a "finder file" method available to Section 111 GHP RREs. This approach involves the RRE first sending a query file of Active Covered Individuals through which the COBC would identify any Medicare beneficiaries based on the information submitted and return these positive identifications to the RRE. The RRE would then submit MSP Input File records for those identified Medicare beneficiaries who have coverage based on their own or a family member's current employment status or those known to have ESRD and for whom Medicare should be the secondary payer of benefits.

If you choose to use the "finder file" approach, query records must be submitted via the Query Only Input File (Basic or Expanded Reporting Option) or as N records on your Non-MSP Input File (Expanded Reporting Option only). Requirements for these file submissions are provided in a later section of this guide. Note that a Non-MSP Input File cannot be submitted with only N records. The query file must be submitted in a timely fashion such that you are able to meet the requirements for quarterly file submission of your MSP Input File during your assigned file submission timeframe. Query records must be submitted using accurate information for the data elements the COBC uses as matching criteria for individuals (HICN or SSN, name, date of birth, and gender). Query files can be submitted no more often than on a monthly basis. All other requirements for the MSP Input File must be adhered to including reporting applicable individuals with new or changed coverage with each quarterly submission.

7.1.3 Inactive Covered Individuals

Inactive Covered Individuals are to be reported on your Non-MSP Input File and can be submitted on your Query Only Input Files. In most cases for these individuals, the GHP coverage you provide will be secondary to Medicare and Medicare will be the primary payer.

Inactive Covered Individuals are people who are currently not employed (most are carried as retired), and a spouse and (or) other dependents, enrolled in your GHP who cannot be classified as Active Covered Individuals.

7.1.4 File Format

All data files submitted for Section 111 must be fixed width, flat files. All records in the file must be the same length as specified in the file layouts. All data fields on the files are of a specified length and should be filled with the proper characters to match those lengths. No field delimiters, such as commas between fields, are to be used. Detailed record and field specifications are found in the appendices of this guide.

Header, Detail and Trailer Records

Each input file format contains at least three record types. The file begins with a header record. Header records identify the type of file being submitted and will contain your Section 111 Reporter ID. You will receive your Reporter ID on your profile report after your registration for Section 111 is processed. Detail records represent coverage information or query requests for individual people. Each file always ends with a trailer record that marks the end of the file and contains summary information including counts of the detail records for validation purposes. Each header record must have a corresponding trailer record. Each trailer record must contain the proper count of detail records. **Do not include the header and trailer records in these counts.** If the trailer record contains invalid counts, your file will be rejected.

7.1.5 Data Formatting Standards

Conventions for Describing Data Values

The table below defines the formatting standard defined for each data type found in the Section 111 files, both input and response.

Data/Field Type	Formatting Standard	Examples
Numeric	Zero through 9 (0 → 9) Padded with leading zeroes	Numeric (5): "12345" Numeric (5): "00045"
Alpha	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.	Alpha (12): "TEST EXAMPLE" Alpha (12): "EXAMPLE "

Data/Field Type	Formatting Standard	Examples
Alpha-Numeric	A through Z (all alpha) 0 through 9 (all numeric) Left justified Non-populated bytes padded with spaces Alphabetic characters sent in lower case will be converted and returned in upper case.	Alphanumeric (8): "AB55823D" Alphanumeric (8): "MM221 "
Text	A through Z (all alpha) + 0 through 9 (all numeric) + special characters: Comma (,) Ampersand (&) Space () Dash (-) Period (.) Single quote (') Colon (:) Semicolon (;) Number (#) Forward slash (/) At sign (@) Left justified Non-populated bytes padded with spaces Alphabetic characters sent in lower case will be converted and returned in upper case.	Text (8): "AB55823D" Text (8): "XX299Y " Text (18): " ADDRESS@DOMAIN.COM " Text (12): " 800-555-1234" Text (12): "#34 "
Date	Format is field specific Fill with all zeroes if empty (no spaces are permitted)	CCYYMMDD (e.g. "19991022") Open ended date: "00000000"
Filler	Populate with spaces	
Internal Use	Populate with spaces	
<i>The above standards apply unless otherwise noted in layouts.</i>		

7.1.6 Section 111 Registration

7.1.6.1 Overview

The registration process requires responsible reporting entities (RREs) to provide notification to the COBC of their intent to report data to comply with the requirements of Section 111 of the MMSEA. Registration by the responsible reporting entity is required and must be completed before testing between the RRE (or its agent) and the COBC can begin. Through the registration process, the COBC will obtain the information needed to:

- Validate information provided by the RRE registrant
- Assign Section 111 Reporter IDs (RRE IDs) to each RRE
- 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 production live date and ongoing file submission timeframe to each entity
- Establish the necessary file transfer mechanisms
- Assign a COBC Electronic Data Interchange Representative (EDI Rep) to each entity to assist with ongoing communication and data exchange, and
- Assign Login IDs to individual users associated with each RRE account.

New Section 111 GHP RREs will register on the COB Secure Web site (COBSW) from April 1, 2009 through April 30, 2009 using a new, interactive, Web portal designed for this purpose.

Former VDSA/VDEA partners who have already registered for Section 111 using the paper form, will also complete the account set up steps on the COBSW. However, the data you provided previously will be pre-loaded. Details on this are provided in Section 7.1.6.3.

The website URL will be www.Section111.cms.hhs.gov. The website is not yet available but you may review the requirements for registration at www.cms.hhs.gov/MandatoryInsRep/Downloads/RegistrationOverview.pdf.

7.1.6.2 Registration and Account Setup Process

Section 111 registration and account set up is a five-step process.

Step 1: Identify an Authorized Representative, Account Manager and other COBSW Users

Each RRE must assign or name an Authorized Representative. This is the individual in the RRE organization who has the legal authority to bind the organization to a contract and the terms of MMSEA Section 111 requirements and processing. The Authorized Representative has ultimate accountability for the RRE's compliance with Section 111 reporting requirements.

The Authorized Representative:

- Cannot be a user of the COBSW.
- Cannot be an agent of the RRE.
- May perform the initial registration on the COBSW, but will not be provided with a Login ID.
- Will designate the Account Manager.
- Must approve the account set up, by physically signing the profile report including the Data Use Agreement, and returning it to the COBC.
- Will be the recipient of COBC notifications related to non-compliance with Section 111 reporting requirements.

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

The Account Manager:

- Must register on the COBSW, obtain a Login ID and complete the account set up tasks.
- Can be associated with another reporting entity if they receive the authorized PIN from the COBC mailing. This would occur when a reporting entity has multiple subsidiaries who will report separately for MMSEA Section 111 or when the entity chooses to name an agent as its Account Manager.
- Can invite other users to register on the COBSW and function as Account Designees.
- Can manage the RRE's profile including selection of a file transfer method.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use his/her Login ID and Password to transmit files if the RRE has specified SFTP as the file transfer method.
- Can review file transmission history.
- Can review file-processing status and file statistics.
- Can remove an Account Designee's association to an account.
- Can change account contact information (e.g. address, phone, etc.)
- Can change his/her personal information.
- Cannot be an Authorized Representative or Account Designee for the same RRE.

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

The Account Designee:

- Must register on the COBSW and obtain a Login ID.
- Can be associated with multiple RRE accounts, but only by an Account Manager invitation for each RRE ID.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use his/her Login ID and Password to transmit files if the RRE has specified SFTP as the file transfer method.
- Can review file transmission history.
- Can review file-processing statuses and file statistics.
- Can change his/her personal information.
- Cannot be an Authorized Representative or Account Manager for the same RRE ID.
- Cannot invite other users to the account.
- Cannot update RRE account information.

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

Step 2: Determine Reporting Structure

Before beginning the registration process, an RRE must also determine how the RRE will submit its Section 111 files to the COBC and how many Section 111 Reporter IDs (RRE IDs) will be needed. Only one MSP Input File may be submitted on a quarterly basis for each RRE ID. Due to corporate organization, GHP enrollment system structures and agents that may be used for file submission, you may want to submit more than one MSP Input File to the COBC on a quarterly basis and therefore need more than one RRE ID in order to do so.

For example, if an RRE will use one agent to submit one set of GHP coverage information and another agent to submit another set of GHP coverage information, the RRE must register on the COBSW twice to obtain two RRE IDs that will be used by each agent respectively. You may name the same Authorized Representative and Account Manager for both accounts or use different individuals. Likewise, if you have two or more subsidiary companies that handle GHPs for different regions of the country (or different lines of business) using different enrollment/claims systems and you will not combine the MSP Input Files for Section 111 reporting, you must register for each claim file submission to obtain separate RRE IDs in order to submit multiple MSP Input Files in one quarter.

You may not set up a separate RRE ID for submission of the Query Only File or Non-MSP Input File only. You must submit a quarterly MSP Input File for every RRE ID you establish.

Step 3: RRE Registration on the COBSW

A company representative for the RRE must go to the Section 111 COBSW URL (www.Section111.cms.hhs.gov), click on the “New Registration” button, complete and

submit the registration for the RRE. This step must be completed by the RRE, not an agent for the RRE.

The application will ask that you submit:

- A Federal Tax Identification Number (TIN) for the RRE
- Company name and address
- Company authorized representative contact information (name, job title, address, e-mail address, phone)
- National Association of Insurance Commissioners (NAIC) company code, if applicable
- Reporter Type (GHP or Liability/No-Fault/Worker's Compensation)
- Optional Subsidiary company information to be included in the file submission for the registration (names, TINs, NAIC company codes for the subsidiaries).

When a registration application is submitted, the information provided will be validated by the COBC. Once this is completed, the COBC will send a letter via the US Postal Service to the named Authorized Representative with a personal identification number (PIN) and the COBC-assigned RRE ID (Section 111 Reporter ID) associated with the registration.

The Authorized Representative must give this PIN and RRE ID to their Account Manager to use to complete the account set up step.

If you need more than one RRE ID for Section 111 reporting, this step must be repeated for each.

Note: Former VDSA/VDEA partners who have already registered for Section 111 prior to April 2009 will not need to perform Step 3. Instead, the COBC will mail a PIN to your Authorized Representative and your Account Manager will pick up from the next step.

Step 4: RRE Account Set Up on the COBSW – Account Manager

In order to perform the RRE account set up tasks, the RRE's Account Manager, on or after April 1, 2009, must go to the Section 111 COBSW URL (www.Section111.cms.hhs.gov) with the PIN and RRE ID and click on the "Account Setup" button.

The Account Manager will:

- Enter the RRE ID and associated PIN
- Enter personal information including name, job title, address, phone and e-mail address
- Create a Login ID for the COBSW
- Enter account information related to expected volume of data to be exchanged under this RRE ID (estimated number of covered individuals and estimated number of covered individuals age 45 and over)
- Enter reporting agent name, address, contact e-mail and TIN
- Select a file transmission method
- Provide file transmission information needed if the Connect:Direct transmission method is selected. See the later section on the Connect:Direct method to see what will be collected. **You must have complete file transmission information**

available if the Connect:Direct method is selected or this step cannot be completed and all the other data you provided will be lost.

Once the Account Manager has successfully obtained a COBSW Login ID, he/she may log into the application and invite Account Designees to register for Login IDs. In addition, after completing account set up for his/her first RRE ID, since only one Login ID is required per user, the Account Manager will bypass the steps for creating another Login ID and password when setting up subsequent RRE IDs.

Step 5: Return Signed RRE Profile Report – Authorized Representative

Once account set up has been completed on the COBSW (including file transmission details for Connect:Direct if that method is selected) and processed by the COBC, a profile report will be sent to the RRE's authorized representative via e-mail.

The Profile Report contains:

- A summary of the information you provided on your registration and account set up
- Important information you will need for your data file transmission
- Your RRE ID that you will need to include on all files transmitted to the COBC
- Your assigned production live date and ongoing quarterly file submission timeframe for the MSP Input File
- Contact information for your COBC EDI Representative who will support you through testing, implementation and subsequent production reporting.

The RRE's authorized representative must review, sign and return the profile report to the COBC. At that point, you may begin testing your Section 111 files. The COBC will send an email to your Authorized Representative and Account Manager indicating that testing can begin.

7.1.6.3 Former VDSA/VDEA Partner Account Setup

Former VDSA/VDEA partners who are GHP RREs registered and transitioned to Section 111 reporting prior to April 2009, before the COBSW was available. The process for setting up your account on the COBSW is as follows:

- Data that was provided on your registration form will be loaded under your assigned RRE ID to the COBSW. Your account will be set to a production reporting status.
- Prior to April 1, 2009, the COBC will mail your Authorized Representative a letter containing a PIN assigned to your RRE ID.
- Your Authorized Representative must give this PIN to the person chosen to be your Account Manager for the RRE ID.
- The Account Manager will go to the Section 111 COBSW home page, on or after April 1, 2009, (www.Section111.cms.hhs.gov) and click on the "Account Setup" button (Step 4 above).
- The Account Manager will enter the RRE ID and PIN.
- The Account Manager will create his Login ID and password and have the opportunity to review the pre-loaded account information. Some of this

information can be updated during this process. However, if you need to change your file transmission method or Authorized Representative, please contact your EDI Representative as that information cannot be changed online.

- After the Account Manager completes the account setup steps on the COBSW, the COBC will mail the Authorized Representative a new profile report that will show the COBSW Account Manager.
- Your Authorized Representative must review, sign and return the last page of the profile report to the COBC.
- After completing account setup, your Account Manager may return to the home page, login and invite Account Designees as desired.

7.1.7 Differences Between VDSA/VDEA and Section 111 Files

Responsible Reporting Entities (RREs) that are current VDSA/VDEA partners will note the following differences between VDSA/VDEA and Section 111 data exchange reporting:

- Each Section 111 RRE will be assigned a Section 111 Reporter ID number. This number will replace the partner's existing VDSA or VDEA ID number. The RRE Reporter ID will be entered in Field 2 of the Header and Trailer Files for the Section 111 GHP MSP, Non-MSP, and TIN Reference Input Files. The partner's previous VDSA or VDEA ID will no longer be valid or used in these files.
- The Query Only File layouts have been updated to reflect submission of the Section 111 Reporter ID (RRE ID) in the header and trailer records. Please see Appendix B. These new layouts will be accepted for test files beginning April 1, 2009 and for production files submitted on or after July 1, 2009. Query Only Files with your former VDSA or VDEA ID will continue to be accepted and processed in production after July 1, 2009. However, it is recommended that you convert and use the new format with your RRE ID to be consistent with your other file submissions.
- Pseudo-TINs for employer EIN reporting will no longer be permitted for inclusion on the MSP Input File and TIN Reference File as of January 1, 2010. All former VDSA/VDEA partners who have transitioned to Section 111 RREs must provide valid TINs for employers on all file type submissions January 1, 2010 and subsequent. RREs must send correct employer TINs in an updated TIN Reference File with their First Quarter 2010 submissions or prior. RREs must also submit MSP Input File update records with valid employer TINs to correct previously submitted records with pseudo-TINs at that time. Valid insurer TINs must be submitted on the TIN Reference File starting January 1, 2009. Pseudo-TINs are not permitted under any circumstances for insurer TINs.
- Effective January 1, 2009 through December 31, 2010, on the MSP Input File, the age threshold for reporting Active Covered Individuals not otherwise known to be Medicare beneficiaries is 55 years of age and older. Effective with files submitted January 1, 2011 and subsequent, this age threshold will be 45 years of age and older. See the section on Active Covered Individuals.

- A "Small Employer Exception (SEE) HICN" field has been added; see Field 32 on the MSP Input File Detail Record. Data supplied in new Field 32 and existing Field 16 will be used in conjunction with records of previously approved small employer exception requests to ensure that we know when Medicare is primary for a particular beneficiary with the exception. A full explanation of the "Small Employer Exception" is provided in a later section of this guide.
- A "SEE Response Code" field has been added to the MSP Response File at Field 81. The full explanation of the "SEE Response Code" is provided in a later section of this guide.
- A "Late Submission Indicator" field has been added on the MSP Response File. It will be filled if the submitted record was not received within its required submission period. The "Late Submission Indicator" is at Field 82.
- Compliance Flag fields have been added on the MSP Response File in Fields 83-92. These flags are explained in a later section of this guide.
- For Section 111 production file exchange, each current VDSA or VDEA partner will be assigned a new file submission timeframe. It will replace the file submission schedule a partner is using in the Voluntary program.

NOTE: If the GHP coverage period for an Active Covered Individual was previously submitted under VDSA/VDEA reporting and an MSP occurrence was created, a former VDSA/VDEA RRE does not need to resubmit that record for Section 111 unless updates are needed.

7.1.8 File Submission Timeframes

MSP Input and TIN Reference Files must be submitted on a quarterly basis during your assigned file submission timeframe. You will receive your file submission timeframe assignment on your profile report which is sent after the COBC has processed your Section 111 registration. Each 3-month calendar quarter of the year has been divided into 12 submission periods as shown in the chart below. For example, if you have been assigned to Group 7, you will submit your MSP Input and associated TIN Reference File between the 15th and 21st day of the second month of each calendar year quarter; February 15th and February 21st for the first quarter, May 15th and May 21st for the second quarter, August 15th and August 21st for the third quarter and November 15th and November 21st for the fourth quarter of each year.

Note: Your MSP Input File receipt date will be set by the COBC system when the batch cycle runs. The COBC batch cycle runs nightly Monday-Friday, except holidays. RREs must send their files as close to the first day of their submission timeframe as possible in order to have the file receipt date fall within their submission timeframe. For example, if you submit a file on a Saturday, the COBC system will not mark the receipt date until the COBC batch cycle runs on Monday night. In addition, if the batch cycle runs past midnight, your file receipt date might not be set until Tuesday. The seven-day submission window is provided to account for this delay between file transmission and receipt date determination. It is not intended to allow you more time to submit your file.

You should be ready to transmit your files to the COBC on the **first** day of your submission timeframe to be compliant with Section 111 reporting requirements.

There is no submission timeframe associated with Query Only or Non-MSP Input Files. You may start sending these files as frequently as monthly, after your production live date, on any day of the month.

Quarterly MSP Input File Submission Timeframes

Dates	1st Month	2nd Month	3rd Month
01 - 07	Group 1	Group 5	Group 9
08 - 14	Group 2	Group 6	Group 10
15 - 21	Group 3	Group 7	Group 11
22 - 28	Group 4	Group 8	Group 12

7.2 MSP Input File Requirements

7.2.1 Overview

The MSP Input File is the data set transmitted from a Section 111 GHP responsible reporting entity to CMS that is used to report information regarding Active Covered Individuals who are Medicare beneficiaries. Please review Sections 7.1.2 and 7.1.2.1 information on the reporting using the definition of Active Covered Individuals and the finder file approach. If using the definition of Active Covered Individuals to report, you must include information about all Active Covered Individuals who are at least 55 years of age and older (age 45 and older effective January 1, 2011). You must also include information on Active Covered Individuals you know or should know to be Medicare beneficiaries or being treated for End Stage Renal Disease (ESRD). Some of the individuals on this file will obviously not be Medicare beneficiaries but CMS has determined that by using the age thresholds, information for the majority of Medicare beneficiaries will be captured. Note that the age threshold will be lowered to 45 effective January 1, 2011. If you are using the finder file method, you must report on all Active Covered Individuals identified as Medicare beneficiaries through the query process.

CMS uses the information in this file to determine GHP coverage for Medicare beneficiaries that is primary to Medicare, data which is then used for proper claims payment. If your hospital/medical coverage for a Medicare beneficiary covered by Parts A and/or B during the same time period is primary to Medicare, the COBC sets up what is known as an “**MSP occurrence**” on the Medicare Common Working File (CWF). In the case of prescription drug coverage primary to Medicare for a Medicare beneficiary covered by Part D during the same time period, the MSP occurrence is established on the Medicare Beneficiary Database (MBD). MSP occurrences have start and end dates based on the beneficiary’s Medicare entitlement and enrollment and your coverage dates. An MSP occurrence will have an open end date if both your coverage and Medicare coverage are active. An end date is applied when either your or Medicare coverage ends. The COBC collects other health insurance information for Medicare beneficiaries from many sources so an MSP occurrence established from your data may get changed as a result of information received from other sources at times.

This file format requires you to initially send an “add” record for the first report of coverage for an Active Covered Individual. If that record is accepted by CMS as reflecting MSP (coverage primary to Medicare) then you only need to apply any changes to that information in “update” or “delete” records going forward. If the record is not accepted due to errors, you must correct it and resend. If the record is not accepted due the individual not being a Medicare beneficiary, then you must continue to send **current** information for the individual as an add record on all subsequent submissions until the record is either accepted, the individual is no longer an Active Covered Individual or your GHP coverage is terminated.

An MSP Response File will be sent back to you by the COBC for each MSP Input File you send. This is the data set transmitted from COBC to the GHP RRE after the information supplied on the MSP Input File has been processed. It consists of the same

data elements in the Input File, with updates applied by the COBC based on Medicare's information for that individual, disposition and error codes which let you know what we did with the record, as well as applicable Medicare entitlement and enrollment information.

MSP Input, TIN Reference and MSP Response Files and data element specifications can be found in Appendix A.

All Section 111 GHP RREs, regardless of the reporting option chosen, must submit MSP Input Files on a quarterly basis.

NOTE: On the MSP Input File, RREs are only to report individuals who have GHP coverage based on their own or a family member's current employment status or those known to have ESRD. It is important that you do **not** submit information for those covered by a retirement plan where Medicare is the primary payer on this file.

7.2.2 TIN Reference File

The TIN Reference File is submitted with the MSP Input File so that Insurer and Employer name and address information does not have to be repeated on every MSP Input Record. The TIN Reference File may be submitted within your MSP Input File as a logically separated file within the same physical file, or in a completely separate physical file. It has its own header and trailer records. It must be sent at the same time as your first MSP Input File.

The TIN Reference File is to be submitted with a record for each insurer and employer TIN reported in Fields 21 and 22 of your MSP Input File. This includes all associated insurer TINs submitted and a record for each employer group or plan sponsor TIN used. If the RRE is a TPA, then the TIN Reference File will contain records for all of its TPA TINs used on the MSP Input File in Field 22 as well as records for each of its client employer groups or plan sponsors that are reported in Field 21 of the MSP Input File.

The TIN Reference File must contain only one record per unique TIN and TIN Indicator combination. In most cases, a TIN has only one associated TIN Indicator (Field 8 of the TIN Reference File). The valid values include 'I' for an insurer/TPA TIN, 'E' for an employer TIN and 'Y' for an employer pseudo-TIN. In the case of an RRE that is a self-insured employer, the same TIN may represent the insurer and employer. In this situation, two TIN Reference File records for the TIN should be submitted, one with a TIN Indicator of 'I' and the other with a TIN Indicator of 'E'.

Each record on the TIN Reference File consists of a business entity's federal Tax ID Number (TIN) and the associated business mailing address that is linked to the particular TIN as reported in Field 21 (Employer TIN) and Field 22 (Insurer/TPA TIN) of an MSP Input File Record. Any TIN submitted on an MSP Input record must be included in the TIN Reference File in order for the MSP Input record to process.

An RRE can have more than one TIN. For example, an insurer or TPA may have claims operations defined for various regions of the country. Because they are separate business operations, each could have its own TIN, and each TIN may be associated with a distinct business mailing address. (Note: The TIN is the same as the federal Employer

ID Number, the EIN.) **The mailing address associated with each TIN on the TIN Reference File should be the address to which health care insurance coordination of benefits issues and recovery demands should be directed.** This mailing address will help CMS and others to direct correspondence to the most appropriate contact for the GHP RRE. If the RRE has more than one TIN, you may choose to report all records under one primary Insurer/TPA TIN or use different TINs on different records as you see fit.

In addition, you must provide complete TIN information about all your employer clients. **Every TIN submitted in Field 21 or 22 on the MSP Input File must have an associated record submitted for it on the TIN Reference File.**

There is no response file specifically associated with the TIN Reference File. If the TIN Reference File is found to be in error, you will be contacted by your COBC EDI Rep to resolve issues with your TIN Reference File. If your TIN Reference File is not processed successfully, records on your MSP Input File will be rejected with errors associated with the Insurer TIN and/or Employer TIN fields.

The TIN Reference File layout and field descriptions can be found after the MSP Input File layout in Appendix A.

NOTE: You do not need to send a TIN Reference File with every MSP Input File submission. After the initial file is processed, you only need to resend it if you have changes or additions to make. Only new or changed TIN records need to be included on subsequent submissions. In addition, all TINs will be verified so it is imperative that accurate information be provided in the file.

NOTE: For Taft-Hartley multiple employer/multi-employer plans (or other plans using an “hours bank” arrangement) covering individuals who routinely work for multiple employers in a single Section 111 reporting period, RREs should submit the plan sponsor TIN rather than the actual employer TIN in the Employer TIN (Field 21) of the MSP Input File record. The name, address, and EIN/TIN of the plan sponsor should then be submitted on the corresponding TIN Reference File detail record. For the time being, the TIN Indicator on the TIN Reference File record should be submitted with a value of ‘E’. A new TIN Indicator value will be added for Plan Sponsor TINs at a later date.

7.2.2.1 Special GHP Extension For Reporting Employer TINs

CMS recognizes the fact that some GHP Section 111 responsible reporting entities may not currently carry the Employer TIN for all of their employer clients in their systems. You must submit the applicable Employer TIN in Field 21 on each MSP Input File detail record and the associated employer name and address on the TIN Reference File detail record. In order to allow you time to obtain valid employer TINs, CMS is allowing a limited extension to the reporting requirement deadline for this particular data element.

Records for all Active Covered Individuals who are Medicare beneficiaries must be submitted per the Section 111 reporting requirements beginning with your initial MSP Input File submission. However, if the applicable Employer TIN is not available,

RREs may submit the record with what is referred to as a “pseudo-TIN” in Field 21. A pseudo-TIN is a 9 digit number made up by the RRE to represent an employer in lieu of a valid employer TIN.

