

## What is MMSEA Section 111?

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

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

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

## What are the penalties for non-compliance?

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Failure to comply may result in a \$1,000 fine per day, per claim.

## Who is responsible for reporting?

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The Responsible Reporting Entity (RRE) is the insurer or self-insured plan (please refer to the July 12, 2010 User Guide for definitions of RRE, insurer and self-insured plan), which can be viewed at the CMS dedicated MMSEA Web page: <https://www.cms.gov/MandatoryInsRep/>.

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

## What are the current implementation timeframes?

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<b>Registration period</b>	Commenced May 1, 2009
<b>Test and Production Query Files Accepted</b>	July 1, 2009
<b>Claim Input File Testing Begins</b>	January 1, 2010
<b>Production Claim Input Files Accepted</b>	April 1, 2010
<b>First Live Production Files Due</b>	January 1, 2011 – March 31, 2011

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

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

## Does MMSEA Section 111 apply to Foreign Nations, American Indians, Alaskan Native Tribes and Multi-National Organizations?

Yes. Liability insurance (including self-insurance), no-fault and workers' compensation plans associated with any of the above are subject to MSP provisions and must be reported accordingly.

## How will the RRE submit data to CMS?

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

## What are the available File Transmission Methods?

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

## What is Direct Data Entry and who should utilize this reporting option?

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Direct Data Entry (DDE) will be available to RREs who meet the definition of a “small reporter” as defined by CMS and will allow manual entry and submission of claims data on the Coordination of Benefits Secure Website (COBSW) in lieu of submitting an electronic file. RREs may register for DDE as a reporting option beginning October 4, 2010.

Small reporters may begin reporting using the DDE option on **January 3, 2011**.

A “small reporter” is an RRE that will submit **500 or fewer** NGHP claim reports per calendar year. However, a separate query function will not be available under the DDE option. Injured party information will be matched real-time online as it is entered on the COBSW. The application will prompt the user performing the data entry to enter the injured party’s information first. Then, the system will attempt to match it to a Medicare beneficiary. If no match is found and the user confirms that the information they entered was complete and accurate, no further data elements will be required at that time. When an injured party’s information does not match to a Medicare beneficiary during the DDE process, the claim submission **WILL** still count toward the RRE’s limit of 500 claims per year.

Small Reporters that use the DDE option have the same responsibility and accountability as any other RRE.

The DDE option is intended for RREs who expect to have only an occasional claim report to make. RREs that will have claims to report on a frequent and on-going basis are advised not to use the DDE.

## When do RREs need to register?

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

RREs must register in enough time to allow for a full quarter of testing before live production files are due.

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

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

- The Query will be available for testing and submission of live files as of July 1, 2009. The Query will only be available once registration has been completed and the RRE has been moved to Testing status. Testing of Query files is not mandatory, but is recommended by CMS. **Each RRE ID can submit one query file per month.** The COBC will return a response file to the entity that submitted the file (either the RRE or the agent).
- The information required for the Query will be Social Security Number (SSN) or Health Insurance Claim Number (HICN), name (first initial and first six characters of the last name), date of birth (DOB) and gender. The SSN is REQUIRED to run the Query. If there is a match—**claimant is currently on Medicare or was on Medicare at some time**—with the above data, CMS will send back the HICN for that individual which must be utilized on all subsequent transactions. The COBC will also supply updated values for the name, DOB and gender based on the information stored for that beneficiary on Medicare's files.
- To determine whether an injured party is a Medicare beneficiary, the COBC must match submitted data to Medicare's. This matching can be done using either an individual's Medicare Health Insurance Claim Number (HICN) or by using an individual's Social Security Number (SSN). The HICN is preferred and once the HICN is returned on a response file from CMS, the Responsible Reporting Entity (RRE) **is required to use it on all subsequent transactions.**
- If an RRE submits **both** the SSN and HICN on a claim or query record, the system will **only use the HICN** for matching purposes and the SSN will be ignored.
- If a value of '0' (unknown gender) is submitted on a query file for an individual, the COBC will change this value to a '1' (male) for matching purposes and may return that changed value of '1' (male) on the response record even if a match is not found.
- HICNs may be reassigned by the Social Security Administration, but the COBC is able to cross-reference the old HICN to the new HICN. The COBC will always return the most current HICN on response records. RREs are encouraged to update their systems with that information and use it on subsequent record transmissions. However, updates may continue to be sent under the original HICN/SSN submitted.

**Even though a query file may be sent monthly, CMS stated that RREs need only query a particular injured party once per quarter and use the results of that query when creating the quarterly Claim Input File. RREs will need to submit the query file allowing enough time to receive and process the query file results for the creation of that quarter's Claim Input File. Since the Query Response File is returned within 14 days, an RRE might consider submitting the query file one month before the Claim Input File is due.**

- Query Response files will be returned within fourteen calendar days.
- If more than one Query Input File is received during a calendar month or is received while a previous file is still processing, the new Query Input File will suspend with a threshold

error. If the second file is suspended due to another file still in process, the EDI Representative must be contacted to have the suspended file released for processing. If more than one file is sent during a calendar month, the second file will not be processed.

- If the CMS response file indicates there is no match, this does not mean the claimant is not on Medicare. It just means there was no match based on the data provided (some data could be incorrect). The Query function is only as good as the data submitted.
- **Social Security entitlement information will not** be provided through the Query function.
- The Query function should be used to filter claims to determine which cases should be reported, as CMS only wants data on Medicare beneficiaries. CMS discourages “data dumping”—sending all claims without verifying Medicare status—and recommends utilization of the Query function.
- CMS confirmed that it is acceptable to report **all** cases where the claimant is age 65 or older rather than performing a Query on these files. This will not be considered “data dumping.”

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

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

### When will the data transfer process be tested?

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CMS has advised that testing of the Claim Input File will take place from January 1, 2010 through December 31, 2010, with live file submission scheduled for the first quarter of 2011—January 1, 2011 through March 31, 2011. However, if the RRE completes testing early and wants to submit their first live production file prior to January 1, 2011 they may do so.

- Test files will continue to be accepted and processed after production status has been attained.
- Testing may continue up until the first Production Claim Input File is due.
- All users associated with the RRE’s account will be able to submit test files. Live data is not required for testing—the RRE should still go through the testing process even if they do not yet have all the required data.

- Test files must be limited to no more than a combined total of 200 detail and auxiliary records.

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

Live reporting will be required as of first quarter of 2011 (January 1, 2011 – March 31, 2011). However, if the RRE completes, CMS will accept live production files prior to January 1, 2011.

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

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

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

## Which claims need to be reported?

- All claims involving a Medicare beneficiary where a settlement, judgment, award or other payment is made as of January 1, 2010 or later for cases with ongoing responsibility for medicals (ORM) – regardless of the date of the initial acceptance of payment responsibility.
  - If a claim was actively closed or removed from current claim record prior to January 1, 2010, the RRE is not required to identify and report that claim unless it is subsequently re-opened. **Earlier reports of ORM will be accepted and RREs may report ORM claims closed prior to January 1, 2010 at their discretion.**
- All claims involving a Medicare beneficiary where a Total Payment Obligation to the Claimant (TPOC) has been made on or after October 1, 2010 (Lump Sum Settlements).
  - CMS will accept TPOC dates prior to October 1, 2010. Therefore RREs can collect and submit data for TPOCs from July 1, 2009, as originally intended when the law was passed if they choose to do so. **The decision to report TPOCs prior to October 1, 2010, is up to each Responsible Reporting Entity.**

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

The Total Payment Obligation to the Claimant (TPOC) refers to the dollar amount of a settlement, judgment, award, or other payment **in addition to/apart from ORM**. A TPOC generally reflects a "one-time" or "lump sum" intended to resolve/partially resolve a claim. It is the dollar amount of the

total payment obligation to or on behalf of the injured party in connection with the settlement, judgment, award or other payment. Individual reimbursements paid for specific medical claims submitted to an RRE, paid due to the RRE's ORM for the claim **do not** constitute separate TPOC amounts.

## What is ongoing responsibility for medicals (ORM)?

Ongoing responsibility for medicals (ORM) refers to the RRE's responsibility to pay on an ongoing basis for the injured party's (the Medicare beneficiary) medicals associated with a claim. Typically, this only applies to no-fault and workers' compensation claims. Please see Section 11.8 of User Guide 3.1 for a more information regarding ORM.

## What is the trigger for reporting ORM?

The trigger for reporting ORM is the assumption of ORM by the RRE—when the RRE has made a determination to assume responsibility for ORM or is otherwise required to assume ORM—not when, or after, the first payment for medicals under ORM has actually been made. CMS confirmed that medical payments do not actually have to be paid on the claim for ORM reporting to be required.