The following rules apply to the use of pseudo-TINs for all GHP RREs:

- Pseudo-TINs are allowed only for employer TINs on files submitted from January 1, 2009 through December 31, 2009.
- A record is to be submitted on the TIN Reference File for all pseudo-TINs used in Field 21 of the MSP Input File records. The pseudo-TIN is placed in Field 1 of the TIN Reference File record. A value of ‘Y’ must be placed in the TIN Indicator (Field 8) of the TIN Reference File record. A valid name and address for the employer must be placed in Fields 2-7 of the TIN Reference file record.
- Pseudo-TINs may only be used for employer TINs. Insurer TINs cannot be pseudo-TINs. You may not use a pseudo-TIN in Field 22 of the MSP Input File detail record. If an MSP Input record is submitted with a pseudo-TIN in Field 22, the COBC will return a compliance flag in the corresponding MSP Response File record. The record will be processed but the RRE will be considered out of compliance with Section 111 reporting requirements. The compliance flags are explained in a later section of this guide.
- Starting with file submissions January 1, 2010 and subsequent, RREs must have valid TINs for all employers. RREs must send correct employer TINs in an updated TIN Reference File. They must also submit MSP Input update records with valid employer TINs in Field 21 in place of the pseudo-TINs previously submitted.
- Starting January 1, 2010, the COBC will return a compliance flag on MSP Input records submitted with pseudo-TINs in the employer TIN field. The record will be processed but the RRE will be considered out of compliance with Section 111 reporting requirements. The compliance flags are explained in a later section of this guide.

7.2.2.2 TIN Validation

This section outlines the steps the COBC will take to validate TINs on the MSP Input File and associated TIN Reference File. Note that full MSP Response File processing and compliance flags are explained in more detail in a later section of this guide.

Employer TINs

- An employer TIN in Field 21 of the MSP Input File detail record must match a TIN on a current or previously submitted TIN Reference File record. The TIN Reference File record must have a TIN Indicator of ‘E’ or ‘Y’.
- If no matching TIN Reference File record is found or a match is found with a TIN indicator of ‘I’, the MSP Input record will be rejected with an ‘SP’ disposition code and errors associated with invalid employer information.
- If a match is found with a TIN Indicator of ‘E,’ then the TIN must be a valid IRS-assigned tax ID. Only the TIN will be used in this validation. The name

and address do not have to match the name and address associated with the TIN by the IRS. If the TIN is not valid, then the MSP Input record will be processed but a compliance flag will be set on the corresponding MSP Response File record.

- If a match is found with a TIN Indicator of 'Y', then the TIN will be considered valid until January 1, 2010. With files submitted after January 1, 2010, the MSP Input record will be processed but a compliance flag will be set on the corresponding MSP Response File record.

Insurer TINs

- An insurer TIN in Field 22 of the MSP Input File detail record must match a TIN on a current or previously submitted TIN Reference File record. The TIN Reference File record must have a TIN Indicator of 'I'.
- If a match is found on a TIN Reference File record with a TIN Indicator of 'Y', then the MSP Input record will be processed but a compliance flag will be set on the corresponding MSP Response File record.
- If a match is found on a TIN Reference File record with a TIN indicator of 'E' or no match is found, the MSP Input record will be rejected with an 'SP' disposition code and errors associated with invalid insurer information.
- If a match is found with a TIN Indicator of 'I', then the TIN must be a valid IRS-assigned tax ID. Only the TIN will be used in this validation. The name and address do not have to match the name and address associated with the TIN by the IRS. If the TIN is not valid, then the MSP Input record will be processed but a compliance flag will be set on the corresponding MSP Response File record.

7.2.3 Record Matching Criteria

7.2.3.1 Individuals

To determine whether an individual is a Medicare beneficiary, the COBC must match your data to Medicare's. You are required to send either a Medicare Health Insurance Claim Number (HICN) or the individual's Social Security Number (SSN) on your MSP Input File records. 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 (Sex).

First 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, you will always be returned the correct HICN to use going forward on all update and delete transactions. You should store this HICN on your internal files and use it on future transactions.

7.2.3.2 MSP Occurrences

MSP occurrences created and stored by the COBC for Medicare claims processing are keyed by:

- HICN
- MSP Effective Date
- Insurance Coverage Type (hospital, medical, drug, etc.)
- Patient Relationship Code (self, spouse, dependent, etc.)
- MSP Type (reason coverage is primary – working aged, ESRD, disability, etc.)

The COBC will use this criterion for subsequent update and delete transactions you send. You should save the MSP Effective Date returned to you on the response files in your internal files so it can be used for claims processing. The insurance coverage is what you provide on your input file. The MSP Type is generated by the COBC and depends on the reason the beneficiary is entitled to Medicare and why the GHP coverage is primary. You should (but are not required) send the HICN that the COBC sends back on the response file on all update and delete transactions.

NOTE: Since Medicare often determines entitlement/eligibility in advance, MSP Effective Dates returned may be future-dated.

7.2.4 Small Employer Exception (SEE)

If an employer, having fewer than 20 full and/or part-time employees, sponsors or contributes to a single-employer GHP, the MSP rules applicable to individuals entitled to Medicare on the basis of age do not apply to such individuals. Nonetheless, if such an employer participates in a multiple employer or multi-employer GHP and at least one participating employer has at least 20 full and/or part-time employees, these MSP rules apply to all individuals entitled to Medicare on the basis of age, including those associated with the employer having fewer than 20 employees. However, the law provides that a multi-employer GHP may be granted an exception with respect to certain individuals entitled to Medicare on the basis of age and who are covered as a named insured or spouse (covered individual) of an employer with fewer than 20 full and/or part-time employees.

In order for an MSP SEE to exist, the multi-employer GHP must request and the Centers for Medicare & Medicaid Services' (CMS) Coordination of Benefits Contractor (COBC) must approve the requested exception to the Working-Aged MSP rules. An approved exception will apply only with respect to the specifically named and approved beneficiaries associated with a specifically named employer participant in a specifically identified multi-employer plan. **This exception applies only to individuals entitled to Medicare on the basis of age.** All approvals are prospective. To request Medicare approval of a SEE, the multi-employer GHP must submit a written request, with all required supporting documents, to the CMS' COBC stating that the plan seeks to elect Medicare as the primary payer for identified beneficiaries who are associated with identified employers that participate in the specific multi-employer plan.

For the purposes of requesting the SEE, the term multi-employer GHP shall mean any trust, plan, association or any other arrangement made by one or more employers to contribute, sponsor, directly provide health benefits, or facilitate directly or indirectly the acquisition of health insurance by an employer member. (If such facilitation exists, the employer is considered to be a participant in a multi-employer GHP even if it has separate contract with an insurer.) However, the GHP can, by agreement or otherwise, delegate the responsibility for requesting the SEE to the insurer.

Multi-Employer GHPs & Medicare Entitlement Based Upon Disability or ESRD:

If an employer participates in a multi-employer GHP and at least one participating employer has at least 100 full and/or part-time employees, the MSP rules apply to all individuals entitled to Medicare on the basis of disability, including those associated with the employer having fewer than 100 full and/or part-time employees.

There are no exclusions to the MSP rules based upon employer size where Medicare entitlement is based upon ESRD/permanent kidney failure.

GHP RRE Section 111 Reporting with Respect to the SEE:

- If reporting on an Active Covered Individual for whom a SEE has been granted, place the individual's HICN in MSP Input File Field 32, Small Employer Exception HICN. If the COBC can match this to its records using the SEE HICN, employer EIN, and insurer policy number, the insurance effective date from the submitted MSP file will be compared to the SEE start and end dates.
- If the insurance coverage period is entirely within the SEE start and end dates, no working-aged MSP occurrence will be created and the coverage will not be considered primary to Medicare. A disposition code of 'BY' (bypassed) and a SEE Response Code (field 81) of 'SA' (SEE Accepted) will be returned on the MSP Response File.
- If the insurance effective date is prior to the SEE start date, an MSP occurrence will be generated if the individual was covered by Medicare for that period. The MSP Effective Date will be set as the insurance effective date submitted on the MSP Input File. The MSP Termination Date will be 1 calendar day prior to the SEE start date. The appropriate disposition code for the updated record and a SEE Response Code of 'SP' (SEE Partial) will be returned on the MSP Response File record.
- If the insurance effective date is within the SEE effective period and the insurance end date is after the close of the SEE effective period, the MSP Effective Date will be set to 1 calendar day after the SEE termination date. The appropriate disposition code for the updated record and a SEE Response Code of 'SP' (SEE Partial) will be returned on the MSP Response File record.
- If an MSP occurrence is created because the insurance coverage period is outside of the SEE effective period, the appropriate disposition code for the

updated record and a SEE Response Code of 'SN' (SEE Not Applicable) will be returned on the MSP Response File record.

- If a SEE match (HICN, EIN, Policy Number) is not found, an MSP occurrence will be generated if applicable. A SEE Response of 'SN' (SEE Not Applicable) will be returned to the submitter indicating that the SEE HICN was not found. This will give the submitter the opportunity to advise the multi-employer plan that CMS has no record of an approved SEE. The plan may then, if it wishes to do so, request a SEE.

Please refer to www.cms.hhs.gov/EmployerServices/05_smallemployerexception.asp for more information on applying for a SEE.

7.2.4.1 Extension for Reporting on Pending SEE Requests

For file submissions during 2009, after a multi-employer or multiple employer plan (or its insurer, if authorized to make the request on behalf of the plan) has submitted a SEE request to the CMS' Coordination of Benefits Contractor (COBC), CMS has determined that Responsible Reporting Entities (RREs) are not required to include data on Active Covered Individuals for whom the request was made until the submitter receives a reply to the request.

If a reply (including approval or rejection) from the COBC is received at any time during 2009, the RRE must then begin submitting data about the individual(s) for whom the SEE request was submitted to the COBC in its next scheduled submission. Effective January 1, 2010, data about individuals for whom a SEE has been requested must be included on MSP Input Files whether or not a reply to the SEE request has been received by the submitter.

Note: The responsible multi-employer or multiple employer plan must keep adequate records of all SEE request activity and be able to produce the documentation when requested by the COBC or by CMS.

7.2.5 Initial MSP Input File Submission

To begin reporting for Section 111, you must create and send a file that contains information for all Active Covered Individuals (or Active Covered Individuals who are identified to be Medicare beneficiaries through the query process) who were enrolled in your plan as of January 1, 2009 and subsequent. Information must be supplied for individuals whose GHP coverage effective date was prior to January 1, 2009 if that coverage was still in effect as of January 1, 2009. Information must be supplied for individuals who had active coverage at that time even if it has since been terminated. Information must be supplied for individuals who have enrolled in your plan(s) subsequent to January 1, 2009 even if their coverage has since been terminated. Information must also be supplied for individuals who are currently enrolled at the time of the report.

At least one record is to be supplied for each individual who qualifies as an Active Covered Individual, including the subscriber, the subscriber's spouse, and every other dependent that fits the definition of an Active Covered Individual. If an individual had multiple periods of coverage during this timeframe, multiple records must be submitted with the applicable effective and termination (end) dates (Fields 10 and 11). The effective date should reflect when the coverage was initially effective even if that occurred prior to January 1, 2009. If the coverage is current and open at the time of the report, the record should reflect an open-ended coverage by putting zeroes in the Termination Date (Field 11). Termination dates should only be supplied when the actual coverage reported has ended. Yearly renewals of the same coverage are not to be reported as separate records. If the coverage remains the same from year to year, a new record does not need to be reported since the previous report should have had an open-ended Termination Date.

Your initial MSP Input File will obviously be larger than your subsequent update files since it will contain the entire population of your Active Covered Individuals for whom you must report. All records on your initial file will be "add" records and have a value of zero ('0') in the Transaction Type (Field 7).

When you register for Section 111 reporting, you will be assigned a production live date and a 7-day window for your quarterly file submission. The production live date is the first day of your first quarterly submission timeframe and your initial MSP Input File must be received inside that 7 day window.

You must submit a TIN Reference File with your initial MSP Input File submission.

7.2.6 Quarterly Update MSP Input File Submissions

Each subsequent quarter after your initial MSP Input File submission, you must send an update MSP Input File to reflect any changes from the last submission, including new enrollees (subscribers and dependents) that are now Active Covered Individuals, changes to previously submitted records, corrections to previously submitted records, and updates to report on a coverage termination date.

Note that you may not have reported on an individual in your plan(s) previously since they were not an Active Covered Individual at that time. Each quarter you must check to see if they now fit that definition (i.e. have reached the age threshold, diagnosed with ESRD, been identified as a Medicare beneficiary through the query process, etc.) and send them on your quarterly update file.

If you are reporting any new TINs on your MSP Input File, submit a TIN Reference File with records for each new TIN with your update MSP Input File submission.

7.2.6.1 Add, Delete, Update Transactions

Add Transactions

An “add” record or transaction is defined with a ‘0’ (zero) in the Transaction Type (Field 7). An add is a new record of coverage information that the COBC has not posted to the Medicare CWF or MBD as an MSP occurrence. Records accepted and added as an MSP occurrence to the CWF or MBD receive an ‘01’ disposition code in your MSP Response File you receive back from the COBC. An add transaction could be a record never sent before or a record that was sent before but not accepted due to errors or the individual not being a Medicare beneficiary during the GHP coverage period at the time of processing.

Example: Mr. John X. Smith has not yet been included on an Input File. Although he had health insurance as a covered benefit through his employer, Mr. Smith was not yet 55 years of age. Mr. Smith reaches age 55. Consequently, in the next quarterly update MSP Input File, a record for Mr. Smith is sent as an add transaction if he was still covered under the plan after age 55. Note that this age threshold will be lowered to age 45 and older as of January 1, 2011.

Example: Information about Mr. John Jones, an Active Covered Individual, was included on a previous MSP Input File as an add transaction, but the record did not include enough of Mr. Jones’ required personal identification data elements. The COBC could not determine whether the name and SSN submitted belonged to a Medicare beneficiary, and so this attempt to add Mr. Jones was rejected. With the next quarterly update MSP Input File, an add transaction is sent with complete personal identification data elements for Mr. John Jones. The record now includes enough information for the COBC to confirm that he is a beneficiary and is accepted. NOTE: If rejected again, the record must continue to be sent as an add transaction (or re-queried using the finder file method) until you receive a response file from the COBC indicating the individual is a Medicare beneficiary and an MSP occurrence was posted, until the individual no longer satisfies the definition of an Active Covered Individual, or the individual is no longer covered by the plan.

Update Transactions

An “update” record or transaction is defined with a ‘2’ in the Transaction Type (Field 7). An update transaction is sent when you need to change information on a record previously accepted and added as an MSP occurrence to the Medicare CWF or MBD

by the COBC for which you received an '01' disposition code in your MSP Response File.

To successfully update a previously added record, the COBC must be able to match on the key fields of the MSP occurrence. Please refer to the Record Matching Criteria section of this guide. The COBC will use this criterion for update and delete transactions you send. You should save the HICN returned to you on the response files in your internal file so it can be used in subsequent update and delete transactions. Report the actual GHP effective date for the individual. The COBC will make the necessary calculations to match to the GHP effective date to the effective date of the corresponding MSP occurrence.

Example: In January, an add transaction was sent for an Active Covered Individual identified as a Medicare beneficiary, and a MSP occurrence was created and posted for the individual by the COBC. On July 15th, the individual stopped working and retired. On the next quarterly update MSP Input File, an update transaction is sent with July 15th in the termination date. The COBC updates the MSP occurrence previously posted with this termination date which will result in an indication that Medicare is the primary payer subsequent to July 15th.

Delete Transactions

A "delete" record or transaction is defined with a '1' in the Transaction Type (Field 7). A delete transaction is sent to remove an MSP occurrence previously posted to the CWF or MBD by the COBC. Records accepted and added as a MSP occurrence to the CWF or MBD receive an '01' disposition code in your MSP Response File you receive back from the COBC. If your add transaction did not result in an '01' disposition code, there's no need to delete it even if it was previously sent in error.

To successfully delete a previously added record, the COBC must match on the key fields of the MSP occurrence. Please refer to the Record Matching Criteria section of this guide. The COBC will use this criterion for update and delete transactions you send. You should (but are not required to) save the HICN returned to you on the response files in your internal file so it can be used in subsequent update and delete transactions to assure a match. Aside from the transaction type and possibly the HICN, a delete transaction should be submitted with the same values in other fields that were submitted on the original.

Example: A record was previously sent to the COBC and an MSP occurrence posted indicating that a GHP was a primary payer based on the individual's current employment status. Subsequently, it is discovered that the individual was not employed and that Medicare should have been the primary payer. The original record was sent and posted in error. A delete transaction is sent on the next quarterly update MSP Input File and the COBC removes the MSP occurrence from the CWF or MBD.

How to Report a Coverage Termination Date

If coverage for an Active Covered Individual previously sent and accepted by the COBC ends, you must send an update record with the Termination Date (Field 11). The COBC will update the MSP occurrence Termination Date and Medicare will

become the primary payer after that date. **Do not send a delete transaction** in these cases. A delete transaction will remove the MSP occurrence entirely, as though Medicare was always supposed to be the primary payer, and claims will be paid erroneously.

Correcting MSP Occurrence Key Information - When to Send a Delete and Add to Make Corrections

If you need to **correct** one of the key matching fields used for MSP occurrences (HICN/SSN, Effective Date, Insurance Coverage Type, or Patient Relationship), you need to follow a special process to make this update. First, a delete transaction must be sent in your file to remove the previously added record. The delete transaction should then be followed by an add transaction in the same file to add the record back with the corrected information. This process will completely replace the previously added MSP occurrence with the correct information.

Example: A record was previously sent with March 1 as the coverage effective date. The COBC returned a disposition code of '01' for the record on the response file and indicated that the MSP Effective Date on the posted record is March 1. Subsequently it is determined that the Active Covered Individual's GHP coverage effective date was actually April 1. A delete transaction is sent in the next quarterly MSP Input File with March 1 in the effective date. In the same file, but following the delete transaction, an add transaction is sent with April 1 as the effective date. The COBC removes the MSP occurrence with the March 1 effective date and adds the correct MSP occurrence with an April 1 effective date.

Changing Information Used to Determine Medicare Secondary Payer

The following fields are used, in part, by the COBC in determining whether Medicare is secondary to an RRE's GHP coverage for an individual:

- Coverage Type – Field 8
- Relationship Code – Field 12
- Employer Size – Field 16
- Employee Coverage Election – Field 19
- Employee Status – Field 20

If the information for any of these fields **changes** after an MSP occurrence has been created, do the following:

- Submit an update transaction with the old values and a termination date reflecting the last day the information was true.
- Submit an add transaction with the new data values with an effective date equal to the date the changed value became effective (the day after the termination date in the update record previously described.)

Example: An add transaction was sent indicating that the Coverage Type was Hospital and Medical (a value of 'A' in Field 8). The Effective Date submitted was January 1 and the Termination Date was open-ended. The record was accepted and the COBC created an MSP occurrence and returned a disposition code of '01'. Effective June 1, the coverage for the individual changed to Hospital Only. In the next quarterly file submission, an update transaction should be sent with a Coverage

Type value of 'A', Effective Date of January 1 and a Termination Date of May 31. In the same update file an add transaction should be sent with an Effective Date of June 1, an open-ended Termination Date and a Coverage Type of 'J' reflecting the new Hospital Only coverage.

Note that this situation differs from the previous discussion of deleting the original record and adding a new record. In this case the original record was correct but the information changed subsequent to the MSP occurrence being posted by the COBC. If information changes for other fields than those listed here and MSP occurrence key fields listed previously, you may simply submit one update transaction with the new information in the applicable field.

Initial Reporting When Employer Size Reaches 20 and Employer is Not Part of a Multi-Employer/Multiple Employer Plan

If coverage was not previously reported for any individuals due to the employer size being less than 20 employees, and subsequently the number of employees increases to 20 or more, the affected covered individuals must be reported on add records if they meet the other requirements to be included on the MSP Input File. Please refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 for details on the calculation of employer size. When these add records are submitted, you must use the **later** of the effective date of the new employer size or the individual's GHP coverage effective date in Field 10 (Effective Date) of the MSP Input File Detail record rather than simply the effective date of the individual's GHP coverage. This will ensure that the COBC creates an MSP occurrence starting at the date that Medicare becomes the secondary payer.

7.2.7 MSP Input File Detailed Requirements

- MSP Input Files must contain properly formatted header, detail and trailer records as defined in Appendix A.
- MSP Input Files must be submitted on a quarterly basis, four times a year.
- Files must be submitted within your assigned, 7-day submission period each quarter. The receipt date of your file will be set to the date the COBC batch system processes it. The COBC runs batch processes nightly Monday – Friday excluding holidays. As batch processing may cross midnight, the receipt date may not be defined until the day after transmission by the Section 111 RRE. Files submitted on weekends will be held and not processed until the Monday night batch cycle. If your receipt date falls after your 7 day submission timeframe, your file will be processed but will be marked as late on subsequent compliance reports.
- Current GHP VDSA/VDEA partners must submit their initial production Section 111 MSP Input File during the First Quarter (January – March) of 2009 during their assigned submission timeframe. Current VDSA/VDEA partners must submit their registration form to the COBC by October 31, 2008 and complete testing in time to submit their production file as specified above.
- Section 111 responsible reporting entities who do not (or did not) have a VDSA/VDEA in place with CMS must submit their initial production Section 111 MSP Input File during the Third Quarter (July – September) 2009 during their

assigned submission timeframe. They must register on the COB Secure Web site by April 30, 2009 and complete testing in time to submit their production file as specified above.

- RREs' initial file submissions must report on all Active Covered Individuals (or Active Covered Individuals identified as Medicare beneficiaries through the query process) with coverage as of January 1, 2009, regardless of the assigned date for a particular RRE's first submission.
- The initial MSP Input File must contain records for all Active Covered Individuals (or Active Covered Individuals identified as Medicare beneficiaries through the query process) who had open coverage under your GHP(s) as of January 1, 2009 even if it has since been terminated.
- A TIN Reference File must be submitted with the Initial MSP Input File containing records for each TIN or EIN submitted in Fields 21 and 22 of the MSP Input File.
- Subsequent MSP Input Files do not need to be accompanied by a TIN Reference File unless there are changes to previously submitted TIN information or new TINs have been added.
- All TINs (or EINs) on the MSP Input File records must have a corresponding TIN record on the TIN Reference File.
- The initial MSP Input File must contain records for all Active Covered Individuals (or Active Covered Individuals identified as Medicare beneficiaries through the query process) who have active coverage under your plan as of the date of submission. However, if the GHP coverage effective date is within 45 days prior to the start of your 7-day file submission timeframe, you may submit that information on your next quarterly file (the following quarterly file submission period). This grace period allows you time to process the new enrollee information internally prior to submission for Section 111. Records not received on time will be processed but marked as late and used for subsequent compliance tracking.
- Subsequent quarterly update files must include records for any Active Covered Individual (or an Active Covered Individual identified as a Medicare beneficiary through the query process) that you have added to your plan since the last file submission. However, if the coverage effective date is within 45 days prior to the start of your 7-day file submission timeframe, then you may submit that information on your next quarterly file. This grace period allows you time to process the new enrollee information internally prior to submission for Section 111. For example, if an Active Covered Individual's GHP coverage effective date is May 1, 2010, and your file submission period for the second quarter of 2010 is June 1-7, 2010, then you may delay reporting that individual until your third quarter file submission during September 1-7, 2010. However, if the individual's GHP coverage effective date is April 1, 2010, then you must include this individual on your second quarter file submission during June 1-7, 2010. Records not received timely will be processed but marked as late and used for subsequent compliance tracking.
- Subsequent quarterly update files must include updates to any previously submitted record that has changed since the last submission.
- Quarterly update files must contain resubmission of any records found in error on the previous file (Disposition Code of SP) with corrections made. Please refer to the Processing Response Files section for more information.
- Quarterly update files must contain resubmission of any records that received the Disposition Codes 'ID', '51' or '55' on the previous response file, if the individual

is still covered and is an Active Covered Individual (or an Active Covered Individual identified as a Medicare beneficiary through the query process), with corrections applied as needed. Please refer to the Processing Response Files section for more information.

- If you have no new information to supply on a quarterly update file, you must submit an “empty” MSP Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count.
- E-mail notifications will be sent to the Section 111 responsible reporting entity contacts after a file has been initially processed and when a response file has been transmitted or is available for download.
- Each detail record on the MSP Input File must contain a unique Document Control Number (DCN) generated by the RRE. This DCN is required so that response records can be matched and issues with files more easily identified and resolved. It can be any format of the RREs choosing as long as it is not more than 15 text characters as defined in the record layout. The DCN only needs to be unique within the current file being submitted.
- Employer size (the number of full or part-time employees, not the number of covered lives under a particular GHP) is critical to determining primary vs. secondary payment responsibility. RREs must report all Active Covered Individuals for all employers who are part of a multiple/multi-employer GHP regardless of the number of full or part time employees for a particular employer. RREs must have employer size information for all of the employers in a multiple/multi-employer GHP. Employer size must be reported on each MSP Input File record in Field 16. If the employer is part of a multi-employer plan, this field should reflect the size of the **largest** employer in the plan.
- Employer size must be based on the size of the entire company or corporation, not just the subsidiary. When calculating the number of employees, RREs should use the total number of employees in an organizational structure (parent, subsidiaries and siblings) rather than just the number of employees in the particular subsidiary being reported on. Subsidiaries of foreign companies must count the number of employees of the organization worldwide. Refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 for details on this calculation.
- A Flexible Savings Account (FSA) product is not considered to be GHP coverage for MSP purposes. RREs are not required to include FSA programs in Section 111 reporting.
- A Health Savings Account (HSA) is typically associated with a high deductible GHP product. Under current law, Medicare beneficiaries may not make further contributions to the savings portion of an HSA, although they retain access to previous contributions, both their own and those made by an employer. The CMS will not consider HSAs to be reportable under Section 111 as long as Medicare beneficiaries may not make a current year contribution to an HSA or did not make a contribution during the time he/she was a Medicare beneficiary.
- The CMS considers a Health Reimbursement Account (HRA) to be a GHP product for MSP purposes. RREs will be required to include HRA programs in Section 111 reporting beginning with MSP Input Files submitted in 4th Quarter 2010 (October – December 2010). This extension is being implemented to allow RREs time to gather the necessary information to report on HRA coverage. CMS will provide further instructions on reporting HRA coverage at a later date. **RREs are NOT to report HRA coverage information until the 4th Quarter of 2010.**

- Routine dental services and dentures are not covered benefits in the Medicare program although Medicare does cover inpatient hospital services required in dental services. Routine vision care is also not a covered Medicare benefit, although Medicare does cover periodic eye exams to check for the presence of diabetic retinopathy and will pay for one pair of glasses after one particular type of cataract surgery. When offered as stand-alone products, dental and vision care GHP coverage are not to be included in Section 111 reporting. However, RREs are responsible for being aware of situations where dental or vision care services are covered by Medicare and paying primary to Medicare for all beneficiaries who have such stand-alone coverage when appropriate.
- Behavioral/mental healthcare services are generally not covered benefits in the Medicare program. When offered as stand-alone products, behavioral and/or mental healthcare GHP coverage is not to be included in Section 111 reporting. However, RREs are responsible for being aware of situations where healthcare services are covered by Medicare and paying primary to Medicare for all beneficiaries who have such stand-alone coverage when appropriate.
- Information concerning an individual's coverage under TRICARE or a Medicare Advantage plan should not be included on the MSP Input File. TRICARE coverage is always secondary to Medicare, Medicare is the primary payer. Medicare Advantage is a form of Medicare coverage so it does not apply to MSP determinations.
- CMS recommends that RREs send a covered individual's HICN on MSP Input File records whenever it is available. The HICN is CMS' Medicare identifier for Medicare beneficiaries and is the preferred data element for matching purposes. RREs are encouraged to obtain HICNs from Medicare beneficiaries they cover and to use the HICNs passed back to them by the COBC on response files.

7.2.8 Special GHP Reporting Extension For Dependents

CMS recognizes the fact that some GHP Section 111 RREs may not currently carry the Social Security Number (SSN) for spouses and family members in their systems. You must send either the SSN or HICN for individuals on each detail record. In order to allow you time to obtain the SSN or the Medicare Health Insurance Claim Number (HICN) of Active Covered Individuals who are covered as dependents, CMS is allowing a limited extension to the reporting requirement deadline for these individuals.

RREs must have Social Security Numbers (SSNs) for all spouses and other family members who are Active Covered Individuals, in addition to having SSNs for the subscribers. RREs must submit the SSNs for all spouses and family members who are Active Covered Individuals and whose initial date of coverage is January 1, 2009, or later, in their initial file submission for Section 111 reporting and all subsequent submissions. However, RREs have until their file submission in the first quarter of 2011 to submit records with the SSNs for spouses and other family members who are Active Covered Individuals and whose initial date of coverage was **prior** to January 1, 2009. CMS considers the term "family member" to include any individual covered by the plan because of his/her association with the employed individual.

The extension is provided to all Section 111 GHP responsible reporting entities during 10/1/2008 to 12/31/2010. It is intended to allow you time to obtain the SSN or HICN of

spouses and family members. ***It does not apply to reporting subscriber information under any circumstances.*** You must have the SSN or HICN for subscribers at the start of Section 111 reporting and submit coverage information for Active Covered Individuals who are subscribers on your initial and all subsequent update MSP Input Files.

As of 1/1/2011, GHPs that were not reporting all required dependent coverage information must do so in their First Quarter (January – March) 2011 file. This report is to be retroactive and include all dependents with coverage effective dates prior to 1/1/09, and who were still active on 1/1/09.

For example, if you cover a spouse of a subscriber whose GHP coverage effective date was 1/1/2006, his coverage is still active as of 1/1/2009, but you do not have his SSN or HICN on file, you may delay reporting on this spouse until First Quarter 2011. However, if you cover a spouse whose GHP coverage effective date is 2/1/2009, you must obtain his SSN or HICN and report on this individual in your initial MSP Input File. **The extension does not apply to spouse/family members whose initial GHP coverage effective dates are 1/1/09 or later.**

7.2.9 Processing Response Files

For every MSP Input File you send to the COBC for Section 111 reporting, the COBC will send you a response file in return. The MSP Response File specifications are in Appendix A. The response file will be transmitted back to you within 45 days of receipt of your input file in the same manner you used to send your input file. The response file contains a header record, followed by detail records for each record you submitted on your input file, followed by a trailer record that contains a count of the detail records supplied. This count does not include the header and trailer records. In some cases (explained in a later section) you may receive more than one detail record for the input records you sent, but ordinarily it will be a one for one exchange. The response file detail records consist of the same data elements in the input file you sent with updated Medicare information applied by the COBC, the disposition and error codes which let you know what the COBC did with the record, as well as new information, such as Medicare entitlement and enrollment data, regarding the covered individuals themselves.

You must develop processing to react to the response file. Disposition, SP and Rx error codes are shown in Appendix D.

7.2.9.1 Disposition Codes

Every MSP Input File record will receive a disposition code on the corresponding response file record and you must take the following actions:

- Records marked in error with a 'SP' disposition code must be corrected and resent on your next quarterly submission.
- If a record was rejected with a disposition code of '51' or '55' which indicate the Active Covered Individual could not be matched to a Medicare Beneficiary, you must continue to resend **current information** for this individual in subsequent quarterly file submissions until it is accepted, your coverage for this individual is terminated, or the individual no longer meets the definition of an Active Covered Individual (e.g. employment ends, retirement, etc.).
- A disposition code of '51' will also be returned if neither a HICN nor SSN is submitted on the input record. You must obtain a valid HICN or SSN for the Active Covered Individual and resubmit the record on your next quarterly file submission.
- Records accepted with an '01' disposition code have been added by the COBC as coverage primary to Medicare in the form of an MSP occurrence on the Medicare CWF or MBD and will be used in Medicare claims processing to make sure Medicare pays secondary. The following fields may contain **updated** information from the COBC based on Medicare's information and could be used to update your internal files:
 - HICN
 - Active Covered Individual/Beneficiary Name
 - Date of Birth
 - Gender

- SSN

In addition, records returned with an '01' disposition code will contain the following information which you may use in your claims processing for coordination of benefits and proper claim processing:

- MSP Effective and Termination Dates – start and end dates for the period of time your coverage overlaps Medicare coverage, your coverage is primary to Medicare and should pay first. Note that in some cases, the MSP Effective Date may reflect a future date based on an established Medicare entitlement date in the future.
 - Medicare Part A, B, and C Coverage Dates
 - End Stage Renal Disease (ESRD) information
- Records that are rejected with any other disposition code must be resubmitted on your next quarterly update file. As a rule, you should check these records for accuracy, update the information previously sent, as applicable, and resubmit.
 - Note that since the age threshold for Active Covered Individuals is 55 (age 45 as of January 1, 2011) but most people are not entitled to Medicare until they are 65, you will receive a significant number of records back with disposition '51' each quarter. This is a completely acceptable situation and you should continue to send current information for these individuals with each quarterly submission until you receive an '01' disposition code, the GHP coverage is terminated or the individuals no longer fit the definition of Active Covered Individuals.

7.2.9.2 SP Error Codes

In Appendix D, all possible SP error codes are listed for reference. In the table, each error code is marked as "RRE Responsible" or "COBC Responsible". There are some errors that an RRE cannot fix, such as those related to conflicting data on internal Medicare databases.

Since the COBC must send records to other Medicare databases to post the MSP occurrences, errors beyond your control can occur. Usually the COBC corrects these errors before creating and sending your response file. At times though, due to the requirement to send a response file back to an RRE within 45 days, a response file might be sent back to you before these errors can be properly addressed. Thus, on rare occasions you may see such an error on your response file, accompanied by an SP disposition code. When this occurs, correct any other errors that are your responsibility and resend the record on your next quarterly submission.

Some SP error codes received on your MSP Response File may be due to errors on your TIN Reference File. If there is an error in a TIN or an insurer name or address submitted on a TIN Reference File, you will see the associated SP error codes posted on your corresponding MSP records. In order to correct these errors, you will need to resubmit an updated TIN Reference File with your next quarterly MSP Input File submission.

Special Consideration for the SP ES Error Code

On the MSP Input File you are asked to submit a code in Field 16, Employer Size, to reflect the size of the employer sponsoring the GHP associated with each Active Covered Individual. A value of zero indicates the employer has less than 20 employees; a value of 1 indicates 20 to 99 employees and a value of 2 indicates the employer has 100 or more employees.

The COBC uses the value provided in the Employer Size field when determining whether the GHP coverage is primary to Medicare and thus establishing MSP occurrences. In some cases an MSP occurrence is not created. For example, if an employer has less than 100 employees and the beneficiary is entitled to Medicare due to disability, Medicare will be the primary payer in any case and an MSP occurrence will not be created. (Note: If the employer is part of a multi-/multiple employer plan, Medicare is secondary if any employer in the plan has 100 or more employees.) In these situations, the COBC will return a disposition code of SP and put 'SPES' in one of the SP error code fields on the corresponding response file record.

Usually when processing an SP disposition code, you are to correct all errors and resubmit a record in your next quarterly response file. The SPES error code requires special handling and is an exception to this general rule.

When you receive an SPES error on a response file record, check that the employer size submitted was correct, update it if the employer size was submitted incorrectly, and continue to resend the record on all subsequent quarterly file submissions until the individual is no longer covered by your plan or an '01' disposition code is returned. Since the employer size may not change, you may continue to receive a response record back with a SP disposition and SPES error code for these situations.

Special Consideration for Non-Overlapping GHP and Medicare Coverage

If the Active Covered Individual you submit on a MSP Input File add record is not found to be a Medicare Beneficiary, you will receive a disposition code '51' back on your response file. However, if the individual is a Medicare beneficiary but your GHP coverage does not overlap Medicare coverage because it ended prior to Medicare enrollment, no MSP occurrence will be built. For example, the GHP coverage may be from 1/1/2009 to 3/31/2009 and Medicare coverage begins on 4/1/2009. In this particular situation, you will receive a disposition code of SP with a SP error code of SP32 or SP62 indicating you sent an invalid termination date or an SP75 indicating that the beneficiary did not have Medicare Part A entitlement during your GHP coverage period. Of course you cannot change the dates of your GHP coverage arbitrarily to "fix" this error. You may ignore the error, and if the individual is no longer considered to be an Active Covered Individual because he or she is no longer covered by your plan, discontinue sending a record for him or her on subsequent quarterly file submissions. If the individual is still an Active Covered Individual, you must continue to send the record on subsequent files.

This situation applies only to add records. If you receive a SP32/SP62 error on an update record you are sending to apply a termination date to a previously added

MSP occurrence (your GHP coverage has ended), then you most likely have an error in your system that needs to be addressed. Please see the description of SP error codes in Appendix D.

7.2.9.3 Rx Disposition and Rx Error Codes

If you are reporting under the Expanded Option, you will send primary prescription drug coverage on your MSP Input File. Prescription drug information can be sent as part of a combined coverage record with hospital and/or medical coverage (Input Field 8 Coverage Types V, W, X, Y, 4, 5, 6) or as a separate coverage record for drug-only (Input Field 8 Coverage Types U and Z). Records that contain information for both hospital/medical coverage and prescription drug coverage will receive one response record. The status of the hospital/medical coverage period will be provided in the disposition code field (Response Field 8) and the status of the drug coverage period will be provided in the Rx disposition code field (Response Field 69). If the input record contains drug coverage information only, then the disposition code in Field 8 will be spaces and the disposition of the drug coverage record will be in Response Field 69. This is due to the fact that MSP occurrences for hospital/medical coverage are stored on a different Medicare system database (CWF) than the MSP occurrences for prescription drug coverage (MBD).

The matching criterion for a MSP occurrence for prescription drug coverage that is primary to Medicare Part D is:

- HICN
- MSP Effective Date (later of GHP drug coverage effective date or Part D Enrollment Date)
- Patient Relationship Code (self, spouse, dependent, etc.)
- Section 111 Reporter ID (supplied on your header record)
- Insurance Coverage Type (Comprehensive hospital/medical/drug, Drug Only Network Drug, etc.)

The COBC will need to match on these fields when processing update and delete transactions for drug coverage records later.

The Rx Disposition Code (Response Field 69) provides you information regarding what was done with the prescription drug information you sent. The Rx Error Codes (Response Fields 71-74) are specific to the prescription drug coverage data elements on the MSP Input File including Rx Insured ID (Field 24) Rx Group (Field 25), Rx PCN (Field 26), Rx BIN (Field 27), Toll-Free Number (Field 28) and Person Code (Field 29). Drug records may also have errors for the non-drug-specific fields in the regular error codes found in Response Fields 40-43.

To process a response record for an input record that contains only hospital/medical information, you must examine:

- **The disposition code in response field 8**
- **The error codes in response fields 40-43**

To process a response record for an input record that contains drug and hospital and/or medical information, you must examine:

- **The disposition code in response field 8**
- **The error codes in response fields 40-43**
- **The Rx disposition code in response field 69**
- **The Rx error codes in response fields 71-74**

To process a response record for an input record that contains only drug information, you must examine:

- **The error codes in response fields 40-43**
- **The Rx disposition code in response field 69**
- **The Rx error codes in response fields 71-74**

Every MSP Input File record containing drug coverage information will receive an Rx disposition code on the corresponding response file record and you must take the following actions:

- Drug records marked in error with a 'SP' Rx disposition code must be corrected and resent on your next quarterly submission.
- If a drug record was rejected with a Rx disposition code of 'ID', '51' or '55' which indicate the Active Covered Individual could not be matched to a Medicare Beneficiary, you must check the information you sent for accuracy and then continue to send **current information** for the individual until it is accepted or this individual is no longer an Active Covered Individual.
- Drug records accepted with an '01' Rx disposition code have been added by the COBC as drug coverage primary to Medicare in the form of an MSP occurrence on the Medicare MBD and will be used in Medicare claims processing to make sure Medicare pays secondary. The following fields may contain updated information from the COBC and could be used to update your internal files:
 - HICN
 - Active Covered Individual/Beneficiary Name
 - Date of Birth
 - Gender
 - SSN

In addition, drug records returned with an '01' Rx disposition code will contain the following information which you may use in your claims processing for coordination of benefits and proper claim processing:

- MSP Effective and Termination Dates – start and end dates for the period of time your coverage is primary to Medicare and should pay first.
- Medicare Part A, B, C and D Coverage Dates
- End Stage Renal Disease (ESRD) information
- Records that are rejected with an Rx disposition code other than those listed above must be resubmitted on your next quarterly update file. As a rule, you

should check these records for accuracy, update the information previously sent as applicable, and resubmit.

7.2.9.4 Expanded Option Only - Part D Eligibility and Enrollment Data

For those reporting under the Expanded Reporting Option only, the MSP Response Files contain five related fields that can have information about current Medicare Part D eligibility and enrollment. These fields will be left blank on MSP Response File records for those reporting under the Basic Reporting Option.

Part D Eligibility Start Date (Field 60). This will be the first date a Medicare beneficiary can enroll in Part D. It is almost always the effective date of coverage for the beneficiary's Part A or Part B participation or January 1, 2006 since that was the start date of the Medicare Part D program. Information in this data field does not show that a beneficiary has enrolled in Part D.

Part D Eligibility Stop Date (Field 61). This is the date that a Medicare beneficiary's right to enroll in Part D has ended, for any reason.

The beneficiary's current Part D Plan is identified in Current Medicare Part D Plan Contractor Number (Field 57).

Current Medicare Part D Enrollment Date (Field 58). This is the effective date of a Medicare beneficiary's most recent enrollment in Part D. It is the current first date the beneficiary can receive Part D benefit coverage.

Current Medicare Part D Plan Termination Date (Field 59). This is the last date a Medicare beneficiary can receive Part D benefit coverage from the beneficiary's current Part D plan. After this date the beneficiary is no longer enrolled, and can no longer receive benefit coverage from the (most recent former) Part D plan.

MSP Response File Fields 58 and 59 tell you whether a beneficiary has actually chosen Part D coverage, and the period of time the current benefit coverage is in force. For Section 111 RREs, these two fields are the most immediate indicators of Part D coverage.

7.2.9.5 File Level and Threshold Errors

After completion of data quality edits, the COBC will check your MSP Input File to ensure it does not exceed any threshold restrictions. The file threshold checks include:

- 10% or more 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 MSP Input File was submitted during your defined quarter.

A file that exceeds the threshold checks will be suspended from further processing until the suspension is overridden by your COBC EDI Rep. An e-mail will be sent to your contacts named during registration to inform them of this suspension. You must contact your assigned EDI Rep to discuss and resolve file threshold errors. Your file

may be released for processing or, if sent in error, deleted by your EDI Rep in which case you must resend a corrected file as instructed by your EDI Rep.

7.2.9.6 Late Submission and Compliance Flags

The MSP Response File contains indicators or flags that provide information on issues related to reporting requirement compliance. 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 indicators is found on the record. Instead, the record is processed and an MSP occurrence posted if applicable. However the COBC will set the flags, track this information, and include it on compliance reports. The flags provide the RRE notice that the submitted record was not in compliance with Section 111 reporting requirements. You must review these flags, apply corrections to your internal system or data used for Section 111 reporting, and resubmit records with corrections, when applicable.

The first such field on the MSP Response File is the Late Submission Indicator in Field 82, which indicates that the submitted record was not sent timely. It is set to a value of 'Y' when the effective date of the covered individual's GHP coverage (Field 10 on the incoming MSP Input File) is more than 45 calendar days older than the start of the RRE's prior quarter submission timeframe. If the coverage effective date is within 45 days prior to the start of your 7-day file submission timeframe, then you may submit that information on your next quarterly file. This grace period allows you time to process the new enrollee information internally prior to submission for Section 111. Another way to look at it is that any record received on a quarterly file submission will be marked as late if the effective date is more than 135 days older than the start date of that same file submission period.

For example, suppose your second quarter file submission timeframe is June 1-7 and your third quarter file submission timeframe is September 1-7. The start date of your second quarter file submission is then June 1 and the start date of your third quarter file submission is September 1. A record with a GHP effective date of April 1 **MUST** be submitted on your second quarter file submission since April 1 is more than 45 days older than June 1. If it is received in your third quarter file submission in September (or later), it will be considered late, and the corresponding response record will have a 'Y' in the Late Submission Indicator field. However, a record with a GHP effective date of May 1, if received in your third quarter file submission, will not be marked as late since it is not more than 45 days older than June 1. The record with an effective date of May 1 may be submitted with your second quarter file submission in June if you have the information available in your system at that time. If not submitted in June, it **MUST** be submitted in your third quarter file submission in September. Note that the COBC will account for an individual's age in this determination. If the individual was not over the age threshold for reporting on April 1 in the previous example, the late submission indicator will not be set.

Following the Late Submission Indicator are a set of ten two-byte Compliance Flags in Fields 83-92. The possible values that could be posted in these flags are documented in the Compliance Flag Code table in Appendix D. If no compliance issue is found with the record, all the Compliance Flags on the response file record will be blank. If only one issue is found, then the corresponding code will be placed in

the first flag. If additional issues are found with the same record, then the corresponding compliance code will be placed in the second and subsequent flags (the first available flag field).

For example, if an MSP Input File record is submitted with an employer TIN that matches a TIN submitted on the TIN Reference File but that TIN could not be validated by the COBC, then the record will be processed and an MSP occurrence created if applicable, but the corresponding MSP Response File record will contain a value of '02' in Compliance Flag 1 (Field 83). The COBC will consider the TIN invalid if it cannot be matched to a valid IRS tax identification number or employer identification number (EIN) or if the TIN was submitted on the TIN Reference File as a pseudo-TIN (value of 'Y' in the TIN Indicator field) after January 1, 2010. A similar compliance check is applied to the insurer/TPA TINs submitted on the MSP Input File. The COBC will place a compliance code of '01' in the first available Compliance Flag when an insurer TIN cannot be validated or if the TIN was submitted on the TIN Reference File as a pseudo-TIN. When either of these codes is received back in a Compliance Flag on a response record, you must obtain the valid TIN and resubmit the record as an update transaction on your next quarterly file submission. At the same time, the valid TIN and TIN Indicator must also be submitted on an updated TIN Reference File record.

7.2.9.7 Split Entitlement Indicator – Multiple Response Records

Medicare entitlement and enrollment can begin, end and then begin again depending on many factors, which can result in a beneficiary having multiple periods of Medicare coverage. In addition, the reason for Medicare entitlement can change due to a disabled beneficiary turning age 65. Due to these multiple periods of coverage and reasons for entitlement, the COBC may create more than one MSP occurrence for a period of coverage under your plan. When this situation occurs, you will receive more than one MSP Response File record for the one Input File record submitted. Each response record will have a different MSP Effective and Termination Date depending on the periods of Medicare coverage. Your GHP coverage is primary during the MSP Effective and Termination Dates and during any periods where there is no Medicare coverage. Each Response File record will contain a 'Y' in the Split Entitlement Indicator (Response Field 44). Each record will contain your original DCN supplied on the input file record so you can match them to the original record submitted.

7.2.9.8 End Stage Renal Disease (ESRD)

In order to allow Section 111 reporting entities to better coordinate benefits for Medicare beneficiaries related to End Stage Renal Disease (ESRD), the COBC will provide ESRD data fields on your MSP Response File. These fields are the ESRD Coordination Period Start and End Dates, the First (oldest) Dialysis Date, the Self-Training Date, the most recent Kidney Transplant Date, and the most recent Kidney Transplant Failure Date. Please refer to response file fields 75-80 in the file specifications in Appendix A.

For an individual with ESRD there is an initial 30-month coordination of benefits period where the patient's GHP coverage may be primary to Medicare. Subsequent to that 30-month period, Medicare becomes the primary payer regardless of the patient's other GHP coverage. There are conditions that must be met in order for a patient to receive Medicare benefits and coverage for an ESRD diagnosis. Refer to <http://www.cms.hhs.gov/ESRDGeneralInformation/> [http://www.cms.hhs.gov/OrigMedicarePartABEligEnrol/06_PartAEligibilityforEnd-StageRenalDisease\(ESRD\).asp](http://www.cms.hhs.gov/OrigMedicarePartABEligEnrol/06_PartAEligibilityforEnd-StageRenalDisease(ESRD).asp) and http://www.cms.hhs.gov/EmployerServices/04_endstagerenaldisease.asp for more information related to the coordination of benefits with Medicare for ESRD.

Note that the MSP Effective Date on the MSP Response File may be adjusted to coincide with the start date for the 30-month coordination period in which GHP coverage is considered primary to Medicare.

7.3 Query Only Input File Requirements

7.3.1 Overview

The Query Only Input File is a dataset transmitted from a GHP Section 111 responsible reporting entity under the Basic and Expanded Reporting Options to request information regarding Medicare Part A entitlement and Parts B and C enrollment of potential Medicare beneficiaries. Note that this file does not currently provide Medicare Part D enrollment information. You may use this information in your claims processing to determine the primary payer. In most cases for Inactive Covered Individuals, if the individual is a Medicare beneficiary, then Medicare will be the primary payer.

The Query Only Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set. You may use your own translator software, or the HIPAA Eligibility Wrapper (HEW) software (provided by the COBC) to submit a Query Only Input File and process the Query Only Response File. To use the HEW software, you first will create an input file according to the specifications in Appendix B. This flat file is then used as input to the HEW software. You will install and run the HEW software at your processing site. The HEW software produces the X12 270 eligibility query file format which you then transmit to the COBC. The COBC will send back your response file in the X12 271. You will feed that into the HEW software to produce the Query Only Response File according to the specifications in Appendix B. This flat file containing Medicare entitlement and enrollment information for the individuals found to be Medicare beneficiaries can then be used in your internal systems to assist with coordination of benefits in your claims processing. Note that the Query Only Response File that is output from the HEW software does not contain any header or trailer records.

During registration for Section 111 reporting, you will be asked to indicate whether you wish to use the HEW software. If you choose that option, please contact your assigned COBC EDI Rep to provide you with a copy of the software. Mainframe and PC/Server-based versions of the HEW software are available.

If you choose to use your own ANSI X12 translator to create the ANSI X12 270 files for the Section 111 Query Only File and process the X12 271 response, please contact your EDI Rep for the necessary mapping documents.

The COBC is using the 4010A1 version of the X12 270/271. An upgrade to the 5010 version is tentatively planned for a January 2011 date.

Query Only Input and Response File specifications for the flat files that are the input and output of the HEW software can be found in Appendix B.

7.3.2 Query Only Input File Detailed Requirements

- Query Only Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set.

- Query Only Input Files may be submitted up to once per calendar month. These files do not have to be submitted during a specific submission timeframe.
- Only Medicare Part A, Part B and Part C coverage information will be supplied on the Query Only Response File. Part D coverage information will be added at a later date but only provided to those reporting under the Expanded Reporting Option.
- Query Only Response Files will be returned to you within 14 days.
- The following edits will be applied to the Query Only Input File. Any failure of these edits will result in the file being placed in a severe error status. You will receive an e-mail notification and are to contact your EDI Rep to address the identified errors. Files failing for these errors must be corrected before they can be processed.
 - File does not contain a header record
 - Header record does not contain a valid Section 111 Reporter ID
 - File does not contain a trailer record.
- E-mail notifications will be sent to the Section 111 responsible reporting entity contacts after the file has been received and when a response file has been transmitted or is available for download.
- Query Only Response Files will be returned with NO header and trailer records.

7.4 Non-MSP Input File Requirements

7.4.1 Overview

This is the data set transmitted from a GHP Responsible Reporting Entity (RRE) under the Expanded Reporting Option to the COBC that is used to report information regarding the prescription drug insurance coverage information of your Inactive Covered Individuals. These are people who are not currently employed by the GHP Plan Sponsor (most are carried as retired), a spouse, and other dependents, that are enrolled in a GHP but cannot be classified as Active Covered Individuals. The Non-MSP Input File is used to report drug coverage information that is secondary or supplemental to Medicare Part D. Information related to End Stage Renal Disease (ESRD) is also provided back on the Non-MSP Response File. You may use this information in your claims processing to determine the primary payer. In most cases for Inactive Covered Individuals, if the individual is a Medicare beneficiary, then Medicare will be the primary payer. The Non-MSP Input File can also be used to query CMS about potential beneficiary Medicare Parts A, B, C and D coverage. Finally, this file may also be used as a way to submit retiree files to the Retiree Drug Subsidy (RDS) Center on behalf of Plan Sponsors claiming the Retiree Drug Subsidy.