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

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

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

## **Does Accident & Health, Short Term Travel and Occupational Accident claims need to be reported?**

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Accident & Health, Short Term Travel and Occupational Accident products are considered no-fault insurance by CMS and are reportable as such under MMSEA Section 111.

## **Do injuries arising out of clinical trials need to be reported under MMSEA Section 111?**

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When payments are made by sponsors of clinical trials for complications/injuries arising out of the trials, such payments are considered payments by liability insurance (including self-insurance) and must be reported. The appropriate RRE should report this situation as ORM with the date that the injury/complication first arose as the Date of Incident (DOI).

## **Are risk management write-offs and other actions reportable?**

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Risk management write-offs (including a reduction in the amount due as a risk management tool) constitute liability self-insurance for the purposes of the Medicare Secondary Payer provisions.

As a risk management tool (to lessen the probability of a liability claim against it and/or to facilitate/enhance customer good-will) entities may reduce charges for items and services (write-off) or provide something of value (e.g., cash, gift card, etc.). If an entity takes such actions, it may or may not constitute a reporting obligation (as a TPOC) as explained below.

- In instances where a provider, physician or other supplier has reduced its charges or written off some portion of a charge for items/services provided to a Medicare beneficiary (as a risk management tool), the provider, physician or other supplier is expected to submit a claim to Medicare reflecting the unreduced permissible (e.g., limiting charge) charges and showing the amount of the reduction provided or write-off as a payment from liability insurance (including self-insurance). Medicare's interests with respect to this particular TPOC amount have been protected through this billing procedure; the provider, physician or other supplier shall not report the reduction or write-off as a TPOC.
- In instances where a provider, physician, or other supplier has provided property of value (other than a reduction in charges or write-off) to a Medicare beneficiary as a risk management tool when there is evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the value of the property provided as a TPOC from liability insurance (including self-insurance). If the value of the property provided is less than the TPOC reporting threshold, it need not be reported under Section 111.

- In instances where any other entity has reduced its charges, written off some portion of a charge or provided other property of value to a Medicare beneficiary as a risk management tool when there is evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the reduction, write-off or property of value provided as a TPOC from liability insurance (including self-insurance). If the amount of the reduction, write-off or property of value provided is less than TPOC reporting threshold, it need not be reported under Section 111.

### **What if a claimant is not a Medicare beneficiary at the time ORM is assumed? Does that claim need to be reported?**

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

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

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

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If a claim was actively closed or removed from current claim record prior to January 1, 2010, the RRE is not required to identify and report that claim unless it is subsequently re-opened/has further activity. ***Earlier reports of ORM will be accepted and RREs may report ORM claims closed prior to January 1, 2010 at their discretion.***

### **Can ORM Termination Dates in the future be supplied?**

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**RREs are not to submit an expected, anticipated, or contingent ORM Termination Date. ORM Termination Dates should only be submitted when the termination of ORM is certain. Future-dated ORM Termination Dates can be dated no more than 6 months after the file submission date.**

For example, if the statute of limitation (SOL) laws provide that the claimant has 3 years to file a claim for further benefits and if not done the SOL applies, the ORM termination date is not certain.

Systems that interface with the COBC require that the ORM Termination Date be at least 30 days after the CMS Date of Incident. If the ORM Termination Date is less than 30 days from the CMS Date of Incident, the 'CJ06' error code will be returned on the response record. In situations where

the ORM Termination Date is less than 30 days from the CMS Date of Incident, a date 31 days after the CMS Date of Incident should be supplied in the ORM Termination Date. If the no-fault policy limits were reached, the actual date that the policy limits were reached should be listed in the Exhaust Date for Dollar Limit for No-Fault Insurance Field (82).

## When does an RRE report claims involving appeals?

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

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

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

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

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

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Assumption of ORM typically occurs with respect to no-fault insurance or workers' compensation. Because claims involve all levels of injury, the result can be the continuation of open ORM records even where, as a practical matter, there is no possibility of associated future treatment. (i.e., a minor fully healed cut finger injury in a state where workers' compensation requires life-time medicals).

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

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

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

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

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

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

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In situations where the applicable workers' compensation or no-fault law or plan requires the RRE to make regularly scheduled periodic payments, pursuant to statute, for obligation(s) other than medical expenses, to or on behalf of the claimant, the RRE does not report these periodic payments as long as the RRE separately assumes/continues to assume ORM and reports ORM appropriately. Otherwise, such scheduled periodic payments are considered to be part of and are reported as, ORM.