CMS uses the information in the Non-MSP File to determine GHP coverage that is secondary to Medicare Part D for Medicare beneficiaries, which is then used for proper claims payment and the calculation of the beneficiary's True Out of Pocket (TrOOP) drug costs. If the individual reported is a Medicare beneficiary enrolled in Part D and it is determined that your prescription drug coverage is secondary or supplemental to Medicare Part D, the COBC sets up a supplemental Part D record on the Medicare Beneficiary Database (MBD). Part D supplemental records have start and end dates

based on the beneficiary's Medicare entitlement, enrollment in Part D, and your coverage dates. A supplemental Part D record will have an open end date if both your coverage and Medicare coverage are active. An end date is applied when either your or Medicare coverage ends.

This file format requires you to initially send an "add" record for the initial report on supplemental prescription drug coverage for an Inactive Covered Individual or a RDS retiree file record. If that record is accepted by the COBC then you only need to apply any changes to that information in "update" or "delete" records going forward. If the record is not accepted due to errors, you must correct it and resend. If the record is not accepted due to the individual not being a Medicare beneficiary or not being enrolled in Part D during the reported drug coverage period, then you must continue to send it as an add record on all subsequent submissions until the record is either accepted or your coverage is terminated.

A Non-MSP Response File will be transmitted from the COBC back to you after the information supplied in your Non-MSP Input File has been processed. It consists of the same data elements in the Non-MSP Input File, with updates applied by the COBC based on Medicare's information, disposition and edit codes which let you know what we did with the record, as well as applicable Medicare entitlement and enrollment information.

This Non-MSP Response File format is also used to send you unsolicited response files originating from the RDS Center if you are opting to report RDS retiree files through Section 111 reporting. These transmissions from the RDS Center will notify you that significant data you previously submitted has changed. Unsolicited RDS responses are designated by the "RDSU" file type in Field 3 in the header and are discussed in a later section of this guide.

Non-MSP Input and Response File and data field specifications can be found in Appendix C. Each field description includes an explanation on how to use the field for the different record (action) types.

7.4.2 Action Types

Each record on the Non-MSP Input File contains an Action Type field to indicate what the record represents.

7.4.2.1 N – Query Records

Action Type "N" is known as a Non-Reporting Record and is used to query Medicare entitlement and enrollment information. The corresponding record in the Non-MSP Response File will contain the Medicare entitlement and enrollment information requested for the individual.

7.4.2.2 D – Supplemental Prescription Drug Coverage Records

Action Type “D” is known as a Drug Reporting Record and is used to submit prescription drug coverage that is secondary or supplemental to Medicare Part D for Inactive Covered Individuals. The corresponding record in the Non-MSP Response File will contain the Medicare entitlement and enrollment information requested for the individual as well as information about whether the supplemental drug record was accepted and posted by the COBC on the MBD.

7.4.2.3 S – RDS Retiree File Records

Action Type “S” is known as a Subsidy Reporting Record and is used to submit retiree file information to the RDS Center. The corresponding record in the Non-MSP Response File will contain information from the RDS Center indicating whether the retiree was accepted for the subsidy program as well as Medicare entitlement and enrollment information for the individual.

Note: If you are **not** submitting retiree file information to the RDS Center on behalf of a Plan Sponsor participating in the Part D Retiree Drug Subsidy Program, then you may disregard any further information regarding S records.

7.4.3 Record Matching Criteria

7.4.3.1 Individuals

To determine whether an individual is a Medicare beneficiary, the COBC must match your data to Medicare’s. You are required to send either a Medicare Health Insurance Claim Number (HICN) or the individual’s Social Security Number (SSN) on your Non-MSP Input File records. For matching an individual to determine if they are 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 (Sex)

First the COBC must find an exact match on the SSN or HICN. Then at least 3 out of the four remaining criteria must be matched exactly. If a match is found, you will always be returned the correct HICN to use going forward on all update and delete transactions. You should store this HICN on your internal files and use it on future transactions.

7.4.3.2 Supplemental Prescription Drug Records

Supplemental drug coverage records created and stored by the COBC for Medicare claims processing are keyed by:

- HICN
- Supplemental Coverage Effective Date
- Coverage Type (network drug only, comprehensive hospital/medical/drug, etc.)
- Patient Relationship Code (self, spouse, dependent, etc.) and
- Section 111 Reporter ID

The COBC will use this criterion for subsequent update and delete transactions you send. You should (but are not required) send the HICN that the COBC sends back on the response file on all update and delete transactions.

7.4.4 Initial Non-MSP Input File Submission

To begin Non-MSP reporting of supplemental drug coverage for Section 111, you must create and send a file of D records that contains information for all Inactive Covered Individuals who were enrolled in your plan as of January 1, 2009 and subsequent. Information must be supplied for individuals who had open coverage at that time even if it has since been terminated. Information must be supplied for individuals who have enrolled in your plan(s) subsequent to January 1, 2009 even if their coverage has since been terminated. Information must also be supplied for individuals who are currently enrolled at the time of the report.

One D record is to be supplied for each individual who qualifies as an Inactive Covered Individual including the subscriber, the subscriber's spouse, and every other dependent that fits the definition of an Inactive Covered Individual. If an individual had multiple periods of coverage during this timeframe, multiple records must be submitted with the applicable effective and termination (end) dates (Fields 10 and 11). The effective date should reflect when the coverage was initially effective even if that occurred prior to January 1, 2009. If the coverage is current and open at the time of the report, the record should reflect an open-ended coverage by putting zeroes in the Termination Date (Field 11). **Termination dates should only be sent when the actual coverage reported has ended. Yearly renewals of the same coverage are not to be reported as separate records. If the coverage remains the same from year to year, a new record does not need to be reported since the previous report should have had an open-ended termination date.**

Your initial Non-MSP Input File will obviously be larger than your subsequent update files since it will contain D records for the entire population of your Inactive Covered Individuals for whom you must report. All records on your initial file will be "add" records and have a value of zero ('0') in the Transaction Type (Field 21).

Your initial Non-MSP Input File may contain N query records for Inactive Covered Individuals for whom you wish to obtain Medicare coverage information.

You may submit your initial Non-MSP Input File at anytime during the first quarter you go live with production data as long as testing has been successfully completed.

N and D records can be mixed together on one "logical" file between the same header and trailer records. S records must be submitted on their own logical file with their own header and trailers. S records cannot be mixed in the same logical file as N/D records.

RREs may send in retiree files for multiple plan sponsors (employers) for multiple RDS applications. The RDS application number goes on the header record of the Non-MSP Input File. So if you are submitting retiree files for multiple plan sponsors, you must put the S records associated with each application number in separate logical files separated by the corresponding header and trailer records. All of these logical files can either be submitted separately or be concatenated together and submitted in one "physical" file as shown below. However, only one logical Non-MSP Input File with N/D records will be accepted per month. Multiple Non-MSP Files with S records will be accepted and are to be sent on the frequency required by the RDS Center. If you are not using the Non-MSP File to submit RDS retiree files, then one Non-MSP File can be submitted per month with a mixture of N and D records.

Non-MSP File Structure
Header Record for N/D Record File
N Record
D Record
D Record
D Record
Trailer Record for N/D Record File
Header Record for RDS Application 1
S Record
S Record
Trailer Record for RDS Application 1
Header Record for RDS Application 2
S Record
S Record
S Record
Trailer Record for RDS Application 2

7.4.5 Update Non-MSP Input File Submissions

An update Non-MSP Input File reflects any changes from the last submission including new enrollees (subscribers and dependents) that are now Inactive Covered Individuals with drug coverage under your plan, changes to previously submitted drug or subsidy records, corrections to previously submitted records, updates to report on a coverage termination date, and new query records. Update files containing N and D records may be submitted on a monthly or quarterly basis. No specific submission timeframe is assigned for Non-MSP Input Files. The only restrictions are that N and D records must be submitted on one input file and files with N and D records cannot be sent more often than once per calendar month.

RDS retiree files submitted via S records should be sent in separate Non-MSP Files with their own header and trailer records reflecting the associated RDS Application Number. Multiple Non-MSP Files with S records will be accepted and are to be sent according to the frequency required by the RDS Center.

Your Non-MSP Input update file may contain N query records for Inactive Covered Individuals for whom you wish to obtain Medicare coverage information.

7.4.5.1 Add, Delete, Update Transactions

Add, update and delete records are identified by a value in the Transaction Type (Field 21) on your Non-MSP Input File. *They do not apply to N query records.* These transactions are processed on Non-MSP Input Files in very much the same manner as described previously for the MSP Input Files.

Add Transactions

An “add” record or transaction is defined with a ‘0’ (zero) in the Transaction Type (Field 21). An add is a new record of coverage information that the COBC has not posted to the Medicare Beneficiary Database (MBD). D records accepted and added as supplemental drug coverage to the MBD receive an ‘01’ D/N disposition code (Field 48) in your Non-MSP Response File you receive back from the COBC. An add transaction could be a record never sent before or a record that was sent before but not accepted due to errors or the individual not being a Medicare beneficiary at the time of processing.

Update Transactions

An “update” record or transaction is defined with a ‘2’ in the Transaction Type (Field 21). An update transaction is sent when you need to correct information on a record previously accepted and added as a supplemental drug record to MBD for which you received an ‘01’ disposition code in your Non-MSP Response File.

To successfully update a previously added record, you must match on the key fields of the supplemental drug or subsidy record. Please refer to the Record Matching Criteria section of this guide. The COBC will use this criterion for update and delete transactions you send. You should save the HICN returned to you on the response files in your internal files so it can be used in subsequent update and delete transactions.

Delete Transactions

A “delete” record or transaction is defined with a ‘1’ in the Transaction Type (Field 21). A delete transaction is sent to remove a supplemental drug or subsidy record previously posted to the MBD from an add transaction. If your add transaction did not result in an ‘01’ disposition code, there’s no need to delete it even if it was previously sent in error.

To successfully delete a previously added record, the COBC must match on the key fields of the supplemental drug or subsidy record. Please refer to the Record Matching Criteria section of this guide. The COBC will use this criterion for update and delete transactions you send. You should save the HICN returned to you on the response files in your internal file so it can be used in subsequent update and delete transactions to assure a match.

How to Report a Coverage Termination Date

If your coverage for an Inactive Covered Individual previously sent and accepted ends, you must send an update record with the Termination Date (Field 11). The COBC will update the supplemental drug or subsidy record termination date. **Do not send a delete transaction** in these cases as that will remove the record entirely as though the coverage never existed and result in potential erroneous claims payment.

Correcting Supplemental Drug Record Key Information - When to Send a Delete and Add to Make Corrections

If you need to **correct** one of the key matching fields used for supplemental drug records, you need to follow a special process to make this update. First, a delete transaction must be sent in your file to remove the previously added record. The delete transaction should then be followed by an add transaction in the same file to add the record back with the corrected information.

Changing Coverage Information on a Supplemental Drug Record

If coverage information **changes** on a subsequent date after a supplement drug record has been posted by the COBC, then:

- Submit an update transaction with the old values and a termination date reflecting the last day the information was true.
- Submit an add transaction with an effective date equal to the date the changed value became effective (the day after the termination date in the update record previously described.)

7.4.6 Detailed Non-MSP Input File Requirements

- Non-MSP Input Files must contain properly formatted header, detail and trailer records as defined in Appendix C.
- Non-MSP Input Files may be submitted on a monthly or quarterly basis.
- Non-MSP Input Files must be received on at least a quarterly basis in order to be considered compliant with the requirements for the Expanded Reporting Option unless you are submitting supplemental drug coverage on E02 under a COBA.
- Only Section 111 responsible reporting entities that registered for the Expanded Reporting Option may submit Non-MSP Input Files.
- A Non-MSP Input File must contain at least one D or S record. It may not be used exclusively for querying about Medicare coverage with N records only.
- A single Non-MSP Input File may contain D and N records. S records are to be submitted on separate files.
- A Non-MSP response file for N and D records will be generated within 14 calendar days after the day of release into the system for processing. A response file will be generated when all records have been processed or after 14 calendar

days. If all records have not been applied, a disposition code will be returned indicating what records should be resent.

- Non-MSP Response Files for S records will be returned after the COBC has received a response from the RDS Center.
- The initial Non-MSP Input File must contain D records for all Inactive Covered Individuals who had open prescription drug coverage under your GHP(s) as of January 1, 2009 even if it has since been terminated.
- The initial Non-MSP Input File should contain D records for all Inactive Covered Individuals who have active prescription drug coverage under your plan as of the date of submission.
- The subsequent, update files should include D records for any Inactive Covered Individual you have added to your plan since the last file submission.
- The subsequent update files must include updates to any previously submitted D and S records that have changed since the last submission.
- Update files must contain resubmission of any records found in error on the previous file (Disposition Codes SP) with corrections made. Please refer to the Processing Response Files section for more information.
- Update files must contain resubmission of any records that received Disposition Codes 'ID', '51' or '55' on the previous file submission response with corrections applied as needed. Please refer to the Processing Response Files section for more information.
- E-mail notifications will be sent to the Section 111 responsible reporting entity contacts when the file has been received and when a response file has been transmitted or is available for download.
- CMS recommends that RREs send a covered individual's HICN on Non-MSP Input File records whenever it is available. The HICN is CMS' Medicare identifier for Medicare beneficiaries and is the preferred data element for matching purposes. RREs are encouraged to obtain HICNs from Medicare beneficiaries they cover and to use the HICNs passed back to them by the COBC on response files.

7.4.7 Processing Response Files

For every Non-MSP Input File you send to the COBC for Section 111 reporting, the COBC will send you a response file in return. The Non-MSP Response File specifications are in Appendix C. The response file will be transmitted back to you in the same manner you sent your input file. Response files for Non-MSP Files submitted with N and D records will be returned within 14 days of receipt of your input file. (See the later section of this guide on response files for Non-MSP Files with RDS retiree S records.) The response file contains a header record, followed by detail records for each record you submitted on your input file followed by a trailer record that contains a count of the detail records supplied. This count does not include the header and trailer records. In some cases which will be explained in later sections, you may receive more than one detail response record for the input record you sent but usually it will be one for one. The response file detail records consist of the same data elements in the input file you sent with corrections applied by the COBC, the disposition and error codes which let you know what the COBC did with the input record, as well as Medicare Part A, B, C and D coverage information.

You must develop processing to react to the response file. Disposition and error codes are shown in Appendix D.

7.4.7.1 Part D Eligibility and Enrollment Data

In addition to information on Medicare Part A, B and C coverage, in the Non-MSP Response Files there are five related fields that can have information about current Medicare Part D eligibility and enrollment.

Part D Eligibility Start Date (Field 35). This will be the first date a Medicare beneficiary can enroll in Part D. It is almost always the effective date of coverage for the beneficiary's Part A or Part B participation. Information in this data field does not show that a beneficiary has enrolled in Part D.

Part D Eligibility Stop Date (Field 36). This is the date that a Medicare beneficiary's right to enroll in Part D has ended, for any reason.

The beneficiary's current Part D Plan is identified in Current Medicare Part D Plan Contractor Number (Field 41).

Current Medicare Part D Enrollment Date (Field 42). This is the effective date of a Medicare beneficiary's most recent enrollment in Part D. It is the current first date the beneficiary can receive Part D benefit coverage.

Current Medicare Part D Plan Termination Date (Field 43). This is the last date a Medicare beneficiary can receive Part D benefit coverage from the beneficiary's current Part D plan. After this date the beneficiary is no longer enrolled, and can no longer receive benefit coverage from the (most recent former) Part D plan.

Non-MSP Response File Fields 42 and 43 tell you whether a beneficiary has actually chosen Part D coverage, and the period of time the current benefit coverage is in force. For Section 111 RREs, these two fields are the most immediate indicators of Part D coverage for Inactive Covered Individuals.

7.4.7.2 Processing "D" Response Records

Every Non-MSP Input File D record will receive a disposition code in the D/N Disposition Code (Field 48) on the corresponding response file record and you must take the following actions:

- Records marked in error with a 'SP' D/N disposition code must be corrected and resent on your next submission. Error codes are provided in Fields 44 – 47 on the Non-MSP Response File record. An explanation of the error codes is in Appendix D.
- If a record was rejected with a N/D disposition code of 'ID', '51' or '55' which indicate the Inactive Covered Individual could not be matched to a Medicare Beneficiary you must continue to resend **current information** for the individual in subsequent file submissions until it is accepted, your coverage

for this individual is terminated, or the individual no longer meets the definition of an Inactive Covered Individual (e.g. returns to work).

- An N/D disposition code of '51' will also be returned if neither a HICN nor SSN was submitted on the input record. You must obtain a valid HICN or SSN for the individual and resubmit the record in your next file submission.
- Records accepted with an '01' N/D disposition code have been added by the COBC as drug coverage supplemental to Medicare on the MBD and will be used in Medicare Part D claims processing. The following fields may contain updated information from the COBC based on Medicare data and could be used to update your internal files:
 - SSN
 - HICN
 - Inactive Covered Individual/Beneficiary Name
 - Date of Birth
 - Gender

In addition, records returned with an '01' disposition code will contain the following information which you may use in your claims processing for coordination of benefits and proper claim processing:

- Supplemental Drug Record Effective and Termination Dates – start and end dates for the period of time your drug coverage is secondary to Medicare Part D and Medicare should pay first.
- Reason for Medicare entitlement
- Beneficiary Date of Death
- Medicare Part A, B, C and D Coverage Dates
- End Stage Renal Disease (ESRD) information

7.4.7.3 Processing “N” Response Records

Every Non-MSP Input File N record will receive a disposition code in the D/N Disposition Code (Field 48) on the corresponding response file record and you must take the following actions:

- Records marked in error with a 'SP' D/N disposition code must be corrected and resent on your next submission. SP and Rx Error codes are provided in Fields 44 – 47 on the Non-MSP Response File record. An explanation of the error codes is in Appendix D.
- If a record was rejected with an N/D disposition code of 'ID', '51' or '55' which indicate the Inactive Covered Individual could not be matched to a Medicare Beneficiary, you must check the information you sent for accuracy and then resend as appropriate.
- Records accepted with an '01' N/D disposition code have been matched by the COBC to a Medicare Beneficiary and the beneficiary's Medicare coverage information has been provided on the response record. The following fields may contain updated information from the COBC based on Medicare data and could be used to update your internal files:

- SSN
- HICN
- Inactive Covered Individual/Beneficiary Name
- Date of Birth
- Gender

N records returned with an '01' disposition code will contain the following information which you may use in your claims processing for coordination of benefits and proper claim processing:

- Reason for Medicare entitlement
- Beneficiary Date of Death
- Medicare Part A, B, C and D Coverage Dates
- End Stage Renal Disease (ESRD) information

7.4.7.4 Processing "S" Response Records

Please refer to the RDS Retiree File Submission section.

7.4.7.5 Non-MSP Input File Level and Threshold Errors

After completion of data quality edits, the COBC will check your Non-MSP Input File to ensure it **does not exceed** any threshold restrictions. The file threshold checks include:

- 10% or more of the total D records are delete transactions
- More than one Non-MSP Input File with N/D records was submitted during a one month period of time
- No D or S records are included in the file. You may not send a Non-MSP Input File with only N query records. The Non-MSP Input File must contain supplemental drug coverage records. If you only have a need to query for Medicare entitlement, then the Query Only File format must be used.

A file that exceeds the threshold checks will be suspended from further processing until the suspension is overridden by your COBC EDI Rep. An e-mail will be sent to your contacts named during registration to inform you of this suspension. You must contact your EDI Rep to discuss and resolve file threshold errors. Your file may be released for processing or, if sent in error, deleted by your EDI Rep in which case you may resend a corrected file.

7.4.7.6 End Stage Renal Disease (ESRD)

In order to allow Section 111 RREs to better coordinate benefits for Medicare beneficiaries related to End Stage Renal Disease (ESRD), the COBC will provide ESRD data fields on your Non-MSP Response File for Inactive Covered Individuals. These fields are the ESRD Coverage Period Effective and Termination Dates, the

First (oldest) Dialysis Date, the Self-Training Date, the most recent Kidney Transplant Date, and the most recent Kidney Transplant Failure Date. Please refer to fields 55-60 in the Non-MSP Response File specifications in Appendix C.

For an individual with ESRD there is a 30-month coordination of benefits period for ESRD where the patient's GHP coverage may be primary to Medicare. Subsequent to that 30-month period, Medicare becomes the primary payer regardless of the patient's other GHP coverage. There are conditions that must be met in order for a patient to receive Medicare benefits and coverage for an ESRD diagnosis. Refer to <http://www.cms.hhs.gov/ESRDGeneralInformation/> [http://www.cms.hhs.gov/OrigMedicarePartABEligEnrol/06_PartAEligibilityforEnd-StageRenalDisease\(ESRD\).asp](http://www.cms.hhs.gov/OrigMedicarePartABEligEnrol/06_PartAEligibilityforEnd-StageRenalDisease(ESRD).asp) and http://www.cms.hhs.gov/EmployerServices/04_endstagerenaldisease.asp for more information related to the coordination of benefits with Medicare for ESRD.

7.4.8 True-Out-of-Pocket (TrOOP) Facilitation RxBIN and PCN Codes

Section 111 responsible reporting entities that choose the Expanded Reporting Option and provide supplemental prescription drug coverage to Inactive Covered Individuals will need to obtain TrOOP Facilitation RxBIN or PCN codes to route claims through the TrOOP Facilitator. The TrOOP Facilitation RxBIN or PCN codes are routing numbers used to flag claims for coverage supplemental to Medicare Part D that will be paid by Section 111 reporters or their agents. As it is being routed to the pharmacy, the TrOOP Facilitation RxBIN or PCN will enable the TrOOP Facilitation Contractor to identify a Part D supplemental claim, capture it, and transmit the supplemental paid claim amount to the appropriate Part D Plan to support the Plan's TrOOP calculation responsibilities. To route these claims through the TrOOP Facilitation Contractor, you may use a separate and unique RxBIN by itself or a unique PCN in addition to your existing RxBIN.

The organization that issues the original RxBIN is the American National Standards Institute, or ANSI. ANSI can be contacted through its Web address: www.ansi.org.

A different organization, the National Council for Prescription Drug Programs (NCPDP) issues the Processor Control Number, or PCN. For TrOOP routing you can use a new or additional PCN in lieu of an additional RxBIN. The NCPDP can be contacted through its Web address: www.ncpdp.org.

7.4.9 RDS Retiree File Submission

This section only applies to you if you plan to submit retiree files to the Part D Retiree Drug Subsidy (RDS) Center on behalf of a Plan Sponsor (usually an employer) through your Section 111 reporting process. If you have no plan to do that, you may ignore the information in this section.

You may use Section 111 reporting as an alternative method of providing retiree drug subsidy enrollment files to the RDS Center. After enrollment with the RDS program, a Plan Sponsor can use Section 111 for its necessary data transfer and management of retiree files with the RDS Center. Plan Sponsors wishing to receive the Part D Retiree

Drug Subsidy for retiree drug coverage must submit an initial application to the RDS Center, a requirement separate from the Section 111 process. For more information and complete requirements related to the retiree drug subsidy please visit: <http://rds.cms.hhs.gov/>.

As part of the application process, the Plan Sponsor must send an initial enrollment file of all retirees and dependents for whom they wish to claim the subsidy. The initial retiree file will be followed by regularly scheduled update files containing adds, updates and deletes.

Section 111 responsible reporting entities submitting retiree files for RDS may opt to do so using records with the 'S' Action Type in the Non-MSP Input File format. 'S' records require essentially the same data elements required for 'D' records. Non-MSP Input Files containing S records must contain the RDS Application Number, a data element the RDS Center will assign to a Plan Sponsor at the start of the RDS application process, in the associated header record for the file. Since the RDS Application Number is part of the Non-MSP header record, you may submit multiple Non-MSP Files for each RDS Application Number on the frequency prescribed by the RDS Center. These multiple files can be submitted separately or within the same physical file as long as the files are separated by the appropriate header and trailer records as shown below. *Do not put N and D records on a Non-MSP File containing S records.*

Non-MSP File Structure for RDS Retiree Files
Header Record for RDS Application 1
S Record
S Record
S Record
S Record
Trailer Record for RDS Application 1
Header Record for RDS Application 2
S Record
S Record
Trailer Record for RDS Application 2
Header Record for RDS Application 3
S Record
S Record
S Record
Trailer Record for RDS Application 3

The COBC essentially acts as a pass through and will send S records directly to the RDS Center for processing. The RDS Center will determine whether the covered individuals included on S records are eligible for the Subsidy (Part D eligible, but not enrolled in Part D). On the response records, the RDS Center will indicate whether a covered individual was accepted (eligible to be included as part of the plan sponsor's subsidy population) or rejected by putting a 'Y' or 'N' in the RDS Determination Indicator (Field 54). If the covered individual is not accepted for the subsidy or the record is in error, corresponding reason/error codes will be posted in the RDS Reason Code (Field

53). The COBC will populate the S response record with Medicare Part A, B, C and D coverage information as applicable. The COBC will then return the S records to the Section 111 reporter on a Non-MSP Response File.

Splits – Multiple S Response Records

Because periods of eligibility can be interrupted, or a retiree is not eligible for the subsidy for the entire year, you may get more than one S response record for a given submitted S record for a beneficiary/retiree. If this is the case, the RDS Split Indicator (Field 52) will be set to 'Y' and the RDS Start and End Dates in Fields 50-51 will reflect the split periods on each of the response records. Each response record will contain your original DCN (document control number) in the response Field 21. Each response record will contain the RDS Determination and Reason Codes that apply to the date span specified. For example, if the S record was sent to claim the subsidy for 1/1/2009 through 12/31/2009 but the retiree is not entitled to Medicare until 4/1/2009, one response record will include RDS Start and End Dates for 01/01/2009 through 03/31/2009 with a RDS Determination Indicator of N and a RDS Reason Code of 11 (person is not yet eligible for Medicare). The second response record will have dates 04/01/2009 through 12/31/2009 covering the remainder of the plan year with an RDS Determination Indicator of 'Y' and a blank RDS Reason Code.

RDS Determination and Reason Codes

When the original GHP data sharing process was first expanded to include RDS reporting capabilities, the COBC converted the RDS-specific Determination and Reason Codes to the existing data sharing process Disposition and SP Error Codes that appear in Field 29 (S Disposition Code) and Fields 44-48 (Error Codes) of the Non-MSP Response File. RDS has since added new RDS Reason Codes that could not be cross-walked to the existing codes, which are now the Section 111 Disposition Codes. Therefore, the Non-MSP Response record layout now includes the *actual* RDS Reason Code in Field 53 and the RDS Determination Indicator in Field 54 in addition to the cross-walked fields. Field 53 and 54 contain the same codes you would receive if you submitted the RDS retiree files directly to the RDS Center and not through the Section 111 process.

You should use Fields 53 and 54 for your S record response processing. For questions about the RDS codes please contact the RDS Center directly or visit <http://rds.cms.hhs.gov/>.

Converting an “S” Record to a “D” Record

Prior to transmitting the Non-MSP Response File back to you, when the COBC receives S record responses from the RDS Center, it will screen those responses for covered individuals who do not qualify to be counted in the Plan Sponsor's drug subsidy because they are enrolled in Part D. These individuals will then be considered to have other drug coverage supplemental to their Part D coverage. Accordingly, using the information you sent on the S record the COBC will add a supplemental drug coverage record to the MBD (as it would with a standard D

record). You will receive one response record with a D in the Action Type Field 24 and S in the Original Action Type Field 23. The RDS Determination and Reason Codes in Fields 53 and 54 will indicate why the record was rejected for the subsidy, Field 29 will have the COBC disposition code for the S record, and the D/N Disposition in Field 48 will indicate the results of posting the record as a supplemental drug record. The response record will contain your original DCN (document control number) in Field 21. You will be expected to submit updates and/or deletes to maintain this supplemental drug record going forward on your subsequent Non-MSP Input Files with D record action types.

Unsolicited RDS Response Files or Records

The Non-MSP Response File format is also used to send you *unsolicited* response files originating from the RDS Center. These transmissions from the RDS Center will notify you that significant data you previously submitted that may affect the Plan Sponsor's ability to claim the subsidy for an individual has changed. For example, the retiree may have enrolled in Part D making them ineligible for the subsidy from the Part D enrollment date going forward.

Unsolicited RDS responses are designated by the "RDSU" file type in Field 3 in the header of the Non-MSP Response File and will be sent separately from the regular Non-MSP Response Files ('NMSR' in Header Field 4). The following is a table providing the RDS Reason Codes you may receive on an unsolicited response. The RDS Start and End Dates in Field 50-51 may also have been adjusted. In addition, the RDS Determination Indicator may show a changed value of 'N' instead of 'Y' for Reason Codes 10, 11, and 12. The Plan Sponsor must adjust the periods for claiming the subsidy for affected individuals using this information or resend the original records for proper subsidy determination.

RDS Reason Code	Description
10	<i>Enrolled in Part D.</i> The retiree cannot be covered under the RDS program because (s)he is/was enrolled in Medicare Part D during the coverage period provided by the Plan sponsor.
11	<i>Not eligible for Medicare.</i> The retiree cannot be covered under the RDS program because (s)he is/was not enrolled/entitled to Medicare during the coverage period provided by the Plan sponsor.
12	<i>Beneficiary is deceased.</i>
20	<i>Beneficiary attempted to enroll in Part D and received an initial rejection.</i> The retiree tried to enroll in Medicare Part D when (s)he was already covered under the RDS program and as a result this initial attempt to enroll in Part D was denied. The Plan Sponsor may counsel the beneficiary that they have equal or better prescription drug coverage through the RDS program. The Plan Sponsor will not be able to claim the subsidy for

	the beneficiary if (s)he overrides the denial and enrolls in Part D.
21	<i>New Medicare information has been received – resend record.</i> After an initial rejection of the retiree’s record, the RDS Center has now been notified of a change in the retiree’s Medicare enrollment/entitlement status. The Plan sponsor should resubmit the retiree data on its next monthly update to determine if the retiree is now eligible for RDS program coverage.

7.5 Testing the Section 111 Reporting Process

7.5.1 Overview of the Testing Process

RREs must pass a testing process for each file submission type prior to sending production files for Section 111. The testing process will ensure that the RRE has developed an adequate system internally to capture and report data to the COBC as well as process the corresponding response files. A series of test files will be submitted to the COBC in order to verify that the RRE can transmit files successfully in the correct format, accept and process response files, and properly submit add, update, and delete records. If the RRE is using an agent to test, the agent must submit and pass the testing process on behalf of the RRE. Testing must be completed for each RRE ID registered.

RREs will submit test files in the same manner as the method they choose for submitting production files (HTTPS, SFTP or Connect:Direct). All RREs will be able to monitor the status of the testing process on the COBSW no matter what method is chosen.

Your COBC EDI Representative will be your main point of contact to assist you throughout the testing process.

7.5.2 General Testing Requirements

- RREs must complete the registration and account set up process and return the signed profile report to the COBC before testing may begin.
- The RRE must transmit test files to the COBC in the same transmission method as that chosen for production files.
- The COBC will maintain a test environment that contains a mirror image of the COB Beneficiary Master Database containing all beneficiary information the COBC has in production and programs that will mimic the way the files would be processed in production, with the exception of actually updating other Medicare systems and databases.
- RREs will send actual information for covered individuals on test files in order to test realistic situations. However, no production Medicare databases or systems will be updated from test file submissions.

- Test files must be limited to no more than 100 records. Only the first 100 records will be processed if the submitted file exceeds 100 records.
- The system will apply the same file error threshold checks to test files as those applied to production files. The full file must be processed for threshold and severe error checks to be completed.
- RREs choosing the COBSW to transmit files will receive a test mailbox/directory separate from their production mailbox/directory. RREs choosing Connect:Direct will send test files to a different destination dataset name than production files.
- The COBC will return a test response file within one week of submission of a test input file.
- The COBC will track the progress made with test files, display results on the COBSW and put the RRE in a “production” status after the testing requirements have been successfully completed. The RRE may continue to test with additional test file submissions after being placed in a production status.
- The results of MSP Input File testing will trigger the transition of an RRE from a testing status to a production status. However, testing of the Non-MSP and Query Only Files is highly recommended.
- Once an RRE has moved to a production status, any subsequent test files received will be processed by the COBC and results will be displayed on the COBSW. Test response files will be produced and transmitted.
- Testing progress and completion dates will be tracked and reported in the system by the COBC. The COBSW will provide a Testing Results page to show the status of test file processing. Information regarding the attainment of test requirements will be available there for review. All users associated with the RRE’s account on the COBSW will be able to monitor the status of the testing process on the COBSW. If testing is not completed by an RRE by the production file submission date, an e-mail notification will be sent to the Account Manager. 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 non-compliance with the Section 111 Mandatory Reporting requirement.
- Once all testing has been completed and the COBC has moved the RRE to a production status, an e-mail will be sent to the RRE’s Authorized Representative and Account Manager to notify them of the change in status and that production files may now be submitted.

7.5.3 MSP Input File Testing

GHP RREs selecting either the Basic or Expanded Reporting Option must submit at least the following test MSP Input Files:

- One initial MSP Input File with at least 25 add records.
- A second GHP MSP File with at least 5 updates and 5 deletes for previously submitted and accepted records. This file is submitted after the first response file returned by the COBC is processed.
- A TIN Reference file with information for each TIN submitted on the MSP Input File.

GHP RREs selecting either the Basic or Expanded Reporting Option must process at least two test MSP Response Files sent back by the COBC.

GHP RREs selecting either the Basic or Expanded Reporting Option must successfully perform the following to pass the testing process. These records must receive an '01' disposition code on corresponding response file records:

- Post at least 25 new cases with add records in *one* file submission.
- 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.

7.5.4 Non-MSP Input File Testing

RREs must pass the testing requirements for processing MSP Files in order to attain a "production" status. However, the COBC recommends that GHP RREs selecting the Expanded Reporting Option submit at least the following additional test files:

- One Non-MSP Input File with at least 25 supplemental drug coverage (D records) add transactions and 5 query records (N records).
- A second non-MSP file with at least 5 updates and 5 deletes to previously submitted drug coverage records.

The COBC recommends that GHP RREs selecting the Expanded Reporting Option successfully perform the following before submitting production Non-MSP Input Files. These records must receive an '01' disposition code on corresponding response file records in order to be considered successful transactions:

- Post at least 25 new drug coverage cases with add records in *one* file submission.
- Complete at least 5 updates to previously posted drug coverage records in *one* file submission.
- Complete at least 5 deletes to previously posted drug coverage records in *one* file submission.

Additional test files may be submitted until these requirements are met.

7.5.5 Query Only File Testing

Since the use of the query process is optional, the RRE testing status is only driven off testing results from the MSP Input File and the Non-MSP Input File if the Expanded Reporting Option is selected. The Query Only Input and Response File testing requirements are less stringent. As described previously, you may use the HEW software to produce your test Query Only Input Files and process your test Query Only Response Files or use your own X12 translator software. Your EDI Rep will supply you with the HEW software at your request. If you are using your own translator, contact your EDI Rep for the necessary mapping documentation.

After processing the test Query Only Input File, the COBC will provide you a test Query Only Response File identifying those covered individuals that are entitled to Medicare

and those individuals not matched to a Medicare beneficiary as prescribed by the file record layouts in Appendix B. The COBC may request that you submit another Query Only Input Test File if errors are found with the test submission. After both you and the COBC are satisfied with the results of the testing, you may begin submitting regular production Query Only Input Files on a monthly basis.

Testing for the query process may be completed before, during or after your testing of the MSP Input File. Testing for the query process may be completed after the RRE has been set to a production status. Testing the MSP Input File should be your highest priority.

RREs will submit at least the following test files:

- One Query Only Input File with at least five detail records.
- Additional Query Only Input Files as requested by the COBC or RRE.

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

- One (1) corresponding Query Only Response File.
- Additional response files as needed/requested.

The COBC will return test Query Only Response Files within one week of submission of the test Query Input File.

7.6 Summary of Steps to Register, Test and Submit Production Files

In summary, the following are the high-level steps you need to follow to set up your reporting process for Section 111:

- Complete your registration and account setup (including file transmission information) on the COB Secure Web site (COBSW) between April 1, 2009 and April 30, 2009. Register users for the COBSW.
- Receive your profile report via e-mail indicating your registration was accepted by the COBC.
- Verify, sign and return your profile report to the COBC.
- Complete your file transmission set up. If you choose SFTP/HTTPS on the COBSW, the COBC will create the necessary mailbox/directories. If you choose Connect:Direct (AGNS), establish a connection to AGNS if you don't have one yet, and create transmission jobs and datasets.
- Review file specifications, develop software to produce Section 111 files, and schedule your internal quarterly submission process.
- Test your file transmission method with the COBC.
- Test each Section 111 file type you will be submitting with the COBC.
 - Basic Reporting Option Submitters – MSP and optional Query Only Files.
 - Expanded Reporting Option Submitters – MSP, Non-MSP, and optional Query Only Files.
- Submit your initial MSP Input File with all Active Covered Individuals by your assigned production live date.
- If you are an Expanded Reporting Option submitter, submit your initial Non-MSP File with all Inactive Covered Individuals after your assigned production live date.
- Submit your Query Only File as needed but no more than monthly ongoing.

- Submit your quarterly MSP Input File ongoing during your assigned submission periods.
- Submit your monthly or quarterly Non-MSP Input File ongoing.
- Monitor file processing and statistics on the COBSW on a regular basis.
- Update passwords used for SFTP on a regular basis (at least every 60 days.)

8 Electronic Data Exchange

8.1 File Transmission Methods

There are three separate methods of data transmission that Section 111 responsible reporting entities may utilize. As part of your account setup on the COBSW for Section 111, you will indicate the method you will use and submit the applicable transmission information. Each file type (MSP, Non-MSP and Query Only) can be set up with the same file transmission method or you may select a different file transmission method for each. However, whatever method is selected for the file type will be used to transmit the corresponding response file back to the RRE by the COBC.

Generally speaking, if you expect to be transmitting files with more than 24,000 records on a regular basis, it is suggested that you use either the Connect:Direct or SFTP methods described below. HTTPS is more suitable for use with smaller files due to the time it may take to upload and download files during an active user session using that method.

Note to former VDSA/VDEA partners that have transitioned to Section 111 prior to April 2009: If you are using a CMS SFTP/HTTPS mailbox to submit Section 111 data, and you want to now submit Section 111 data using the COBSW, please contact your EDI Representative. Given that each Section 111 RRE must set up an account on the COBSW, switching your file transfer from a CMS mailbox to the COBSW has some advantages, and we encourage you to make the switch when this option becomes available in April 2009. For example, only one set of user Login IDs and passwords will need to be maintained on the COBSW, rather than user Login IDs for both CMS (your IACS UID) and the COBSW. In addition, the COBSW will provide information on file processing statistics so RRE users will be able to perform all functions related to Section 111 file transfer and monitor file processing results using just one application. Lastly, if problems occur with file transfer or use of the COBSW, your COBC EDI representative will be able to assist you. There will be no need to contact the MMA Help Desk for assistance if you transfer files via the COBSW.

8.1.1 Connect:Direct (NDM via the AT&T Global Network System (AGNS))

For responsible reporting entities with very large transmission volume the preferred method of electronic transmission is Connect:Direct (formerly known as Network Data Mover [NDM]) via the AT&T Global Network System (AGNS). AGNS is capable of transporting multiple protocol data streams to its clients world-wide, and uses triple DES as its encryption default. Use of either SNA or TCP/IP is available to submitters connected to the AGNS network.

Using this method, responsible reporting entities must first establish an AGNS account in order to send files directly to the COBC over AGNS. Section 111 responsible reporting entities that currently do not have an existing AGNS account and plan to send and receive information using this telecommunications link should contact AT&T or one of the well-established resellers of AT&T services to obtain a

dedicated or a dial-up access line to the AGNS VAN. ***You are encouraged to do this as soon as possible since this setup can take a significant amount of time.***

During COBSW account setup, you will provide the AGNS account and connectivity information needed for this file transfer method as well as the dataset names you want the COBC to use when sending back response files. After your registration has been processed, the COBC will e-mail a profile report with the COBC VTAM information and your Section 111 destination dataset names to which you will send your input files. The dataset naming convention you will use to transmit files to the COBC under this method is:

Production Files

For MSP Input/TIN Reference Files:	PCOB.BA.MRMSP.Rxxxxxxx(+1)
For Non-MSP Files:	PCOB.BA.MRNMSP.Rxxxxxxx(+1)
For Query-Only Files:	PCOB.BA.MRQRY.Rxxxxxxx(+1)

Test Files

For MSP Input/TIN Reference Files:	TCOB.BA.MRMSP.Rxxxxxxx(+1)
For Non-MSP Files:	TCOB.BA.MRNMSP.Rxxxxxxx(+1)
For Query-Only Files:	TCOB.BA.MRQRY.Rxxxxxxx(+1)

Where xxxxxx – is the last 7 digits of your Section 111 Reporter ID assigned to you after registration as shown on your profile report.

Files transmitted directly to the COBC via AGNS using Connect:Direct will be automatically converted to EBCDIC.

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

- AGNS Account ID
- Node ID, Net ID and Appl ID for SNA connections or IP Address and Port Address for IP connections
- Test and production destination dataset names to which you want the COBC to send your response files
- Optional special instructions such as file triggers you want the COBC to use.

Note: Your Account Manager must have the file transmission information listed above on hand when completing account setup on the COBSW. If this information cannot be provided, the account setup step cannot be completed, other account information entered during that step will not be saved and your Account Manager will have to return to perform account setup from the beginning at a later time.

8.1.2 Secure File Transfer Protocol (SFTP)

RREs who select the SFTP method will transmit files over the Internet to and from the COBC for Section 111 using directories (mailboxes) created on the COBC Secure Website (COBSW). Separate directories are set up for each RRE ID. Subdirectories are set up for test input, production input, test response files and

production response files (see below). The mailboxes are automatically created when your Account Manager selects SFTP as the file transmission method during COBSW account setup.

A Login ID and Password are required for the SFTP file transmission method. Any Login ID/Password assigned to a user of the Section 111 application on the COBSW associated with the RRE account may be used. During initial account setup on the COBSW, the RRE's Account Manager will create a Login ID and Password (or use his previously defined Login ID when performing setup for multiple RRE IDs). The Account Manager may then log in to the site and invite other users to become Account Designees associated with the RRE. Each Account Designee will obtain his own Login ID and Password. These same Login IDs and Passwords are to be used for SFTP transmission. Each user of the COBSW will have one Login ID and Password. That same Login ID and Password can be used for multiple RRE SFTP transmissions. For example, an agent may be an Account Manager or Account Designee for many RREs. That agent may use his one COBSW Login ID and Password to transmit files for all his RRE clients via SFTP. The agent may also use this Login ID to log in to the COBSW application and monitor file processing.

Note: Passwords for the COBSW must be changed every 60 days. You must sign on to the Section 111 Application on the COBSW in order to change your password. Failure to maintain a current password will result in an unsuccessful SFTP file transfer. The COBC recommends that you login to the COBSW and perform the Change Password function once a month to avoid password expiration.

For this transmission method, CMS has extensive experience using the Sterling Connect:Enterprise Secure Client. The cost to you to acquire this software is nominal. However, you may use other software as long as it is SSH v2 capable.

The following table contains the information you will need to configure your SFTP client software to transmit Section 111 files:

Type of Server	Standard SSH Server
Host IP Address of Server	sftp.section111.cms.hhs.gov
Port Number of Server	10022
Credentials (User ID and Password)	Individual COBSW Login ID and Password assigned to an Account Manager or Account Designee associated with the RRE ID account.

Each RRE mailbox will be defined with the following directory/subdirectories (where RREID is the 9-digit Section 111 Reporter ID or RRE ID.) Subdirectory names are in lower case. These are the directories to which you will send files for upload to the COBSW and from which you will pull files for download. The COBC will not actually transmit response files back to the RRE or its agent. You must pull/download response files from the COBSW.

Input Files (upload):

RREID/submission/test

RREID/submission/prod

Response Files (download):

RREID/response/test/msp

RREID/response/test/non-msp

RREID/response/test/query-only

RREID/response/test/non-msp-rds

RREID/response/prod/msp

RREID/response/prod/non-msp

RREID/response/prod/query-only

RREID/response/prod/non-msp-rds

There is no specific naming convention needed for uploaded input files.

The COBC will name response files according to the following convention and place them in the corresponding subdirectories for download by the RRE or its agent:

MSP:	PCOB.BA.MR.GHPMSP.RESP.Dccyymmdd.Thhmmssmm.TXT
Non-MSP:	PCOB.BA.MR.GHPNMSP.RESP.Dccyymmdd.Thhmmssmm.TXT
Query:	PCOB.BA.MR.GHPQRY.RESP.Dccyymmdd.Thhmmssmm.TXT
RDS:	PCOB.BA.MR.GHPRDS.RESP.Dccyymmdd.Thhmmssmm.TXT

Where 'Dccyymmdd' is 'D' followed by date century/year/month/day and 'Thhmmssmm' is 'T' followed by hours/minutes/seconds/milliseconds.

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.

8.1.3 Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)

Files uploaded via HTTPS are sent over the Internet to the COB Secure Website (COBSW). There is no additional cost associated with using this method as long as a standard Internet browser is used. However, because this method requires a user to be logged in to the COBSW with an active session, use of HTTPS is only

recommended for entities with a relatively small amount of data to submit (less than 24,000 records on a regular basis).

During account setup on the COBSW, your Account Manager can select this method for file transfer. The account setup process is described in a previous section of the guide. The RRE's Account Manager obtains a COBSW Login ID and Password during the account setup process. After that, the Account Manager can sign onto the COBSW and invite other users to obtain Login IDs and be associated with the RRE's account as Account Designees. All users associated with the RRE's account will have the ability to upload input files and download response files.

COBSW users associated with the RRE's account will logon to the Section 111 application on the COBSW at www.Section111.cms.hhs.gov and use the application interface to upload and download files. Instructions are provided in the Section 111 COBSW User Guide available on the site and associated Help pages. Users must maintain an active session on the Section 111 application on the COBSW when uploading or downloading files via the HTTPS file transfer method.

Files uploaded successfully to the COBSW are not subsequently accessible by users of the COBSW. A user cannot view or delete a file once uploaded. If a file is uploaded in error, you should contact your EDI Rep for assistance.

Response files will remain available for downloading for two calendar quarters (180 days). Response files can be downloaded more than once as needed. COBSW users cannot delete response files from the COBSW. The COBC will remove these files automatically after 180 days.

There is no specific naming convention needed for uploaded input files.

The COBC will name response files according to the following convention. A list of files available for download will be presented to users of the COBSW when selecting the download option in the Section 111 COBSW application.

MSP:	PCOB.BA.MR.GHPMSP.RESP.Dccyymmdd.Thhmmssmm.TXT
Non-MSP:	PCOB.BA.MR.GHPNMSP.RESP.Dccyymmdd.Thhmmssmm.TXT
Query:	PCOB.BA.MR.GHPQRY.RESP.Dccyymmdd.Thhmmssmm.TXT
RDS:	PCOB.BA.MR.GHPRDS.RESP.Dccyymmdd.Thhmmssmm.TXT

Where 'Dccyymmdd' is 'D' followed by date century/year/month/day and 'Thhmmssmm' is 'T' followed by hours/minutes/seconds/milliseconds.

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.

9 Querying for Medicare Coverage Information

In order to coordinate benefits and determine primary and secondary payers for health care services, CMS will share Medicare coverage information for Medicare beneficiaries with Section 111 GHP responsible reporting entities. While you must report coverage information for all Active Covered Individuals who are Medicare beneficiaries under Section 111, you may also be interested to know the Medicare status for your other covered individuals. In most cases, when an individual is currently employed (or is a dependent of a currently employed individual) but is also covered by Medicare, your GHP coverage will be primary to Medicare. However, when the subscriber retires, in most cases your GHP coverage is only primary until the covered individual becomes covered by Medicare in which case Medicare becomes the primary payer. It is in our mutual best interest to have claims paid by the correct payer early rather than later. To assist you, you may want to set up a process to query for Medicare coverage on each of your retirees and/or their dependents until primary Medicare coverage is confirmed.

The distinction between an individual's benefit *eligibility* and benefit *enrollment* can be confusing. While it sometimes appears that the two terms are used interchangeably, for CMS they have very different and distinct meanings.

Once an individual is a Medicare beneficiary, he or she is then *eligible to participate* in Medicare's benefit programs, including Part D. Usually, the Medicare beneficiary can choose to participate, and if he or she does, the first day the beneficiary's participation is effective is *the date of enrollment* in the benefit program. For example, individuals who have aged into Medicare Part A are then eligible to enroll in Medicare Parts B and D, if they so choose. Once an application for enrollment is accepted, the beneficiary's effective date of enrollment is determined.

In summary, an eligible Medicare beneficiary may participate in Medicare program benefits beginning on his or her date of enrollment in the benefit program. For beneficiaries who choose to participate in the Part B and D programs, the date of enrollment is, usually, the first day of the following month.

9.1 How to Obtain Medicare Coverage Information

9.1.1 File Transmission

If you report for Section 111 under the Basic Option, you will receive Medicare Parts A, B, and C coverage information back on your MSP Response File for Active Covered Individuals and Query Only Response File for Inactive Covered Individuals.

If you report for Section 111 under the Expanded Option, you will receive Medicare Parts A, B, C and D coverage information back on your MSP Response File for Active Covered Individuals and Non-MSP Response File for Inactive Covered Individuals. Expanded reporters may also submit the Query Only File to get Part A, B and C coverage information back, but Part D data is not yet available on this file

layout. Part D coverage information will be added to the Query Only Response File for Expanded reporters at a later date.

Please refer to the response file layouts in the appendices for the complete set of fields returned with each response file.

9.1.2 Beneficiary Automated Status and Inquiry System (BASIS)

When a Section 111 responsible reporting entity has an immediate need to access Medicare entitlement information, BASIS – the Beneficiary Automated Status and Inquiry System – permits you to make a limited number of on-line queries to CMS to find out if an individual is eligible for or enrolled in Medicare. Using a private, Web-based host, you can use BASIS to access the information on the Medicare Beneficiary Database (MBD) for up to 200 individuals per Section 111 Reporter ID per month. Access to BASIS is contingent on you having submitted your initial MSP Input File.

If you selected the Basic Reporting Option for Section 111, you will only be provided with Medicare Part A, B and C coverage information. Expanded Reporting Option submitters will be additionally provided Part D coverage information.

In overview, BASIS operates as follows:

1. Complete and submit your BASIS Request Attachment, found in Appendix E, to your EDI Rep.
2. The COBC assigns each responsible reporting entity its own personal identification number (PIN) for BASIS. This number is delivered to the designated Section 111 contact persons within 30 days of submission of your initial MSP and receipt of your BASIS Request Attachment. At this time, you will also receive information concerning the designated telephone line to be used for the BASIS application.
3. The COBC will notify you when the BASIS application is operational and will provide detailed instructions on how to use the BASIS application.
4. You will dial a designated telephone line to access the BASIS application, using your assigned BASIS PIN. For each Covered Individual for whom you are requesting Medicare entitlement information, you will enter the following data elements that identify the subject of the query:

Social Security Number
Last Name
First Initial
Date of Birth
Gender

5. The COBC will display the results of the inquiry in BASIS in real time while you are logged into the application.

10 Data Use Agreement

As part of the Section 111 registration process, the Authorized Representative for each Section 111 RRE will be asked to sign a copy of the following data use agreement. It will be included on the profile report sent to the Authorized Representative after Section 111 COBSW registration and account setup. The Authorized Representative must sign and return the last page of the profile report to the COBC. In addition, all users must agree to similar language each time they log on to the Section 111 application of the COBSW. Data exchanged for Section 111 is to be used solely for the purposes of coordinating health care benefits for Medicare beneficiaries between Medicare and Section 111 RREs who provide other health insurance coverage. 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. § 1395k(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.