For example, if an RRE is making periodic "indemnity only" payments to the injured party to compensate for lost wages related to the underlying workers compensation or no-fault claim, the RRE has implicitly, if not explicitly, assumed ORM. Therefore, the RRE shall report the ORM. The periodic payments to compensate for lost wages are not reported as TPOCs.

## When is the Claim Input Auxiliary File used?

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

## Has CMS implemented any reporting thresholds?

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1. For **no-fault insurance**, there is **no low-dollar threshold** for reporting the assumption/establishment of ORM or for reporting the TPOC (i.e., a lump-sum settlement amount).
2. For **liability insurance**, there is **no low-dollar threshold** for reporting the assumption/establishment of ORM.

3. For **workers' compensation ORM**, claims meeting **all** of the following criteria are **excluded from reporting for file submissions due through December 31, 2011**:
- Medicals only
  - The associated "lost time" for the worker is not more than the number of days permitted by the applicable workers' compensation law for a "medicals only" claim (or 7 calendar days if the applicable law has no such limit).
  - All payment(s) has/have been made directly to the medical provider
  - Total payment does not exceed \$750
4. For **liability** insurance and **workers' compensation TPOCs**, the following requirements and dollar thresholds apply:
- RREs are not required to adhere to the TPOC thresholds for claims reported with ORM. RREs are only required to report a TPOC on a claim with ORM when it is over the TPOC threshold, but may report TPOCs under the threshold at the RRE's discretion.
  - RREs are only required to report TPOCs with dates of October 1, 2010 and subsequent. Therefore, only TPOCs with dates of October 1, 2010 and subsequent need to be included in the total for the threshold check. However, TPOCs with dates prior may be included at the RRE's discretion (the record will not be rejected). **The COBC will add all TPOC Amounts reported on the claim record when determining if the claim meets the applicable reporting threshold.**
  - Where there are multiple TPOCs associated with the same claim record, the combined, cumulative TPOC amounts must be considered in determining whether or not the reporting threshold is met.
  - TPOC Threshold checks will only be applied to initial claim reports (add records).
  - The threshold dollar and date ranges apply to the date when the threshold is met (the most recent TPOC Date). The COBC will use the most recent TPOC Date supplied on the claim report when checking the threshold ranges. Timeliness of reports will be determined based upon the applicable date for the TPOC which caused the threshold to be met (the last, latest, most recent TPOC Date reported on the claim record.)
  - For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the TPOC amount includes the total of these two figures which in turn is included in the total TPOC amount used for the threshold check.

## TPOC Threshold dates were updated in User Guide Version 3.1 (July 12, 2010) as follows:

- Claim reports where the last (most recent) TPOC Date is **prior to January 1, 2012**, with TPOC amounts totaling \$0 – \$5,000 are exempt from reporting.
- Claim reports where the last (most recent) TPOC Date is **January 1, 2012 through December 31, 2012**, with TPOC amounts totaling \$0 – \$2,000 are exempt from reporting.
- Claim reports where the last (most recent) TPOC Date is **January 1, 2013 through December 31, 2013**, with TPOC amounts totaling \$0 – \$600 are exempt from reporting.
- No threshold applies to claims where the last (most recent) TPOC date is **January 1, 2014 and subsequent**.

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

## How does an RRE report multiple settlement/TPOC amounts?

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

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

If more than five TPOCs need to be reported for a single claim, add the sixth and subsequent TPOC amounts to the amount reported in TPOC Amount 5 on the Auxiliary Record and put the most recent TPOC Date in TPOC Date 5. This circumstance will be very rare. RREs are **not** to report every payment related to individual medical services, procedures and supplies—ORM should be reported if and RRE has assumed responsibility to pay medicals.

If an RRE has a TPOC settlement, judgment, award or other payment which includes payment to a provider, physician, or other supplier on behalf of a beneficiary (i.e. medical lien), the RRE should report such payment(s) as part of the total TPOC amount.

## How does CMS define the term “payment”?

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When referring to *payment* of an ORM or TPOC, the reference is to the actual physical payment rather than to who/which entity ultimately funds the payment.

## How does CMS distinguish a deductible from a self insured retention (SIR)?

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**Deductible** refers to the risk the insured retains with respect to the coverage provided by the insurer.

**Self Insured Retention** refers to the risk the insured retains that is not included in the coverage provided by the insurer.