11 COB Secure Web Site

The COBC will maintain a new application on the Medicare COB Secure Web site (COBSW) to support Section 111 reporting. All Section 111 GHP RREs will register and set up accounts on the COBSW starting April 1, 2009. The COBSW URL is www.Section111.cms.hhs.gov.

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

- Complete the registration and account setup process. All information will be collected through an interactive Web application.
- Obtain Login IDs and assign users for Section 111 COBSW accounts.
- Exchange files via HTTPS or SFTP directly with the COBC.
- 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.

The registration and account set up process were described in a previous section of this guide. Additional information can be found on the homepage under the “How To...” menu option. Once users are logged into the site, they will have access to a detailed user guide and help pages associated with each function. In addition, Computer-Based Training (CBT) modules for the Section 111 application on the COBSW will be developed and made available to RREs and their agents.

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.

12 Customer Service and Reporting Assistance for Section 111

Please be sure to visit the Section 111 page on the CMS Web site www.cms.hhs.gov/MandatoryInsRep frequently for updated information on Section 111 reporting requirements including updates to this guide. In order to be notified via e-mail of updates to this page, click on the “[For e-mail updates and notifications](#)” link and add your e-mail address to the distribution list for these updates.

12.1 EDI Representative

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

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

12.2 Contact Protocol for the Section 111 Data Exchange

In all complex electronic data management programs there is the potential for an occasional breakdown in information exchange. If you have a program or technical problem involving your Section 111 data exchange, the first person to contact is your own EDI Representative at the COBC. Your EDI Representative should always be sought out first to help you find solutions for any questions, issues or problems you have.

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

If after working with your EDI Representative, you think your problem could benefit from help at a higher level, please contact Jeremy Farquhar, at 646-458-6614. His e-mail address is JFarquhar@ghimedicare.com.

If you feel further escalation is necessary, contact the COBC EDI Manager, Bill Ford, at 646-458-6613. Mr. Ford's e-mail address is WFord@ghimedicare.com.

The COBC Project Director, with overall responsibility for the COBC EDI Department, is Jim Brady. Mr. Brady can be reached at 646-458-6682. His e-mail address is JBrady@ghimedicare.com.

13 Training and Education

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

- The Section 111 CMS Web page at www.cms.hhs.gov/MandatoryInsRep will contain links to all CMS publications regarding the MSP Mandatory Reporting Requirements under Section 111 of the MMSEA of 2007. In order to be notified via e-mail of updates to this page, click on the "[For e-mail updates and notifications](#)" link and add your e-mail address to the distribution list for these updates.
- During implementation of the Section 111 reporting, CMS is conducting a series of teleconferences to provide information regarding Section 111 reporting requirements. The schedule for these calls is posted (and updated as new calls

- are scheduled) on the Section 111 Web page at www.cms.hhs.gov/MandatoryInsRep.
- CMS will make available a curriculum of computer-based training (CBT) courses to Section 111 RREs. These courses will provide overviews of Medicare and MSP in addition to in-depth training on Section 111 reporting requirements, file transmission, file formats, file processing, and the COBSW. Instructions on how to sign up for these courses will be posted on www.cms.hhs.gov/MandatoryInsRep when available.

Note: The Section 111 User Guides and instructions do not and are not intended to cover all aspects of the MSP program. Although these materials may provide high level overviews of MSP in general, any individual/entity which has responsibility as a primary payer to Medicare is responsible for his/her/its obligations under the law. The statutory provisions for MSP can be found at 42 U.S.C. 1395y(b); the applicable regulations can be found at 42 C.F.R. Part 411. Supplemental guidance regarding the MSP provisions can be also be found at: www.cms.hhs.gov/COBGeneralInformation/.

Appendix A – MSP File Specifications

Section 111 GHP MSP Input File

Section 111 GHP MSP Input File Header - 425 bytes					
Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-numeric	Must be: 'H0'
2.	Section 111 Reporter ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by COBC. Required.
3.	File Type	4	12-15	Alpha	Must be 'MSPI' – MSP input file.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD Required.
5.	Filler	402	24-425	Alpha-Numeric	Unused Field – fill with spaces.

Section 111 GHP MSP Input File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	HIC Number (HICN)	12	1-12	Alpha-Numeric	Active Covered Individual's/Beneficiary's Health Insurance Claim (Medicare ID) Number (HICN). Required if SSN not provided. Required if the Active Covered Individual is under 45 years of age and is eligible for Medicare due to ESRD or a disability. Populate with spaces if unavailable.
2.	Beneficiary Surname	6	13-18	Text	Active Covered Individual's/Beneficiary's Last Name – Required.
3.	Beneficiary First Initial	1	19-19	Alpha	Beneficiary's First Initial – Required.
4.	Beneficiary Date of Birth	8	20-27	Date	Beneficiary's DOB (CCYYMMDD) – Required.
5.	Beneficiary Sex Code	1	28-28	Numeric	Beneficiary's Sex – Required. Valid Values: 0 = Unknown 1 = Male 2 = Female
6.	DCN	15	29-43	Text	Document Control Number; assigned by the Section 111 GHP RRE. Required. Each record within the current file must have a unique DCN.
7.	Transaction Type	1	44-44	Numeric	Type of Transaction – Required. Valid Values: '0' = Add Record

Section 111 GHP MSP Input File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
					'1' = Delete record '2' = Update/Change record
8.	Coverage Type	1	45-45	Alpha-Numeric	Type of Insurance – Required. Basic Reporting Option includes Hospital and/or Medical Coverage. Expanded Reporting Option includes all Coverage Types. Valid Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical (non-network Rx) 'W' = Comprehensive Coverage –Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Prescription Drug Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage –Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx)
9.	Beneficiary Social Security Number	9	46-54	Numeric	Active Covered Individual's/Beneficiary's SSN – Required if HICN not provided. Populate with 9 spaces if unavailable.
10.	Effective Date	8	55-62	Date	Start Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). Required.
11.	Termination	8	63-70	Date	End Date of Covered

Section 111 GHP MSP Input File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
	Date				Individual's GHP Coverage. CCYYMMDD, Required. <i>*Use all zeros if open-ended.</i>
12.	Relationship Code	2	71-72	Numeric	Covered Individual's Relationship to Policy Holder – Required. Valid values: '01' = Self; Covered Individual is Policy Holder or Subscriber '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other
13.	Policy Holder's First Name	9	73-81	Text	Employee or Subscriber's First name – Required.
14.	Policy Holder's Last Name	16	82-97	Text	Employee or Subscriber's Last Name – Required.
15.	Policy Holder's SSN	9	98-106	Numeric	Employee or Subscriber's SSN – Required.
16.	Employer Size	1	107	Numeric	Valid Values: '0' = 1 to 19 employees* '1' = 20 to 99 employees* '2' = 100 or more employees If no employer size is provided, the COBC will default this field to a value of '2'. *Employer Size Rule for Multi-Employer Plans: If the employer is part of a multi-employer plan, this field should reflect the size of the largest employer in the plan. Enter '1' if employer has fewer than 20 full or part-time employees but is part of a

Section 111 GHP MSP Input File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
					<p>multi-employer plan (a group of plans) and another employer in that group has 20 or more employees.</p> <p>Enter '2' if employer has fewer than 100 full or part-time employees but is part of a multi-employer plan where another employer in that group has 100 or more employees.</p> <p>Refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 for details on this calculation.</p> <p>Required.</p>
17.	Group Policy Number	20	108-127	Text	<p>Policy Number Assigned by GHP Payer.</p> <p>If no group number exists as in the case of a self-insured RRE, this field may be set to any valid text value as a default.</p> <p>For use when Coverage Type is V, Z, 4, 5, and 6.</p>
18.	Individual Policy Number	17	128-144	Text	<p>Individual Policy Number; GHP's unique individual identifier for the Active Covered Individual (beneficiary) reported on this record. For self-insured RRE's, covered person's member ID or other unique ID used to identify individuals covered by the plan.</p> <p>Required for Coverage Types V, Z, 4, 5, and 6. Required when submitting a record for the Small Employer Exception (SEE).</p>

Section 111 GHP MSP Input File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
19.	Employee Coverage Election	1	145	Numeric	Who the Policy Covers – Required. ‘1’ = Policyholder/Subscriber Only. ‘2’ = Policyholder/Subscriber & Family (also use this value if the coverage reflects Policyholder/Subscriber & Spouse only). ‘3’ = Policyholder/Subscriber & Dependents, but not Spouse.
20.	Employee Status	1	146	Numeric	‘1’ = Active/Currently Employed during GHP effective period reported. ‘2’ = Not Active/Not Currently Employed during GHP effective period reported. This value should only be used for individuals with ESRD. Required.
21.	Employer TIN	9	147-155	Numeric	Employer Tax Identification Number (EIN) – Required. A matching record must be (or have been) submitted on the TIN Reference File. For Taft-Hartley multiple employer/multi-employer plans (or other plans using an “hours bank” arrangement) covering individuals who routinely work for multiple employers in a single Section 111 reporting period, submit the plan sponsor TIN rather than the actual employer TIN.
22.	Insurer/TPA TIN	9	156-164	Numeric	Insurer/TPA Tax Identification Number for the

Section 111 GHP MSP Input File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
					RRE – Required. A matching record must be (or have been) submitted on the TIN Reference File. If the RRE is a TPA, report the TIN of the TPA entity. If the RRE is a self-insured employer/plan sponsor entity, then the TIN of the self-insured employer/plan sponsor RRE is to be used.
23.	National Health Plan	10	165-174	Filler	National Health Plan Identifier – (Future Use). Fill with spaces.
24.	Rx Insured ID Number	20	175-194	Text	Insured’s Identification Number for prescription drug coverage. Applies to drug coverage information reported when using the Expanded Reporting Option. Required for Coverage Types U, W, X, & Y.
25.	Rx Group Number	15	195-209	Text	Group Number for prescription drug coverage. Applies to drug coverage information reported when using the Expanded Reporting Option. For use when Coverage Type is V, Z, 4, 5, and 6.
26.	Rx PCN	10	210-219	Text	Rx Processor Control Number. Applies to drug coverage information reported when using the Expanded Reporting Option. Required if available.
27.	Rx BIN Number	6	220-225	Numeric	Benefit Identification Number for Rx processing. Must be a 6-digit number.

Section 111 GHP MSP Input File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
					Applies to drug coverage information reported when using the Expanded Reporting Option. Required for Coverage Types U, W, X, & Y.
28.	Rx Toll Free Number	18	226- 243	Text plus “(“ and “)”	Prescription Drug/Pharmacy Benefit Information Toll Free Number. Applies to drug coverage information reported when using the Expanded Reporting Option.
29.	Person Code	3	244-246	Text	Person code the plan uses to identify specific individuals on a policy. The values are established by the insurer. May also known as a Dependent Code.
30.	Reserved	10	247-256	Alpha-Numeric	Reserved for COBC use. Fill with spaces only.
31.	Reserved	5	257-261	Alpha-Numeric	Reserved for COBC use. Fill with spaces only.
32.	Small Employer Exception HICN	12	262-273	Alpha-Numeric	Beneficiary’s Health Insurance Claim Number if exception has been approved for a small employer. Fill with spaces if there is no approval.
33.	Filler	152	274-425	Alpha-Numeric	Unused Field. Fill with spaces only.

Section 111 GHP MSP Input File Trailer Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Must be: 'T0'
2.	Section 111 Reporter ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by COBC. Required.
3.	File Type	4	12-15	Alpha	Must be 'MSPI' – MSP input file.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD Required.
5.	Record Count	9	24-32	Numeric	Number of Active Covered Individual records in this file. <i>Do not include the Header and Trailer Records in this Record Count.</i> Required.
6.	Filler	393	33-425	Alpha-Numeric	Unused Field – fill with spaces.

Section 111 GHP MSP TIN Reference File

Section 111 GHP MSP TIN Reference File Header Record – 425 bytes					
Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	Must be: 'H0'
2.	Section 111 Reporter ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by COBC. Required.
3.	File Type	4	12-15	Alpha	Must be: 'REFR' – TIN reference file. Required.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD Required.
5.	Filler	402	24-425	Alpha Numeric	Unused Field – fill with spaces.

Section 111 GHP MSP TIN Reference File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	TIN	9	1-9	Numeric	<p>Tax identification number of the entity, or cross-reference number to TIN field in the detail records. Must be unique – only one record per TIN will be processed and saved by the COBC. If multiple records for the same TIN are submitted on the TIN Reference File, only the information for the last record will be used.</p> <p>Corresponds to either Field 21 or 22 of the MSP Input File.</p> <p>The TIN indicator field identifies which has been used.</p> <p>Required.</p>
2.	Name	32	10-41	Text	<p>Name of the entity.</p> <p>Required.</p>
3.	Address Line 1	32	42-73	Text	<p>Address Line 1.</p> <p>The mailing address associated with each TIN should be the address to which health care insurance coordination of benefits issues should be directed. This mailing address will help CMS and others to direct correspondence to the most appropriate contact at the GHP responsible reporting entity, employer, or plan sponsor.</p> <p>Required.</p>
4.	Address Line 2	32	74-105	Text	<p>Address Line 2.</p>
5.	City	15	106-120	Text	<p>City.</p>

Section 111 GHP MSP TIN Reference File Detail Record – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
					Required.
6.	State	2	121-122	Alpha	State – Must be a valid USPS state abbreviation. Required.
7.	Zip Code	9	123-131	Alpha-Numeric	Zip Code. First 5 positions required.
8.	TIN Indicator	1	132	Alpha	Used to indicate whether the TIN is for an insurer/TPA or employer. Values: E = The TIN field contains a valid TIN (EIN) for an Employer. I = The TIN field contains a valid TIN for an Insurer/TPA. Y = The TIN field contains a “pseudo-TIN” for an employer. Valid employer TIN/EIN is not available. Required. <i>If a “pseudo-TIN” number is contained in the TIN field place a value of ‘Y’ in this field to indicate that the TIN field is only to be used as a cross-reference to the name/address fields. The TIN field does not contain an actual TIN. A value of ‘Y’ will not be accepted after 1/1/2010.</i>
9.	Filler	293	133-425	Text	Future use – Fill with spaces.

Section 111 GHP MSP TIN Reference File Trailer Record – 425 Bytes					
Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Must be: 'T0'
2.	Section 111 Reporter ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by COBC. Required.
3.	File Type	4	12-15	Alpha	Must be: 'REFR' – TIN Reference file.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD Required.
5.	Record Count	9	24-32	Numeric	Number of TIN records in this file. Do not include the Header and Trailer Records in the Record Count. Required.
6.	Filler	393	33-425	Alpha-Numeric	Unused Field – fill with spaces.

Section 111 GHP MSP Response File

Section 111 GHP MSP Response File Header Record – 800 bytes				
Field	Name	Size	Displacement	Description
1.	Header Indicator	2	1-2	Must be: 'H0'
2.	Section 111 Reporter ID	9	3-11	'000000001', '000000002', etc. ID number assigned by COBC. Corresponds to the reporter ID submitted on the MSP Input File.
3.	File Type	4	12-15	'MSPR' – MSP input file.
4.	File Date	8	16-23	CCYYMMDD COBC supplied.
5.	Filler	777	24-800	Unused Field. Space filled.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	Name	Size	Displacement	Description
1.	Filler	4	1-4	For COBC internal use.
2.	HIC Number	12	5-16	Beneficiary Health Insurance Claim Number (HICN). Field will contain either the HICN that has matched or the corrected HICN based on an SSN match. Store this HICN in your system for future updates and deletes.
3.	Beneficiary Surname	6	17-22	Beneficiary's Last Name. Field will contain either the name supplied or the corrected name from COBC database.
4.	Beneficiary First Initial	1	23	Beneficiary's First Initial. Field will contain either the value supplied or the corrected value from COBC database.
5.	Beneficiary Date of Birth	8	24-31	Beneficiary's DOB (CCYYMMDD). Field will contain either the value supplied or the corrected value from COBC database.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
6.	Beneficiary Sex Code	1	32	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Field will contain either the value supplied or the corrected value from COBC database.
7.	COBC DCN	15	33-47	Document Control Number assigned by the COBC. COBC supplied.
8.	Disposition Code	2	48-49	Response Disposition Code from COBC (via the Medicare CWF). See GHP Disposition Code Table for values.
9.	Transaction Type	1	50	Type of Transaction: '0' = Add Record '1' = Delete record '2' = Update record Transaction Type applied by COBC.
10.	Reason for Medicare Entitlement	1	51	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Value returned if individual is entitled. COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
11.	Coverage Type (insurer type/policy type)	1	52	Type of Insurance: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only - network Rx 'V' = Drug with Major Medical - non-network Rx 'W' = Comprehensive Coverage - Hosp/Med/Drug - network Rx 'X' = Hospital and Drug - network Rx 'Y' = Medical and Drug - network Rx 'Z' = Health Reimbursement Account - non-network Rx '4' = Comprehensive Coverage - Hosp/Med/Drug - non-network Rx '5' = Hospital and Drug - non-network Rx '6' = Medical and Drug - non-network Rx Field will contain value supplied on input.
12.	Insurer Name	32	53-84	Insurer name. Field will contain value supplied on TIN Reference File.
13.	Insurer Address 1	32	85-116	Insurer's Address Line 1. Field will contain value supplied on TIN Reference File.
14.	Insurer Address 2	32	117-148	Insurer's Address Line 2. Field will contain value supplied on TIN Reference File.
15.	Insurer City	15	149-163	Insurer's City. Field will contain value supplied on TIN Reference File.
16.	Insurer State	2	164-165	Insurer's State. Field will contain value supplied on TIN Reference File.
17.	Insurer Zip Code	9	166-174	Insurer's Zip Code. Field will contain value supplied on TIN Reference File.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
18.	Beneficiary SSN	9	175-183	Beneficiary's SSN. Field will contain either the SSN matched or the corrected SSN based on a HICN match.
19.	MSP Effective Date	8	184-191	Start date of Beneficiary's Primary GHP Coverage (CCYYMMDD). Effective date of the MSP occurrence posted on the Medicare CWF or MBD. Medicare is the secondary payer between the MSP Effective Date and MSP Termination Date. The MSP Effective Date may be set to a future date since Medicare entitlement/enrollment information is often established in advance. COBC supplied.
20.	MSP Termination Date	8	192-199	End date of Beneficiary's Primary GHP Coverage (CCYYMMDD). End date of the MSP occurrence posted on the Medicare CWF or MBD. *All zeros if open-ended. Medicare is the secondary payer between the MSP Effective Date and MSP Termination Date. COBC supplied.
21.	Relationship Code	2	200-201	Covered Individual's Relationship to Active Employee: '01' = Covered Individual is Active Employee '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other Default is '01'
22.	Policy Holder's First Name	9	202-210	Active Employee's First Name. Field will contain value supplied on input.
23.	Policy Holder's Last Name	16	211-226	Active Employee's Last Name. Field will contain value supplied on input.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
24.	Policy Holder's SSN	12	227-238	Active Employee's SSN. (9 digits, left justified.) Field will contain value supplied on input.
25.	Employer's Name	32	239-270	Employer Providing Coverage. Field will contain the value supplied on the TIN Reference File.
26.	Employer's Address Line 1	32	271-302	Employer's Street Address, line 1. Field will contain value supplied on TIN Reference File.
27.	Employer's Address Line 2	32	303-334	Employer's Street Address, line 2. Field will contain value supplied on TIN Reference File.
28.	Employer's City	15	335-349	Employer's City. Field will contain value supplied on TIN Reference File.
29.	Employer's State	2	350-351	Employer's State Code. Field will contain value supplied on TIN Reference File.
30.	Employer's Zip Code	9	352-360	Employer's Zip Code. Field will contain value supplied on TIN Reference File.
31.	Group Policy Number	20	361-380	Group Policy Number. Field will contain value supplied on input.
32.	Individual Policy Number	17	381-397	Individual's Policy Number. Field will contain value supplied on input.
33.	Last Query Date	8	398-405	Last Date Sent to Medicare CWF (Common Working File) (CCYYMMDD). COBC supplied.
34.	Current Disposition Code	2	406-407	Result from Most Current CWF Transmission (same as Field #8). COBC supplied.
35.	Current Disposition Date	8	408-415	Date of Most Current CWF Transmission (CCYYMMDD). COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
36.	Previous Disposition Code	2	416-417	Result from Previous CWF Transmission. COBC supplied.
37.	Previous Disposition Date	8	418-425	Date of Previous CWF Transmission (CCYYMMDD). COBC supplied.
38.	First Disposition Code	2	426-427	Result from First CWF Transmission. COBC supplied.
39.	First Disposition Date	8	428-435	Date of First CWF Transmission (CCYYMMDD). COBC supplied.
40.	Error Code 1	4	436-439	SP Error Code 1 See SP Error Code Table for values. COBC or CWF supplied.
41.	Error Code 2	4	440-443	SP Error Code 2 See SP Error Code Table for values. COBC or CWF supplied.
42.	Error Code 3	4	444-447	SP Error Code 3 See SP Error Code Table for values. COBC or CWF supplied.
43.	Error Code 4	4	448-451	SP Error Code 4 See SP Error Code Table for values. COBC or CWF supplied.
44.	Split Entitlement Indicator	1	452	Entitlement Split Indicator: 'Y' = yes 'N' or blank = no COBC supplied.
45.	Original Reason for Medicare Entitlement	1	453	Original Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
46.	Original Coverage Effective Date	8	454-461	The original GHP coverage effective date sent. This gets populated if a SP31 error occurs (CCYYMMDD). Field will be the value supplied on input.
47.	Original Coverage Termination Date*	8	462-469	The original GHP coverage termination date sent. This gets populated if a SP32 error occurs (CCYYMMDD). Field will be the value supplied on input. *All zeros if open-ended.
48.	RRE Assigned DCN	15	470-484	The Document Control Number assigned by the Section 111 GHP responsible reporting entity. It is moved here so we can provide our own unique COBC DCN in Field 7. Field will be the value supplied on input.
49.	Current Medicare Part A Effective Date	8	485-492	Effective Date of Medicare Part A Coverage (CCYYMMDD). COBC supplied.
50.	Current Medicare Part A Termination Date*	8	493-500	Termination Date of Medicare Part A Coverage (CCYYMMDD). COBC supplied. * All zeros if open-ended.
51.	Current Medicare Part B Effective Date	8	501-508	Effective Date of Medicare Part B Coverage (CCYYMMDD). COBC supplied.
52.	Current Medicare Part B Termination Date*	8	509-516	Termination Date of Medicare Part B Coverage (CCYYMMDD). COBC supplied. * All zeros if open-ended.
53.	Medicare Beneficiary Date of Death	8	517-524	Medicare Beneficiary Date of Death (CCYYMMDD). COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
54.	Current Medicare Part C Plan Contractor Number	5	525-529	Contractor Number of the current Medicare Part C Plan in which the beneficiary is enrolled. COBC supplied.
55.	Current Medicare Part C Plan Enrollment Date	8	530-537	Effective Date of coverage provided by current Medicare Part C Plan (CCYYMMDD). COBC supplied.
56.	Current Medicare Part C Plan Termination Date*	8	538-545	Termination Date of coverage provided by current Medicare Part C Plan (CCYYMMDD). COBC supplied. * All zeros if open-ended (i.e., if coverage is not terminated).
57.	Current Medicare Part D Plan Contractor Number	5	546-550	Contractor Number of the current Medicare Part D Plan in which the beneficiary is enrolled. COBC supplied. Only provided to Expanded Reporting Option Section 111 reporters.
58.	Current Part D Plan Enrollment Date	8	551-558	Effective Date of coverage provided by current Medicare Part D Plan (CCYYMMDD). COBC supplied. Only provided to Expanded Reporting Option Section 111 reporters.
59.	Current Medicare Part D Plan Termination Date*	8	559-566	Termination Date of coverage provided by current Medicare Part D Plan (CCYYMMDD). COBC supplied. * All zeros if open-ended (i.e., if coverage is not terminated). Only provided to Expanded Reporting Option Section 111 reporters.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
60.	Part D Eligibility Start Date	8	567-574	Earliest date that Beneficiary is eligible to receive Part D Benefits – Refer to Field 58 for Part D Plan Enrollment Date (CCYYMMDD). COBC supplied. Only provided to Expanded Reporting Option Section 111 reporters.
61.	Part D Eligibility Stop Date*	8	575-582	Date the Beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 59 for Part D Plan Termination Date (CCYYMMDD). COBC supplied. * All zeros if open-ended. Only provided to Expanded Reporting Option Section 111 reporters.
62.	National Health Plan ID	10	583-592	National Health Plan Identifier. (Future requirement.) Field will contain value supplied on input.
63.	Rx Insured ID number	20	593-612	Insured's Identification Number. Field will contain value supplied on input.
64.	Rx Group Number	15	613-627	Group Number. Field will contain value supplied on input.
65.	Rx PCN	10	628-637	Processor Control Number. Field will contain value supplied on input.
66.	Rx BIN Number	6	638-643	Benefit Identification Number for Rx processing. Field will contain value supplied on input.
67.	Rx 800 Number	18	644-661	Pharmacy benefit information Toll Free Number. Field will contain value supplied on input.
68.	Person Code	3	662-664	Person Code. Field will contain value supplied on input.
69.	Rx Disposition Code	2	665-666	Response Rx Disposition Code from COBC (Medicare Beneficiary Database or MBD). See GHP Disposition Code Table for values. Code supplied by the COBC.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
70.	Rx Disposition Date	8	667-674	Date Rx Disposition Code was generated (CCYYMMDD). Code supplied by the COBC.
71.	Rx Error Code 1	4	675-678	Rx Error Code 1. Refer to GHP Rx Error Codes for values. COBC supplied.
72.	Rx Error Code 2	4	679-682	Rx Error Code 2. Refer to GHP Rx Error Codes for values. COBC supplied.
73.	Rx Error Code 3	4	683-686	Rx Error Code 3. Refer to GHP Rx Error Codes for values. COBC supplied.
74.	Rx Error Code 4	4	687-690	Rx Error Code 4. Refer to GHP Rx Error Codes for values. COBC supplied.
75.	ESRD Coordination Period Start Date	8	691-698	The start date for the 30-month coordination period in which GHP coverage is considered primary to Medicare because the beneficiary has a diagnosis of End Stage Renal Disease (CCYYMMDD). COBC supplied.
76.	ESRD Coordination Period End Date	8	699-706	The ending date for the 30-month coordination period in which GHP coverage is considered primary to Medicare because the beneficiary has a diagnosis of ESRD. A corresponding GHP coverage will no longer be considered an MSP record after the 30-month coordination period is terminated (CCYYMMDD). COBC supplied.
77.	First Dialysis Date	8	707-714	A date that indicates when the ESRD Dialysis first started (CCYYMMDD). Value will be zero if not applicable. COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
78.	ESRD Self-Training Date	8	715-722	A date that indicates when the beneficiary participated in ESRD Self - Care Training (CCYYMMDD). Value will be zero if not applicable. COBC supplied.
79.	Transplant Date – Most Recent	8	723-730	A date that indicates when a Kidney Transplant Operation occurred (CCYYMMDD). Value will be zero if not applicable. COBC supplied.
80.	Transplant Failure Date – Most Recent	8	731-738	A date that indicates when a Kidney Transplant failed. Last occurrence will be reported (CCYYMMDD). COBC supplied.
81.	SEE Response Code	2	739-740	Small Employer Exception (SEE) Response Code. (Spaces): Not applicable. SEE HICN not provided SA – SEE HICN accepted SN – SEE HICN not accepted SP – SEE HICN partially accepted (SEE HICN period does not cover entire MSP period) COBC supplied.
82.	Late Submission Indicator	1	741-741	Indicates that the submitted record was not received on schedule. The GHP effective date was more than 45 calendar days older than the start date of the scheduled Section 111 submission. COBC supplied.
83.	Compliance Flag 1	2	742-743	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. COBC supplied.
84.	Compliance Flag 2	2	744-745	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than one issue found. COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
85.	Compliance Flag 3	2	746-747	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than two issues found. COBC supplied.
86.	Compliance Flag 4	2	748-749	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than three issues found. COBC supplied.
87.	Compliance Flag 5	2	750-751	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than four issues found. COBC supplied.
88.	Compliance Flag 6	2	752-753	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than five issues found. COBC supplied.
89.	Compliance Flag 7	2	754-755	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than six issues found. COBC supplied.
90.	Compliance Flag 8	2	756-757	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than seven issues found. COBC supplied.
91.	Compliance Flag 9	2	758-759	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than eight issues found. COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes

Field	Name	Size	Displacement	Description
92.	Compliance Flag 10	2	760-761	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than nine issues found. COBC supplied.
93.	Filler	39	762-800	Unused field. Space filled.

Section 111 GHP MSP Response File Trailer Record – 800 bytes

Field	Name	Size	Displacement	Description
1.	Trailer Indicator	2	1-2	Will contain a value of 'T0'. COBC supplied.
2.	Section 111 Reporter ID	9	3-11	'000000001', '000000002', etc. ID number assigned by COBC. Corresponds to the reporter ID submitted on the MSP Input File. COBC supplied.
3.	File Type	4	12-15	'MSPR' – MSP Response File. COBCF supplied.
4.	File Date	8	16-23	CCYYMMDD COBC supplied.
5.	Record Count	9	24-32	Number of response records contained in this file. Does not include the header and trailer records in the count. COBC supplied.
6.	Filler	768	33-800	Unused field. Space filled.

Appendix B – Query Only HEW Input/Output File Specifications

Section 111 Query Only Input File (ANSI X12 270/271 Entitlement Query HEW Flat File Format)

Note: These file layouts are for use with the HIPAA Eligibility Wrapper (HEW) software supplied by the COBC to process the X12 270/271. If you are using your own ANSI X12 translator, please contact your assigned COBC EDI Representative for the necessary mapping documentation.

Section 111 Query Only Input File Header Record – 38 Bytes				
Field	Name	Size	Displacement	Description
1.	Header Indicator	2	1-2	Must be: 'H0'. Required.
2.	Section 111 Reporter ID (RRE ID)	9	3-11	'000000001', '000000002', etc. ID number assigned by COBC. Required.
3.	File Type	4	12-15	Must be 'IACT'. Required.
4.	File Date	8	16-23	Date RRE created or transmitted the file. (CCYYMMDD). Required.
5.	Filler	15	24-38	Unused Field. Fill with spaces.

Section 111 Query Only Input File Detail Record – 38 Bytes

Field	Name	Size	Displacement	Description
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number. Required if SSN not provided.
2.	Last Name	6	13-18	Surname of Covered Individual. Required.
3.	First Initial	1	19-19	First Initial of Covered Individual. Required.
4.	DOB	8	20-27	Covered Individual's Date of Birth (CCYYMMDD). Required.
5.	Sex Code	1	28-28	Covered Individual's Gender: 0 = Unknown 1 = Male 2 = Female Required.
6.	SSN	9	29-37	Social Security Number of the Covered Individual. Required if HICN not provided.
7.	Filler	1	38	Filler. Fill with spaces.

Section 111 Query Only Input File Trailer Record – 38 Bytes

Field	Name	Size	Displacement	Description
1.	Trailer Indicator	2	1-2	Must be: 'T0'
2.	Section 111 Reporter ID (RRE ID)	9	3-11	'000000001', '000000002', etc. ID number assigned by COBC. Must match RRE ID used on the header record. Required.
3.	File Type	4	12-15	Must be 'IACT'. Required.
4.	File Date	8	16-23	Date RRE created or transmitted the file. Must match the date used on the header record. (CCYYMMDD). Required.
5.	Record Count	9	24-32	Number of individual query records in this file. Do not include the Header and Trailer Records in the Record Count. Required.
6.	Filler	6	33-38	Unused Field. Fill with spaces.

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

Section 111 Query Only Response File Record – 116 Bytes				
Field	Name	Size	Displacement	Description
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number. COBC supplied if individual was matched to a Medicare beneficiary.
2.	Surname	6	13-18	Surname of Covered Individual.
3.	First Initial	1	19-19	First Initial of Covered Individual.
4.	DOB	8	20-27	Covered Individual's Date of Birth (CCYYMMDD).
5.	Sex Code	1	28-28	Covered Individual's Gender: 0 = Unknown 1 = Male 2 = Female
6.	SSN	9	29-37	Social Security Number of the Covered Individual.
7.	Entitlement Reason (Medicare reason)	1	38	Reason for Medicare Entitlement: A = Aged B = ESRD G = Disabled
8.	Current Medicare Part A Effective Date	8	39-46	Effective Date of Medicare Part A Coverage (CCYYMMDD).
9.	Current Medicare Part A Termination Date*	8	47-54	Termination Date of Medicare Part A Coverage (CCYYMMDD). * Blank if ongoing.
10.	Current Medicare Part B Effective Date	8	55-62	Effective Date of Medicare Part B Coverage (CCYYMMDD).
11.	Current Medicare Part B Termination Date*	8	63-70	Termination Date of Medicare Part B Coverage (CCYYMMDD). *Blank if ongoing.
12.	Medicare Beneficiary Date of Death	8	71-78	Beneficiary Date of Death (CCYYMMDD).
13.	Current Medicare Part C Plan Contractor Number	5	79-83	Contractor Number of the current Part C Plan in which the beneficiary is enrolled.

Section 111 Query Only Response File Record – 116 Bytes

Field	Name	Size	Displacement	Description
				COBC supplied value.
14.	Current Medicare Part C Plan Enrollment Date	8	84-91	Effective Date of coverage provided by the beneficiary's current Medicare Part C Plan (CCYYMMDD).
15.	Current Medicare Part C Plan Termination Date*	8	92-99	Termination Date of the coverage provided by the beneficiary's current Medicare Part C Plan (CCYYMMDD). *Blank if ongoing.
16.	Disposition Code	2	100-101	01 = Record Accepted. Individual was matched to a Medicare beneficiary. 51 = Individual was not matched to a Medicare beneficiary.
17.	CMS Document Control Number	15	102-116	COBC generated record tracking number.

Appendix C – Non-MSP File Specifications

Section 111 GHP Non-MSP Input File – Expanded Reporting Option Only

Section 111 GHP Non-MSP Input File Header Record – 300 bytes					
Field	Name	Size	Displacement	Data type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	Must be: 'H0'
2.	Section 111 Reporter ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by COBC. Required.
3.	File Type	4	12-15	Alpha	Must be: 'NMSI' – non-MSP input file.
4.	File Date	8	16-23	Numeric	CCYYMMDD Required.
5.	RDS Application Number	10	24-33	Alpha-Numeric	Retiree Drug Subsidy ID number that is associated with a particular RDS application. Assigned by the RDS Center. When populated this field should contain 10 digits (0-9), right justified with leading positions zero filled. This application number will change each year when a new application is submitted. Required for files containing Action Type S. Fill with spaces for Action Types D and N.
6.	Filler	267	34-300	Filler	Unused Field.

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes

Field	Name	Size	Displacement	Data type	Description
1.	Beneficiary Social Security Number	9	1-9	Numeric	Inactive Covered Individual's Social Security Number. Required if HICN field (below) not populated. Fill with spaces if SSN is not available.
2.	HIC Number (HICN)	12	10-21	Alpha-Numeric	Inactive Covered Individual's Health Insurance Claim Number (Medicare ID number). Required if SSN field (above) not populated. Populate with spaces if not available.
3.	Covered Individual's Surname	6	22-27	Text	Inactive Covered Individual's Last Name – Required.
4.	Covered Individual's First Initial	1	28-28	Alpha	Inactive Covered Individual's First Initial – Required.
5.	Covered Individual's Middle Initial	1	29-29	Alpha	Inactive Covered Individual's Middle Initial – Optional.
6.	Covered Individual's Date of Birth	8	30-37	Numeric Date	Inactive Covered Individual's DOB (CCYYMMDD). Required.
7.	Covered Individual's Sex Code	1	38-38	Numeric	Inactive Covered Individual's Sex – Valid values: 0 = Unknown 1 = Male 2 = Female Required.

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes

Field	Name	Size	Displacement	Data type	Description
8.	Group Health Plan (GHP) Number	20	39-58	Text	GHP Number assigned by Payer for Action Type D, or, <u>Unique Benefit Option Identifier</u> assigned by Payer for Action Type S. For use with Action Types D and S. Required for Action Type S when Coverage Type is V, Z, 4, 5 or 6.
9.	Individual Policy Number	17	59-75	Text	Unique Identifier assigned by the payer to identify the covered individual. For use with Action Types D and S. Required for Action Type D when Coverage Type is V, Z, 4, 5, and 6.
10.	Effective Date	8	76-83	Numeric Date	Start Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). Required for Action Types D and S.
11.	Termination Date**	8	84-91	Numeric Date	End Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). For use with Action Types D and S. Required for Action Type S. **All zeros if open-ended.
12.	National Health Plan	10	92-101	Filler	National Health Plan Identifier. (<i>Future Use.</i>)
13.	Rx Insured ID Number	20	102-121	Text	Insured's Rx Identification Number. For use with Action Types D and S. Required for Action Type D when Coverage Type = U, W, X, or Y.

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes

Field	Name	Size	Displacement	Data type	Description
14.	Rx Group Number	15	122-136	Text	Rx Group Health Plan Number assigned by Payer for Action Type D, or, <u>Unique Benefit Option Identifier</u> , as defined by the RDS Center, and assigned by Payer for Action Type S. Required with Action Type S when Coverage Type = U, W, X, or Y.
15.	Rx PCN	10	137-146	Text	Rx Processor Control Number for Medicare Beneficiaries. For use with Action Type D and S when Coverage Type = U, W, X, or Y. Required if available.
16.	Rx BIN Number	6	147-152	Numeric	Benefit Identification Number for Rx processing - Medicare Beneficiaries. For use with Action Types D and S. Must be a 6-digit number. Required for Action Type D when Coverage Type = U, W, X, or Y.
17.	Rx Toll Free Number	18	153-170	Text plus “(“ and “)”	Toll Free Number Pharmacist can use to contact Rx Insurer. For use with Action Types D and S.
18.	Relationship Code	2	171-172	Numeric	Covered Individual's Relation to Policy Holder: Valid values: '01' = Covered Individual is Policy Holder '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes

Field	Name	Size	Displacement	Data type	Description
					'04' = Other Or spaces. Required for Action Types D and S.
19.	DCN	15	173-187	Text	Document Control Number; assigned by the Section 111 GHP RRE. Required. Each record within the current file must have a unique DCN.
20.	Action Type	1	188	Alpha	Type of Record: Valid values: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Required.
21	Transaction Type	1	189	Alpha-Numeric	Type of Transaction: Valid values: '0' = Add Record '1' = Delete record '2' = Update record Fill with space for Action Type N. Required for Action Types D or S.
22.	Coverage Type	1	190	Alpha-Numeric	Type of Coverage: 'U' - Drug Only - network Rx 'V' - Drug with Major Medical - non-network Rx 'W' - Comprehensive Coverage - Hosp/Med/Drug - network Rx 'X' - Hospital and Drug - network Rx 'Y' - Medical and Drug - network Rx 'Z' - Health Reimbursement Account - non-network Rx '4' = Comprehensive

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes

Field	Name	Size	Displacement	Data type	Description
					Coverage - Hosp/Med/Drug - non-network Rx '5' = Hospital and Drug - non-network Rx '6' = Medical and Drug - non-network Rx Required for Action Types D or S.
23.	Person Code	3	191-193	Text	Person Code the plan uses to identify specific individuals on a policy. For use with Action Types D and S.
24.	Reserved	10	194-203	Internal use	Reserved for COB internal use; Fill with spaces only.
25.	Reserved	5	204-208	Internal use	Reserved for COBC internal use; Fill with spaces only.
26.	Reserved	1	209	Internal use	Reserved for COBC internal use; Fill with spaces only.
27.	Insurer Name	32	210-241	Text	Name of Insurance company providing Prescription Drug coverage. For use with Action Types D and S.
28.	Filler	59	242-300	Filler	Unused field.

Section 111 GHP Non-MSP Input File Trailer Record – 300 bytes

Field	Name	Size	Displacement	Data type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Must be: 'T0'
2.	Section 111 Reporter ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by COBC. Required.
3.	File Type	4	12-15	Alpha	Must be: 'NMSI' – non-MSP input file.
4.	File Date	8	16-23	Numeric	CCYYMMDD Required.
5.	S Record Count	9	24-32	Numeric	Number of Action Type 'S' records on file. Required.
6.	D Record Count	9	33-41	Numeric	Number of Action Type 'D' records on file. Required.
7.	N Record Count	9	42-50	Numeric	Number of Action Type 'N' records on file. Required.
8.	Total Record Count	9	51-59	Numeric	Number of detail records in this file. Do not include the Header and Trailer Records in the Record Count. Required.
9.	Filler	241	60-300	Filler	Unused Field.

Section 111 GHP Non-MSP Response File

Section 111 GHP Non-MSP Response File Header Record – 500 bytes				
Field	Name	Size	Displacement	Description
1.	Header Indicator	2	1-2	Must be: 'H0'
2.	Section 111 Reporter ID	9	3-11	'000000001', '000000002', etc. ID number assigned by COBC. Corresponds to the Reporter ID submitted on the Non-MSP Input File.
3.	File Type	4	12-15	'NMSR' – Non-MSP Response file. 'RDSU' – Unsolicited RDS Response file.
4.	File Date	8	16-23	CCYYMMDD COB supplied.
5.	RDS Application Number	10	24-33	Retiree Drug Subsidy ID number assigned by the RDS contractor that is associated with a particular RDS application. This application number will change each year when a new application is submitted. Field will contain value supplied on input.
6.	Filler	467	34-500	Unused Field. Space filled.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
1.	Filler	4	1-4	COBC use.
2.	SSN	9	5-13	Beneficiary's SSN. Included for Action Types D, S, and N. Field will contain either the SSN matched, or a corrected SSN based on a HICN match.
3.	HIC Number	12	14-25	Beneficiary's Medicare Health Insurance Claim Number (HICN). Included for Action Types D, S, and N. Field will contain either the HICN matched, or a corrected HICN based on a SSN match. Store this HICN in your system for future updates and deletes.
4.	Covered Individual's Surname	6	26-31	Beneficiary's Last Name. Included for Action Types D, S, and N. Field will contain either the name supplied or a corrected name from COBC database.
5.	Beneficiary First Initial	1	32	Beneficiary's First Initial. Included for Action Types D, S, and N. Field will contain either the value supplied or a corrected value from COBC database.
6.	Beneficiary Middle Initial	1	33	Beneficiary's Middle Initial. Included for Action Types D, S, and N. Field will contain the value supplied.
7.	Beneficiary Date of Birth	8	34-41	Beneficiary's DOB (CCYYMMDD). Included for Action Types D, S, and N. Field will contain either the value supplied or a corrected value from COBC database.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
8.	Beneficiary Sex Code	1	42	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Included for Action Types D, S, and N. Field will contain either the value supplied or a corrected value from COB database.
9.	Group Health Plan Number	20	43-62	GHP Number assigned by Payer for Action Type D, or, <u>Unique Benefit Option Identifier</u> , as defined by the RDS Center, and assigned by Payer for Action Type S. Included for Action Types D and S. Field will contain the value supplied on input.
10.	Individual Policy Number	17	63-79	Policy Number. Included for Action Types D and S. Field will contain the value supplied on input.
11.	Effective Date	8	80-87	Start Date of Beneficiary's Supplemental Drug Insurance Coverage (CCYYMMDD). Included for Action Types D and S. Field will contain the effective date applied to the supplemental drug coverage record.
12.	Termination Date	8	88-95	End Date of Beneficiary's Supplemental Drug Insurance Coverage (CCYYMMDD). **All zeros if open-ended or non-applicable. Included for Action Types D and S. Field will contain the term date applied to the supplemental drug coverage record.
13.	National Health Plan ID	10	96-105	National Health Plan Identifier. For Action Types D and S. (<i>Future Use</i>).

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
14.	Rx Insured ID Number	20	106-125	Insured's Rx Identification Number. Included for Action Types D and S. Field will contain the value supplied on input.
15.	Rx Group Number	15	126-140	Rx Group Health Plan Number assigned by payer for Action Type D or <u>Unique Benefit Option Identifier</u> assigned by payer for Action Type S. Included for Action Types D and S. Field will contain the value supplied on input.
16.	Rx PCN	10	141-150	Rx Processor Control Number. Included for Action Types D and S. Field will contain the value supplied on input.
17.	Rx BIN Number	6	151-156	Benefit Identification Number for Rx processing. Included for Action Types D and S. Field will contain the value supplied on input.
18.	Rx Toll Free Number	18	157-174	Pharmacy benefit Toll Free Number. Included for Action Types D and S. Field will contain the value supplied on input.
19.	Person Code	3	175-177	Person Code the Plan uses to identify specific individuals on a policy. Included for Action Types D and S. Defaults to '001' for D records if not provided on input.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
20.	Relationship Code	2	178-179	Beneficiary's Relationship to active employee: '01' = Beneficiary is Policy Holder '02' = Spouse or Common Law Spouse '03' = Child '20' – Domestic Partner '04' = Other Included for Action Types D and S. Field will contain the value supplied on input.
21.	RRE Assigned DCN	15	180-194	The Document Control Number assigned by the Section 111 GHP RRE. Included for Action Types D, S, and N. Field will contain the value supplied on input.
22.	COBC DCN	15	195-209	COBC Document Control Number. Included for Action Types D, S, and N. Field will contain the DCN created for this record by the COBC.
23.	Original Action Type	1	210	Type of Record: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for Action Types D, S, and N. Field will contain value supplied on input.
24.	Action Type	1	211	Type of Record applied by COBC (COBC may change an S action to a D if RDS rejects the record due to Part D enrollment): 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for Action Types D, S and N. COBC supplied value.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
25.	Transaction Type	1	212	Type of Transaction: '0' = Add Record '1' = Delete record '2' = Update record Included for Action Types D and S. Field will contain value supplied on input.
26.	Coverage Type	1	213	Type of Coverage: 'U' = Drug Only - network Rx 'V' = Drug with Major Medical - non-network Rx 'W' = Comprehensive Coverage - Hosp/Med/Drug - network Rx 'X' = Hospital and Drug - network Rx 'Y' = Medical and Drug - network Rx 'Z' = Health Reimbursement Account - non-network Rx '4' = Comprehensive Coverage - Hosp/Med/Drug - non-network Rx '5' = Hospital and Drug - non-network Rx '6' = Medical and Drug - non-network Rx Included for Action Types D and S. Field will contain the value supplied on input.
27.	Filler	1	214	Unused Field.
28.	Reason for Medicare Entitlement	1	215	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Included for Action Types D and N. COBC-supplied value.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
29.	S Disposition Code	2	216-217	Cross-walked result from RDS processing to COBC disposition codes. Included for records submitted with 'S' Action Type. RDS-supplied value converted to Section 111 GHP specific S Disposition Code. Refer to Field 53 (RDS Reason Code) and Field 54 (RDS Determination Indicator) for actual codes supplied by the RDS Center.
30.	S Disposition Date	8	218-225	Date S Disposition determined (CCYYMMDD). Included for records with an original S Action Type. RDS Center supplied value.
31.	Current Medicare Part A Effective Date	8	226-233	Effective Date of Medicare Part A Coverage (CCYYMMDD). Included for all Action Types. COBC supplied value.
32.	Current Medicare Part A Termination Date*	8	234-241	Termination Date of Medicare Part A Coverage (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.
33.	Current Medicare Part B Effective Date	8	242-249	Effective Date of Medicare Part B Coverage (CCYYMMDD). Included for all Action Types. COBC supplied value.
34.	Current Medicare Part B Termination Date*	8	250-257	Termination Date of Medicare Part B Coverage (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
35.	Part D Eligibility Start Date	8	258-265	Earliest date that beneficiary is eligible to enroll in Part D – Refer to Field 42 for the Part D Plan Enrollment Date (CCYYMMDD). Included for all Action Types. COBC supplied value.
36.	Part D Eligibility Stop Date*	8	266-273	Date the beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 43 for the Part D Plan Termination Date (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.
37.	Medicare Beneficiary Date of Death*	8	274-281	Medicare Beneficiary Date of Death (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if not applicable.
38.	Current Medicare Part C Plan Contractor Number	5	282-286	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. Included for all Action Types. COBC supplied value.
39.	Current Medicare Part C Plan Enrollment Date	8	287-294	Effective Date of coverage provided by the Beneficiary's current Medicare Part C Plan (CCYYMMDD). Included for all Action Types. COBC supplied value.
40.	Current Medicare Part C Plan Termination Date*	8	295-302	Termination Date of the coverage provided by the Beneficiary's current Medicare Part C Plan (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
41.	Current Medicare Part D Plan Contractor Number	5	303-307	Contractor Number of the current Medicare Part D Plan in which the Beneficiary is enrolled. Included for all Action Types. COBC supplied value.
42.	Current Medicare Part D Plan Enrollment Date	8	308-315	Effective Date of coverage provided by the Current Medicare Part D Plan (CCYYMMDD). Included for all Action Types. COBC supplied value.
43.	Current Medicare Part D Plan Termination Date*	8	316-323	Termination Date of coverage provided by the current Medicare Part D Plan (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.
44.	Error Code 1	4	324-327	Error Code 1 – May contain SP or RX error codes from COBC or RDS processing if applicable. See SP and Rx Error Code Tables for values. COBC supplied value for D/N records. RDS supplied value for S records.
45.	Error Code 2	4	328-331	Error Code 2 – May contain SP or RX error codes from COBC or RDS processing if applicable. See SP and Rx Error Code Tables for values. COBC supplied value for D/N records. RDS supplied value for S records.
46.	Error Code 3	4	332-335	Error Code 3 – May contain SP or RX error codes from COBC or RDS processing if applicable. See SP and Rx Error Code Tables for values. COBC supplied value for D/N records. RDS supplied value for S records.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
47.	Error Code 4	4	336-339	Error Code 4 – May contain SP or RX error codes from COBC or RDS processing if applicable. See SP and Rx Error Code Tables for values. COBC supplied value for D/N records. RDS supplied value for S records.
48.	D/N Disposition Code	2	340-341	Result from processing of an Action Type D or N record. This will also be used to provide a disposition for D records converted from S records – in such case, the S Disposition (Field 30) will also be populated. See GHP Disposition Code Table for values. Code supplied by the COBC.
49.	D/N Disposition Date	8	342-349	Processing date associated with the D/N Disposition Code (CCYYMMDD). Supplied by the COBC.
50.	RDS Start Date	8	350-357	Start date for the RDS subsidy period (CCYYMMDD). RDS-supplied value.
51.	RDS End Date	8	358-365	End date for RDS subsidy period (CCYYMMDD). RDS-supplied value.
52.	RDS Split Indicator	1	366	Indicates multiple subsidy periods within the plan year. Expect multiple records. Values: 'Y' if applicable. Space if not applicable. RDS-supplied value.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
53.	RDS Reason Code*	2	367-368	<p>Spaces = Accepted 01=Application deadline missed 02=Invalid Application Number 03=Invalid Last Name 04=Invalid First Name 05=Invalid Date of Birth 06=Invalid Gender 07=Invalid Coverage Effective Date 08= Invalid Coverage Termination Date 09= Invalid Benefit Option Identifier 10= Enrolled in Part D 11= Not eligible for Medicare 12= Beneficiary is deceased 13= Invalid HICN or SSN 14=Termination Date less than Effective Date 15= Missing Trailer Record 16= Not a valid Medicare beneficiary 17= No coverage period exists for delete transaction 18= Invalid Action Type 19= Invalid Relationship Code 20= Beneficiary attempted to enroll in Part D and received an initial rejection. 21= New Medicare information has been received – resend record.</p> <p>*RDS Center-supplied codes.</p>
54.	RDS Determination Indicator	1	369	<p>Y = Yes, the retiree qualifies for the RDS subsidy. N = No, the retiree does not qualify for the RDS subsidy. <i>This indicator may be blank on records in unsolicited RDS response files.</i> RDS supplied value.</p>
55.	ESRD Coverage Period Effective Date	8	370-377	<p>The date on which the beneficiary is entitled to Medicare in some part because of a diagnosis of End Stage Renal Disease (CCYYMMDD). Last coverage period will be reported if multiple coverage periods exist. Supplied by the COBC.</p>

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes

Field	Name	Size	Displacement	Description
56.	ESRD Coverage Period Term Date	8	378-385	The date on which the beneficiary is no longer entitled to Medicare under ESRD Provisions (CCYYMMDD). Last coverage period will be reported if multiple coverage periods exist. Supplied by the COBC.
57.	First Dialysis Date	8	386-393	A date that indicates when the beneficiary first started ESRD Dialysis (CCYYMMDD). Supplied by the COBC.
58.	ESRD Self-Training Date	8	394-401	A date that indicates when the beneficiary participated in ESRD Self Care Training (CCYYMMDD). Supplied by the COBC.
59.	Transplant Date – Most Recent	8	402-409	A date that indicates when a Kidney Transplant Operation Occurred (CCYYMMDD). Last occurrence will be reported. Supplied by the COBC.
60.	Transplant Failure Date – Most Recent	8	410-417	A date that indicates when a Kidney Transplant failed (CCYYMMDD). Last occurrence will be reported. Supplied by the COBC.
61.	Filler	83	418-500	Unused Field. Filled with spaces.