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

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Generally, the insurer is the RRE for Section 111 reporting for deductible plans regardless of funding (refer to Section 7.1 of User Guide version 3.1). However, CMS states that if an insured entity acts “without recourse to its insurance, it is responsible for Section 111 reporting with respect to those actions.” CMS does not explicitly define the term “acting without recourse” other than to give the following example:

*A claim is made against Company X which has insurance through Insurer Y. Company X settles the claim without informing its insurer. Company X is responsible for Section 111 reporting for the claim regardless of whether or not the settlement amount is within the deductible or in excess of the deductible.*

Where an entity engages in a business, trade, or profession, deductible amounts are self-insurance for MSP purposes. **However**, where the self-insurance in question is a deductible, and the insurer is responsible for Section 111 reporting with respect to the policy, it is responsible for reporting both the deductible and any amount in excess of the deductible. The deductible is not reported as “self-insurance”; it is reported under the applicable policy number. The total of both the deductible and any amount in excess of the deductible is reported. (Please note that government entities are considered to be entities engaged in a business.)

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

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

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

“Review or approval authority” (according to CMS) means that the self-insured entity has the ability to affect the payment or other terms of the settlement, judgment, award or other payment (including ORM).

Exception: Where the statute authorizing the establishment of a self-insurance pool stipulates that said self-insurance pool shall be licensed and regulated in the same manner as liability insurance (or workers’ compensation, where applicable), then the self-insurance pool is the RRE. Absent meeting this exception, unless all three of the characteristics specified above apply to the self-insurance pool, the participating self-insured entity is the RRE.

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

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

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

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

*Note: This would be an example of the rare situation where a TPA entity would also be an RRE for NGHP.*

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

“Review or approval authority” means that the State agency has the ability to affect the payment or other terms of the settlement, judgment, award or other payment (including ORM).

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

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

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

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

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

- Injured Party SSN or HICN (Fields 4 or 5 of the Detail Record)
- CMS Date of Incident (Field 12 of the Detail Record)
- Plan Insurance Type (Liability, No-Fault, Workers’ Compensation (Field 71 of the Detail Record)
- ORM Indicator (Field 98 of the Detail Record)

## When does an SSN or HICN need to be corrected?

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RREs only need to correct the HICN/SSN in cases where an incorrect person was submitted and accepted. HICNs which are reassigned by the Social Security Administration will be identified by the COBC and matched to the old HICN.

In those instances where the correct person was previously submitted and the HICN changes for that person at a later date, the RRE does not need to correct the record. In fact, updates may continue to be sent under the original HICN/SSN submitted. The COBC will always return the most current HICN on response records and RREs are encouraged to update their systems with that information and use it on subsequent record transmissions.

## How does CMS determine “receipt date” for Section 111 files?

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The file receipt date is based on when it is recognized by the daily batch cycle. Files submitted prior to 6pm (EST) on business days will be marked as received on that day. Files received after Friday at 6pm (EST) will not be marked as received until the next business day which would be Monday (or Tuesday in the event of a Federal holiday). RREs should send their files as close to the first calendar day of their submission timeframe as possible in order to have the file receipt date fall safely within their submission timeframe.

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

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

The Claim Response File, which will be received from the COBC, contains 3 Compliance Flags that provide information on issues related to compliance as follows:

- Late Submission of TPOC
- Invalid RRE TIN
- Late Submission of ORM Termination Date

**A record will not be rejected if one of the conditions to set the flags is found on the record.** However, the COBC will set the flags, track this information, and include it on compliance reports.

The flags provide the RRE notice that the submitted record did not comply with Section 111 reporting requirements. These flags should be reviewed and corrections applied to internal systems/data used for Section 111 reporting.

On February 24, 2010, CMS issued an Alert providing guidance on the steps NGHP RREs can work within the Section 111 NGHP reporting requirements and remain in compliance. In general, an NGHP RRE will be compliant with its Section 111 reporting requirements if it registers with the Coordination of Benefits Contractor (COBC), and once registered the RRE engages in testing with the COBC and once testing is completed, begins and continues to production data exchanges with the COBC.

CMS also noted that RREs are expected to compile the required data which includes, but is not limited to, maintaining a record of all the RREs data development activities. CMS recommended an RRE and/or its agent maintains ongoing communication with the assigned EDI Representative throughout the Section 111 reporting process.

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

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

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

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

An RRE's response file for a given quarterly report must be processed before submission of the next quarterly Claim Input File.