Section 111 GHP Non-MSP Response File Trailer Record – 500 bytes

Field	Name	Size	Displacement	Description
1.	Trailer Indicator	2	1-2	Must be: 'T0'
2.	Section 111 Reporter ID	9	3-11	'000000001', '000000002', etc. ID number assigned by COBC. Corresponds to the Reporter ID submitted on the Non-MSP Input File and the Response File Header Record.
3.	File Type	4	12-15	'NMSR' – Non-MSP Response File. 'RDSU' – Unsolicited RDS Response File. Field will contain value supplied on input.
4.	File Date	8	16-23	CCYYMMDD COB supplied.
5.	Record Count	9	24-32	Number of detail records in this file. Header and trailer records are not included in this count. COBC Supplied.
6.	Filler	468	33-500	Unused Field. Space filled.

Appendix D – Disposition, Error and Compliance Codes

Section 111 GHP Disposition Codes

Disposition Codes	Description
01	Record accepted by the Medicare Common Working File (CWF) or the Medicare Beneficiary Database (MBD) as an “Add” or an “Update” record. An MSP occurrence or supplemental drug record was added, updated or deleted. For queries, the individual was found to be a Medicare beneficiary and the response record contains Medicare entitlement and enrollment information.
SP	Transaction edit; record returned with at least one SP or RX edit (specific SP and RX edits are described below). Record must be corrected and resubmitted on the next file submission.
50	Record still being processed by CMS. Internal CMS use only; <i>resubmit record on next file submission.</i>
51	Individual was not found to be a Medicare Beneficiary. Record will not be recycled. Individual is most likely not entitled to Medicare. RRE should verify individual’ status based on information in its files and <i>resubmit record on next file submission.</i> RREs will receive this disposition code if neither the HICN nor SSN is submitted on the input record. In this case the RRE must obtain a valid HICN or SSN and resubmit the record on the next file submission.
52	Record still being processed by CMS. Internal CMS use only; <i>resubmit record on next file submission.</i>
53	Record in alpha match at CMS. Internal CMS use only; <i>resubmit record on next file submission.</i>
55	Name/Personal Characteristic Mismatch. Name or personal characteristic of beneficiary does not match the Health Insurance Claim Number (HICN) on Medicare's files. RRE needs to verify name, HICN, date of birth and gender based on information in its files; <i>resubmit record on next file submission.</i>
61	Cross-Reference Data Base Problem. Internal CMS use only; <i>resubmit record on next file submission.</i>
AB	CWF problem that can only be resolved by CWF Technician. Internal CMS use only; <i>resubmit record on next file submission.</i>
CI	Processing Error. Internal CMS use only; <i>resubmit record on next file submission.</i>

Disposition Codes	Description
ID	Drug Record Processing Error. Internal CMS use only; <i>resubmit record on next file submission.</i>
BY	<p>Bypass. Record was bypassed. SEE HICN was submitted by RRE and accepted; <i>resubmit record on next file submission.</i></p> <p>RREs will also receive this disposition code if the employee's status is shown to be inactive ('2' in Field 20 of MSP Input File detail record) and the individual was found to be entitled to Medicare due to age or disability (not ESRD). Resubmit record on next file submission as the beneficiary's reason for Medicare entitlement is subject to change.</p>

Section 111 GHP SP Error Codes

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
SP 11	Invalid MSP Transaction Record Type. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 12	Invalid HICN (Mandatory). Field must contain alpha and numeric characters. You received this error because an invalid character was found in this field.		X
SP 13	Invalid Beneficiary/Individual Surname (Mandatory). Field must contain alpha characters. Field cannot be blank or contain spaces or numeric characters.		X
SP 14	Invalid Beneficiary/Individual First Name Initial (Mandatory). Field must contain alpha character. Field cannot be blank or contain spaces, numeric characters, or punctuation marks.		X
SP 15	Invalid Beneficiary/Individual Date of Birth (Mandatory). Field must contain numeric characters. Field cannot be blank or contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.		X
SP 16	Invalid Beneficiary/Individual Sex Code (Mandatory). Field must contain numeric character. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 0 = Unknown 1 = Male 2 = Female		X
SP 17	Invalid Contractor Number (Mandatory). No correction necessary - resubmit records with this error on your next file submission.	X	
SP 18	Invalid Document Control Number (DCN) submitted by COBC to CWF. No correction necessary - resubmit records with this error on your next file submission.	X	

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
SP 19	Invalid Transaction Type (Mandatory). This error results from what is provided in the type of record transaction field. Field must contain a numeric character. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record		X
SP 20	Invalid Validity Indicator. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 21	Invalid MSP Code. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 22	Invalid Diagnosis Code. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 23	Invalid Remarks Code. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 24	Invalid Coverage Type. Valid Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical (non-network Rx) 'W' = Comprehensive Coverage – Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage – Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx)		X
SP 25	Invalid Insurer Name. Insurer name on the Non-MSP Input record or associated MSP TIN Reference File record for the insurer TIN has an invalid insurer name. Correct and resend the Non-MSP Input record or both the TIN Reference File and MSP Input File records. Spaces are allowed between words in an		X

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
	<p>insurer plan name. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. Field cannot be blank. If the MSP Insurers name is equal to SUPPLEMENT, SUPPLEMENTAL, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, MISC, NA, NO, BC, BX, BS, BCBX, BLUE CROSS, BLUE SHIELD, or MEDICARE, SP 25 error will occur.</p> <p>This error will also be returned if no Insurer TIN was submitted on the MSP Input record.</p>		
SP 26	<p>Invalid Insurer Address 1 and/or Address 2. Address field(s) on the associated TIN Reference File record for the insurer TIN is/are invalid. Correct and resend TIN Reference File and MSP Input File records. Spaces are allowed between words in a plan address. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. Field cannot be blank.</p>		X
SP 27	<p>Invalid Insurer City. City field on the associated TIN Reference File record for the insurer TIN is invalid. Correct and resend the TIN Reference File and MSP Input File record. Field cannot contain numeric characters. Spaces are allowed for multi-city word name. If field is not used, field must contain spaces. Field may contain alpha characters, commas, & - ' . @ # / : ;.</p>		X
SP 28	<p>Invalid Insurer State. State field on the associated TIN Reference File record for the insurer TIN is invalid. Correct and resend the TIN Reference File and MSP Input File record. Field may contain alpha characters. Alpha characters provided must match U.S. Postal State Abbreviation Table. When the Insurer's state does not match a state code on the U.S. Postal Service state abbreviation table, SP28 error will occur.</p>		X
SP 29	<p>Invalid Insurer Zip Code. Zip Code on the associated TIN Reference File record for the insurer TIN is invalid. Correct and resend the TIN Reference File and the MSP Input File record. First five positions must be numeric; last four positions may be numeric or spaces.</p>		X

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
SP 30	Invalid Policy Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ; .		X
SP 31	<p>Invalid Effective Date (Mandatory). Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. The date must be in the following format: CCYYMMDD. Number of days must correspond with the particular month. For example, the date 19500230 is not acceptable (February cannot have 30 days). Effective date must be less than or equal to the current date and cannot be a future date. For example, today is 20030312 and an RRE submits a record with an effective date of 30000901. Since this is a future date, the RRE will receive an SP 31.</p> <p>This error may also be returned if the individual is found to be a Medicare beneficiary but the GHP coverage dates fall completely outside the Medicare entitlement period. In this case, continue to resend the record until the individual is no longer an Active Covered Individual or GHP coverage is terminated.</p>		X
SP 32	<p>Invalid Termination Date (Mandatory). Field must contain numeric characters. The date must be in the following format: CCYYMMDD. Number of days must correspond with the particular month. For example, the date 19500230 is not acceptable (February cannot have 30 days). Plan termination date cannot be earlier than the effective date or beneficiary's eligibility start date.</p> <p>If there is no termination date (coverage is still active), you must use zeros (not spaces) in this field. For Working-Aged beneficiaries, the termination date cannot be greater than the current date plus 6 months. For Disability beneficiaries, the termination date cannot be greater than the first day the beneficiary turned 65. Will accept future date for ESRD up to 30 months.</p> <p>Termination date must be greater than 30 days after the MSP Effective Date.</p>		X

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
	This error could also be posted when the GHP coverage and Medicare coverage do not overlap – the GHP coverage ended prior to the start of Medicare coverage. The RRE cannot fix this error. Continue to send the record until the individual is no longer considered to be an Active Covered Individual or GHP coverage is terminated.		
SP 33	Invalid Patient Relationship (Mandatory). Field must contain numeric characters. Field cannot be blank or contain alpha characters. Acceptable numeric values are as follows: 01 = Beneficiary 02 = Spouse 03 = Child* 04 = Other 20 = Domestic Partner * Applies only for children covered under the ESRD provision or disabled adult children covered under the disability provision.		X
SP 34	Invalid Policy Holder/Subscriber First Name. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If field is not used, field must contain spaces.		X
SP 35	Invalid Policy Holder/Subscriber Last Name. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If field is not used, field must contain spaces.		X
SP 36	Invalid Policy Holder SSN. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; . If field is not used, field must contain spaces.		X
SP 37	Invalid Source Code. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 38	Invalid Employee Information Data Code. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 39	Invalid Employer Name. Employer Name on the associated TIN Reference File record for the Employer TIN is invalid. Correct and resend the TIN Reference File and MSP Input File record. Field must contain alpha and/or numeric characters, commas, & - ' . @ # / : ; . If field is not used, field must contain spaces.		X

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
	<p>(For those beneficiaries that are Working Aged or Disabled, this field should always contain the name of the actual employer.)</p> <p>This error will also be returned if no Employer TIN was submitted on the MSP Input record.</p>		
SP 40	<p>Invalid Employer Address. Employer Address on the associated TIN Reference File record for the Employer TIN is invalid. Correct and resend the TIN Reference File and MSP Input File record. Field must contain alpha and/or numeric characters, commas, & - ' . @ # / : ; . If field is not used, field must contain spaces. (For those beneficiaries that are working aged or disabled, this field should always contain the address of the actual employer.)</p>		X
SP 41	<p>Invalid Employer City. Employer City on the associated TIN Reference File record for the Employer TIN is invalid. Correct and resend the TIN Reference File and MSP Input File record. Field may contain alpha and/or numeric characters. If field is not used, field must contain spaces. Valid characters include commas, & - ' . @ # / : ; .</p>		X
SP 42	<p>Invalid Employer State. Employer State on the associated TIN Reference File record for the Employer TIN is invalid. Correct and resend the TIN Reference File and MSP Input File record. Field must contain alpha characters. Field cannot be blank. If a foreign country, use 'FC' for state code. Alpha characters provided must match U.S. Postal State Abbreviation Table.</p>		X
SP 43	<p>Invalid Employer Zip Code. Employer Zip Code on the associated TIN Reference File record for the Employer TIN is invalid. Correct and resend the TIN Reference File and MSP Input File record. First five positions may be numeric; the last four positions may be spaces. Field cannot contain alpha characters. Must be within valid zip code range on zip code table. The first five digits can be zeros, and last four can be blanks.</p>		X
SP 44	<p>Invalid Insurance Group Policy Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric</p>		X

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
	characters, commas, & - ' . @ # / : ; .		
SP 45	Invalid Individual Policy Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ; .		X
SP 46	Invalid Pre-Paid Health Plan Date. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 47	Beneficiary MSP Indicator not on for delete transaction. An attempt was made to delete an MSP record where there is no MSP indicator on the beneficiary Medicare record. According to CMS records Medicare has always been the primary payer.		X
SP 48	MSP auxiliary record not found for delete data transaction. This edit occurs when an attempt is made to delete a non-existent MSP occurrence.		X
SP 49	MSP auxiliary occurrence not found for delete data transaction. Where there is an existing MSP period, the incoming record must match on certain criteria so the system can differentiate among various periods of MSP on the beneficiary's Medicare file. These criteria are: patient relationship, MSP effective date, MSP type, and coverage type. An SP 49 is received when an RRE attempts to delete an occurrence that is not on CWF, or one for which there is no "match" on CWF, or you send in a delete transaction for a record that has been previously deleted by the RRE or another entity and the record no longer exists.		X
SP 50	Invalid function for update or delete. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 51	MSP auxiliary record has 17 occurrences and none can be replaced. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 52	Invalid patient relationship code ("PRC"). (Mandatory) The MSP Code (Type) must correspond with valid PRC as cited below. MSP Code/Patient Relationship Codes A = Working Aged 01 = Beneficiary		X

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
	<p>02 = Spouse</p> <p>G = Disabled 01 = Beneficiary 02 = Spouse 03 = Child 04 = Other 20 = Domestic Partner</p> <p>B = ESRD 01 = Beneficiary 02 = Spouse 03 = Child 04 = Other 20 = Domestic Partner</p> <p>For example, you will receive this edit when the MSP Code is equal to or determined to be 'A' 'G' or 'B' by the COBC and one of the following occurs: 1) If the MSP Code is equal to 'A' and the MSP patient relationship does not equal '01' and '02' or 2) the MSP code is equal to 'G' and the patient relationship does not equal '01', '02', '03', '04' and '20'.</p>		
SP 53	MSP Code 'G' or 'B' overlaps another Code 'A', 'G', or 'B'. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 54	MSP Code 'A' or 'G' has an effective date that is in conflict with the calculated date the beneficiary reaches 65 years old. For MSP Code 'A', the effective date must not be less than the date at age 65. For MSP Code 'G', the effective date must not be greater than the date at age 65. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 55	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 SP 55 error. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 56	MSP pre-paid health plan date must equal or be greater than the MSP Effective Date or less	X	

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
	than MSP Termination Date. No correction necessary - resubmit records with this error on your next file submission.		
SP 57	Termination Date greater than 6 months before date of accretion. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 58	Invalid Coverage Type, MSP Code, and validity indicator combination. Mapped coverage type must equal 'J', 'K', or 'A'. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 59	Invalid insurer type and validity indicator combination. RREs should not receive this edit. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 60	Other insurer type for same period on file (not 'J' or 'K'). RRE submits a 'J' or 'K' insurer type, but Medicare's CWF shows 'A' insurer type. Insurer type does not match previously submitted insurer type. Note: Edit only applies to MSP codes. A - Working Aged B - ESRD EGHP G - Disability EGHP No correction necessary - resubmit records with this error on your next file submission.	X	
SP 61	Other insurer type for same period on file ('J' or 'K'). RRE submits an 'A' insurer type, but Medicare's CWF shows 'J' or 'K' insurer type. Insurer type does not match previously submitted insurer type. Note: Edit only applies to MSP codes: A - Working Aged B - ESRD EGHP G - Disability EGHP No correction necessary - resubmit records with this error on your next file submission.	X	

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
SP 62	<p>Incoming termination date is less than MSP Effective Date. MSP Termination Date provided must be greater than the MSP effective date. The RRE sent a termination date prior to the MSP Effective Date. This edit occurs when an RRE fails to note CMS' modification of the RRE's MSP Effective Date to correspond with the commencement of the Medicare entitlement date. The RRE should go back to its previous response file and identify the correct MSP Effective Date for this record. If the termination date is earlier than the MSP Effective Date on the previous response file, this indicates that there was no MSP and the RRE should send a transaction to delete the record.</p> <p>This error could also be posted when the GHP coverage and Medicare coverage do not overlap – the GHP coverage ended prior to the start of Medicare coverage. In this case, the RRE cannot fix this error but should continue to send the record until the individual is no longer considered to be an Active Covered Individual.</p>		X
SP 66	<p>MSP Effective Date is greater than the Effective Date on matching occurrence on Auxiliary file. SP 66 occurs when the Effective Date on the maintenance record is greater than the Effective Date on the Auxiliary record to be updated, and Effective Date plus 30 is greater than "+30."</p> <p>No correction necessary - resubmit records with this error on your next file submission.</p>	X	
SP 67	<p>Incoming Termination Date is less than posted Termination Date for Provident. SP 67 occurs when the Termination Date on the maintenance record is less than the Termination Date on the Auxiliary record that is to be updated.</p> <p>No correction necessary - resubmit records with this error on your next file submission.</p>	X	
SP 69	<p>Updating contractor number is not equal to the header contractor number. CMS assigns the contractor number.</p> <p>No correction necessary - resubmit records with this error on your next file submission.</p>	X	

SP ERROR CODE	DESCRIPTION	COBC Responsible	RRE Responsible
SP 71	Attempting to change source code P-S. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 72	Invalid transaction attempted. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 73	Invalid Termination Date/Delete Transaction attempted. Internal CMS use only. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 74	Invalid - cannot update 'I' record. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 75	Invalid transaction. Beneficiary does not have Medicare Part A benefits for the time period identified in the RRE's update file. If there is no Part A entitlement, there is no MSP. No correction necessary - resubmit records with this error on your next file submission.	X	
SP 99	HICN required if individual is less than 45 years of age		X
SP ES	Due to the employer size, an MSP occurrence is not created. Check that the employer size submitted was correct and continue to resend the record on all subsequent quarterly file submissions until an '01' disposition code is received or the individual is no longer covered by your plan. Since the employer size may not change, you may continue to receive a response record back with an 'SP' disposition code for these situations.		X

Section 111 GHP Rx Error Codes

These codes only apply to records submitted for prescription drug coverage.

Error Code	Error Description
RX 01	Missing RX ID
RX 02	Missing or invalid RX BIN. Must be 6-digit number when required.
RX 03	Missing RX Group Number
RX 04	Missing Group Policy Number
RX 05	Missing Individual Policy Number
RX 06	Missing/Invalid Retiree Drug Subsidy Application Number
RX 07	Beneficiary does not have Part D enrollment
RX 09	Invalid Action Code
RX 10	Record not found for delete
RX 11	Record not found for update
RX 12	Invalid Supplemental Type

Section 111 SEE (Small Employer Exception) Response Codes

SEE Response Codes	Description
SA	SEE-HICN accepted. Record bypassed and not submitted to CWF. Disposition code of BY has been applied
SN	SEE-HICN not-accepted. SEE HICN could not be confirmed. Record processed as normal MSP occurrence. Disposition code should be used to determine subsequent processing required.
SP	SEE-HICN partially accepted. SEE HICN confirmed, but insurance effective period outside of SEE effective period. Disposition code should be used to determine subsequent processing required.

Section 111 Compliance Flag Codes

Compliance Code	Description
01	An invalid insurer/TPA TIN was supplied in the MSP Input record Field 22. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. Refer to the disposition code for results. Record must be resubmitted with the correct insurer/TPA TIN in the next quarterly file submission in order to comply with Section 111 requirements.
02	An invalid employer TIN was supplied in the MSP Input record Field 21. The corresponding TIN on the TIN Reference File could not be validated by the COBC. The record was processed without the TIN. Refer to the disposition code for results. Record must be resubmitted with the correct employer TIN in the next quarterly file submission in order to comply with Section 111 requirements.

Appendix E – MMSEA Section 111 BASIS Request Attachment

MMSEA Section 111 BASIS Request

Section 111 Reporter ID: _____

Date: _____

Section 111 Reporter Company Name: _____

SECTION I – Please list all persons to be given access to your BASIS account. MUST BE COMPLETED FOR ALL REQUESTS

User Name	Title	E-mail Address	Telephone Number	Indicate: A – Add R – Remove	User Mother Maiden Name

SECTION II: AUTHORIZATION

Administrative Contact Name: _____

Administrative Contact E-Mail Address: _____

Administrative Contact Phone Number: _____

Administrative Contact Signature

SECTION III: FOR COBC USE ONLY

Date Received: _____

Date Completed: _____

Date Plan Notified: _____

Method of Notification: _____

Processor Name: _____

Processor Signature: _____

Date: _____

Appendix F – MMSEA Section 111 Statutory Language

The Medicare Secondary Payor Mandatory Reporting Provisions Of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (See 42 U.S.C. 1395y(b)(7)&(b)(8))

SECTION 111 – MEDICARE SECONDARY PAYOR

(a) In General - Section 1862(b) of the Social Security Act ([42 U.S.C. 1395y\(b\)](#)) is amended by adding at the end the following new paragraphs:

(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS-

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall--

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) ENFORCEMENT-

(i) IN GENERAL- An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of \$1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

(C) SHARING OF INFORMATION- Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

- (i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);
- (ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and
- (iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS-

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall--

- (i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and
- (ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) REQUIRED INFORMATION- The information described in this subparagraph is--

- (i) the identity of the claimant for which the determination under subparagraph (A) was made; and
- (ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) TIMING- Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) CLAIMANT- For purposes of subparagraph (A), the term 'claimant' includes--

- (i) an individual filing a claim directly against the applicable plan; and
- (ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) ENFORCEMENT-

- (i) IN GENERAL- An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of \$1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such

provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) APPLICABLE PLAN- In this paragraph, the term `applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) SHARING OF INFORMATION- The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(b) Rule of Construction- Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.

(c) Implementation- For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act ([42 U.S.C. 1395i](#)) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act ([42 U.S.C. 1395t](#)), in such proportions as the Secretary determines appropriate, of \$35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.

Appendix G – MMSEA Section 111 Definitions and Reporting Responsibilities

Attachment A – Definitions and Reporting Responsibilities

(Attachment A to the Supporting Statement for the MMSEA Section 111 Paperwork Reduction Act (PRA) Federal Register (FR) Notice published February 13, 2009.)

SUPPORTING DOCUMENT FOR PRA PACKAGE FOR MEDICARE SECONDARY PAYER REPORTING RESPONSIBILITIES FOR SECTION 111 OF THE MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

Note: The second paragraph under Liability Self-Insurance was revised subsequent to the initial publication of this Attachment on August 1, 2008.

DEFINITIONS AND REPORTING RESPONSIBILITIES

GROUP HEALTH PLAN (GHP) ARRANGEMENTS (42 U.S.C. 1395y(b)(7)) --

INSURER

For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), an insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. In instances where an insurer does not process GHP claims but has a third party administrator (TPA) that does, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

THIRD PARTY ADMINISTRATOR (TPA)

For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), a TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of GHPs (as defined at 42 U.S.C. 1395y(b)(1)(A)(v)), the plan sponsor(s) or the plan insurer. A TPA may perform these services for, amongst other entities, self-insured employers, unions, associations, and

insurers/underwriters of such GHPs. If a GHP is self-funded and self-administered for certain purposes but also has a TPA as defined in this paragraph, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(7):

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7), agents may submit reports on behalf of :

- Insurers for GHPs
- TPAs for GHPs
- Employers with self-insured and self-administered GHPs

Accountability for submitting the reports in the manner and form stipulated by the Secretary and the accuracy of the submitted information continues to rest with each of the above-named entities.

The CMS will provide information on the format and method of identifying agents for reporting purposes.

LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION (42 U.S.C. 1395y(b)(8) --

INSURER

For purposes of the reporting requirements for 42 U.S.C. 1395y(b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8) regardless of whether it uses another entity for claim processing.

CLAIMANT:

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), "claimant" includes: 1) an individual filing a claim directly against the applicable plan, 2) an individual filing a claim against an individual or entity insured or covered by the applicable plan, or 3) an individual whose illness, injury, incident, or accident is/was at issue in "1)" or "2)".

APPLICABLE PLAN:

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the “applicable plan” as defined in subsection (8)(F) has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). For workers’ compensation information this would be the Federal agency, the State agency, or self-insured employer or the employer’s insurer.

NO-FAULT INSURANCE:

Trade associations for liability insurance, no-fault insurance and workers’ compensation have indicated that the industry’s definition of no-fault insurance is narrower than CMS’ definition. For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the definition of no-fault insurance found at 42 C.F.R. 411.50 is controlling.

LIABILITY SELF-INSURANCE:

42 U.S.C. 1395y(b)(2)(A) provides that an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no-fault insurance, or workers’ compensation law or plan) for a business, trade or profession. See also 42 C.F.R. 411.50.

Special Considerations where liability self-insurance which is a deductible or co-payment for liability insurance, no-fault insurance, or workers’ compensation is paid to the insurer or workers’ compensation entity for distribution (rather than directly to the claimant): As indicated in the definition of “liability self-insurance,” such deductibles and co-payments constitute liability self-insurance, and require reporting by the self-insured entities. However, in order to avoid two entities reporting where the deductibles and/or co-payments are physically being paid by the insurance company or workers’ compensation rather than the self-insured entity, CMS has determined that the liability insurance company, no-fault insurance company, or workers’ compensation, as appropriate, must include the self-insurance deductible or co-pay in the amount it reports. Note that this rule only applies where the self-insurance deductible or co-pay is paid to the insurer for distribution rather than directly to the claimant

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. Where such a plan is directly funded by the employer, the employer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). Where such a plan is indirectly funded by the employer, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8).

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.