## What does an RRE do if they have no claims to report during their assigned quarterly submission period?

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If an RRE does not have any new information to supply on a quarterly update file, they **may, but are not required to**, submit an "empty" Claim Input File.

## Can reporting be suspended?

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Yes, reporting can be suspended due to severe errors or a threshold error. Files with severe or threshold errors will be suspended from processing. The EDI Rep should be contacted to resolve the situation.

Files with severe errors will be deleted by the EDI Rep and a corrected file must be re-sent.

### Severe errors include:

- File does not contain a Header Record
- Header Record not properly formatted (refer to file layout)
- Header Record does not contain a valid Section 111 RRE ID
- Header Record must be at the beginning of a file
- File does not contain a Trailer Record
- Trailer Record not properly formatted (refer to file layout)
- Trailer Record must have a corresponding Header Record
- RRE ID on the Trailer Record must match the RRE ID of the Header Record
- Record count on the Trailer Record must equal the number of detail records submitted
- File must start with a Header Record and end with a Trailer Record.

A file that exceeds the threshold checks will be suspended from further processing until the suspension is overridden by the EDI Representative. An e-mail will be sent to the Account Manager informing them of the suspension. The EDI Representative must be contacted to discuss/resolve file threshold errors. Your file may be released for processing or, if sent in error, deleted by your EDI Representative in which case you may need to resend a corrected file as instructed by your EDI Representative.

### Threshold errors:

- More than 5% of the total records are delete transactions
- 20% or more of the total records failed with a disposition code of "SP" due to errors
- More than one Claim Input File was submitted during the defined quarter

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

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

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

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

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CMS publishes a list of valid ICD-9 diagnosis codes once per year at [www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06\\_codes.asp](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp). CMS will accept ICD-9 codes from the latest three versions of the listing of valid ICD-9 codes posted as long as that code does not appear on the list of Excluded ICD-9 Diagnosis Codes in Appendix H of User Guide 3.1.

CMS has determined that certain valid ICD-9 diagnosis codes do not provide enough information related to the cause and nature of an illness, incident or injury to be complete, useful, and/or adequate for Section 111 reporting. A list of these codes is provided in Appendix H of User Guide 3.1 and should not be used on claim reports.

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

When there is a **TPOC**, RREs are to submit ICD-9 codes to reflect all the alleged illnesses/injuries claimed and/or released.

Where **ORM** is reported, RREs are to submit ICD-9 codes for all alleged injuries/illnesses for which the RRE has assumed ORM.

If, due to a subsequent ruling, an ICD-9 diagnosis code previously submitted no longer applies to the claim, RREs may send an update transaction without the particular ICD-9 diagnosis code but must include all ICD-9 diagnosis codes that still apply.

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

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

**OR**

- Description of Illness/Injury (Field 57).

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

To be considered valid, the **ICD-9 Diagnosis Codes (fields 19-55)** must begin not with an 'E' or 'V' and be on the list of valid ICD-9 codes for Section 111 reporting (the code supplied must **NOT** be on the list of Excluded ICD-9 Diagnosis Codes provided in Appendix H).

***A record will be rejected if one code submitted is invalid even if other valid codes are provided.***

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

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

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Foreign RREs who are based in countries outside the United States and have no IRS-assigned Federal Tax Identification Number (TIN) and/or U.S. mailing address must follow additional steps to register for Section 111 reporting.

Guam, Puerto Rico and the U.S. Virgin Islands are considered part of the United States with valid U.S. mailing addresses.

CMS encourages foreign entities that do not have a U.S. TIN/EIN to apply for a U.S. EIN by completing the Internal Revenue Service (IRS) SS-4 Application and to use that number for registration if possible. The delay in registration for foreign entities does not alter the date of their required initial file submission deadline for first quarter of 2011 or the retroactive reporting requirements for ORM and Total Payment Obligation to the Claimant (TPOC).

Foreign RREs must follow the same steps to register as a domestic RRE, as well as these additional instructions (effective April 5, 2010):

- An individual assigned by the RRE must go to the Section 111 Coordination of Benefits Secure Web Site (COBSW) url ([www.Section111.cms.hhs.gov](http://www.Section111.cms.hhs.gov)), click on the “New Registration” button, complete and submit the registration for the RRE.
- If the RRE has a valid IRS-assigned TIN, provide that number. If the RRE does not have an IRS-assigned TIN, then enter a fake or pseudo-TIN in the format of 9999xxxxx where ‘xxxxx’ is a 5-digit number created by the RRE.
- Supply a valid e-mail address for the Authorized Representative.
- If the RRE does not have a mailing address in the United States, enter ‘FC’ in the RRE state code and leave the other RRE address fields blank.
- If the Authorized Representative does not have a mailing address in the United States, enter ‘FC’ in the Authorized Representative state code and leave the other address fields blank.
- After successfully completing the New Registration step on the COBSW, a page will display with your RRE ID and assigned Section 111 EDI Representative.
- Contact the EDI Representative or call the Coordinator of Benefits Contractor (COBC) EDI Department at 646-458-6740 to continue with the registration process.
- Provide the assigned EDI Representative with the actual valid international addresses for the RRE, Authorized Representative and Account Manager as applicable.
- A letter will then be sent to the Authorized Representative with the PIN needed to complete the Account Setup step on the COBSW.
- Upon receipt of the PIN, the Account Manager for the RRE must go to the Section 111 COBSW Login page and click on the “Account Setup” button to continue with the registration process.
- If the Account Manager does not have a mailing address in the US, then he/she may enter ‘FC’ in the Account Manager state code field and leave the rest of the address fields blank.
- Once the Account Manager has completed the Account Setup step on the COBSW and the registration has been accepted by the COBC, an e-mail will be sent to the RRE’s Authorized Representative and Account Manager with a profile report.
- Once the Authorized Representative has signed and returned the profile report to the COBC, and its receipt has been noted, the status for the RRE ID will be set to “Testing”.

The assigned RRE ID will be the primary identifier used by the COBC for a foreign entity that registers with a pseudo-TIN. Effective April 5, 2010, foreign RREs who have registered with a pseudo-TIN, will be able to use it in the TIN Field of the Claim Input File and TIN Reference File. International addresses for the RRE may be provided in the Foreign Address Lines 1-4 (Fields 12-15) on the TIN Reference File.

### **What does an RRE do if they no longer require an RRE ID?**

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If an RRE erroneously registered for an RRE ID that is no longer needed and/or an RRE ID which they have abandoned due to starting the registration process over, the assigned EDI Representative should be contacted to have that number deleted. Unused RRE IDs may trigger automated warning notifications and follow-up by the COBC to the associated Authorized Representative and/or Account Manager.

**Delete** requests should only be made for RRE IDs that have **not** been used for production file submission.

## What does an RRE do if they have reported claims under an RRE ID, but will stop reporting?

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If an RRE has been reporting production Section 111 files under an RRE ID but will cease reporting under it in the future, contact the assigned EDI Representative and inform them of the circumstances affecting the change. Since the RRE ID was used for production reporting, it will **not** be deleted.

Effective April 5, 2010, a new “inactive” RRE ID status will be established. The RRE or their agent and the assigned EDI Representative will create a transition plan. The EDI Representative will change the status of the RRE ID to an “inactive” status after the last production file has been processed. Once the status is changed, information for the RRE ID will remain in the COBC Section 111 system, but production file submissions will no longer be accepted or expected.

The transition of reporting responsibility from one RRE to another is the responsibility of the RREs involved. The COBC cannot supply a file of previously submitted and accepted records for use in the transition by the new or former RRE or their reporting agents. The new RRE may register for a new RRE ID or report the transitioned claim records under one of its existing RRE IDs. **The new RRE may update and delete records previously submitted by the former RRE under a different RRE ID as long as the key fields for the records match.** The RRE IDs do not need to match. The former RRE must **not** delete previously submitted and accepted records. The new RRE may send *add transactions* (new cases) and *update transactions* (change existing records with new information such as ORM termination dates or the new RRE TIN).

If an RRE is changing reporting agents, the new agent should continue to submit files under the RRE’s existing RRE ID(s). Note: The COBC cannot supply a file of previously submitted and accepted records for the RRE IDs.

## How does an RRE change information pertaining to their organization?

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After registration is complete, the Account Manager may update certain information related to the RRE profile. After logging on to the COBSW, Account Managers may use the RRE Information action on the RRE Listing page to update the RRE name, address and telephone information.

Changes to other information such as reporting agent, Authorized Representative, Account Manager, file transmission method or TIN associated with the RRE ID, must be requested through the assigned EDI Representative.

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

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

### The escalation process for the EDI Department is as follows:

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

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

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

E-Mail Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	Sent after Account Setup step is complete on the COBSW. Included attachment with Profile Report.
Non-Receipt of Signed Profile Report	Authorized Representative, Account Manager	Generated 30 days after the Profile Report e-mail if a signed copy has not been received by the COBC. The Authorized Representative for the RRE ID must sign and return the Profile Report. If another copy is needed contact the assigned EDI Rep.
Successful File Receipt	Account Manager	Sent after an input file has been successfully received at the COBC. No action required.

E-Mail Notification	Recipient	Purpose
Late File Submission	Authorized Representative, Account Manager	Sent 7 days after the end of the file submission period if no Claim Input File is received. Send the file immediately and contact the assigned EDI Rep.
Threshold Error	Account Manager	Sent when a Claim Input File has been suspended for a threshold error. Contact the assigned EDI Rep to resolve.
Severe Error	Account Manager	Sent when a Claim Input File has been suspended for a severe error. Contact the assigned EDI Rep to resolve.
Ready for Testing	Account Manager	Account Setup is complete and the signed Profile Report has been received by the COBC. The RRE may begin testing.
Ready for Production	Account Manager	Testing requirements have been met and production files will now be accepted for the RRE ID.
Successful File Processed	Account Manager	The COBC has completed processing on a Claim Input File and the response file is available.
Account Designee Invitation	Account Designee	Sent to an Account Designee after the Account Manager for the RRE ID adds them to the COBSW. If the Account Designee is a new user to the COBSW, the e-mail will contain a URL with a secure token link for the user to follow and obtain a login ID for the COBSW.
Personal Information Changed	User Affected (Account Manager or Account Designee)	Generated after a user changes his personal information on the COBSW.
Password Reset	User Affected (Account Manager or Account Designee)	Generated when a user's password is reset on the COBSW.
Login ID Request	User Affected (Account Manager or Account Designee)	Generated after a user completes the "forgot login ID" function on the COBSW.

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

No. CMS has made it clear that MMSEA Section 111 does not change or alter any legal obligation/requirements under the MSP statute. The MMSEA does not have a direct impact on the MSP. Therefore, insurers are still responsible for protecting Medicare's interest for both past (conditional payments/liens) and future (MSA) payments. MMSEA Section 111 does impose new

claims reporting requirements on claims handlers, which are in addition to the necessity of protecting Medicare as a secondary payer under the MSP. The indirect impact is that CMS will now have a report outlining every case where Medicare should be protected as a secondary payer. **At any time in the future, CMS can select cases to audit for MSP compliance.**

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

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

## How will the registration process work?

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

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

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

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

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

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

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The registration process includes five phases:

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

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

## How does an RRE begin the registration process?

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

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

- **Company EIN/TIN** – The IRS assigned tax ID for the company associated with this Section 111 registration. If there is more than one EIN/TIN, the registration can be submitted with any one of the EIN/TIN IDs.
- **Company Name** – The company name associated with this Section 111 registration.
- **Company Address** – The corporate address associated with the EIN or TIN supplied.
- **NAIC Number** – The code assigned to the company by the National Association of Insurance Commissioners (NAIC). **If the RRE is not registered with the NAIC, this field should be filled with five zeros.** If there is more than one NAIC company code, the registration may be submitted with any one of the codes.
- **Company Telephone Number** – For the corporate office.

- **Company Fax Number** – For the corporate office.
- **Reporter Type** – Choose “Liability/No-Fault/Workers’ Compensation.”

The RRE will also enter information regarding any subsidiaries for which the RRE will be reporting under that specific RRE ID number, if necessary. Subsidiary information and corresponding TINs are completely optional. Only one TIN is required to register the RRE.

The RRE will provide contact information for the Authorized Representative.

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

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

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

## How many RRE ID numbers should be used?

---

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

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

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

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

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

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

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

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

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

The Account Manager will:

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

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

## Can I register for additional RRE ID or change RRE information after I have initially registered?

---

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

- Alter their reporting structure
- Request one or more additional RRE IDs if changes in business operations require changes in data reporting requirements
- Disable an RRE ID which is no longer needed by contacting the assigned EDI Representative

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

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

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

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

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

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

## When can the RRE begin testing?

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Once the COBC has received the RRE's signed Profile Report (which will be provided to the Authorized Representative via e-mail), they will change the RRE ID account to a "testing" status. The COBC will send an e-mail to the Authorized Representative and the Account Manager indicating testing may begin.

## What are the duties of Account Designees?

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

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

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

## What will "users" on the COBSW be able to do?

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

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

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