

Non-Group Health Plan (NGHP) Section 111 Reporting Webinar



December 6, 2022

Presentation Overview



S111 Reminders and
Best Practices

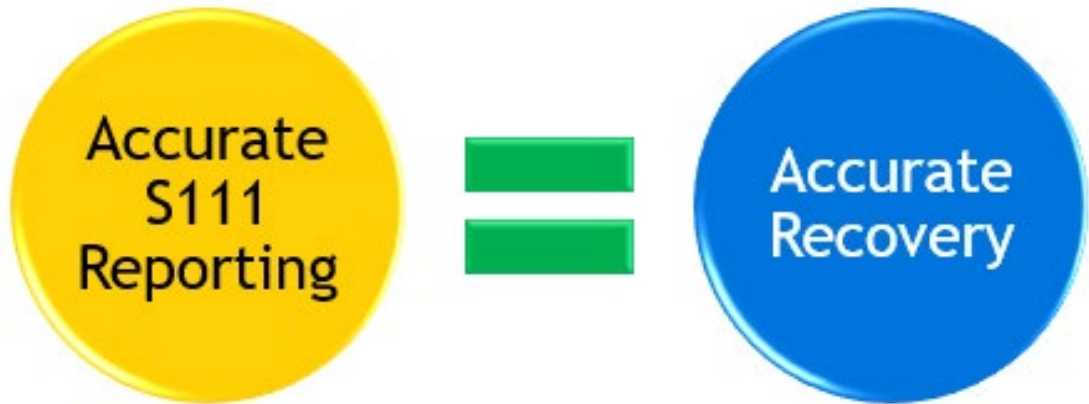


Additional Resources

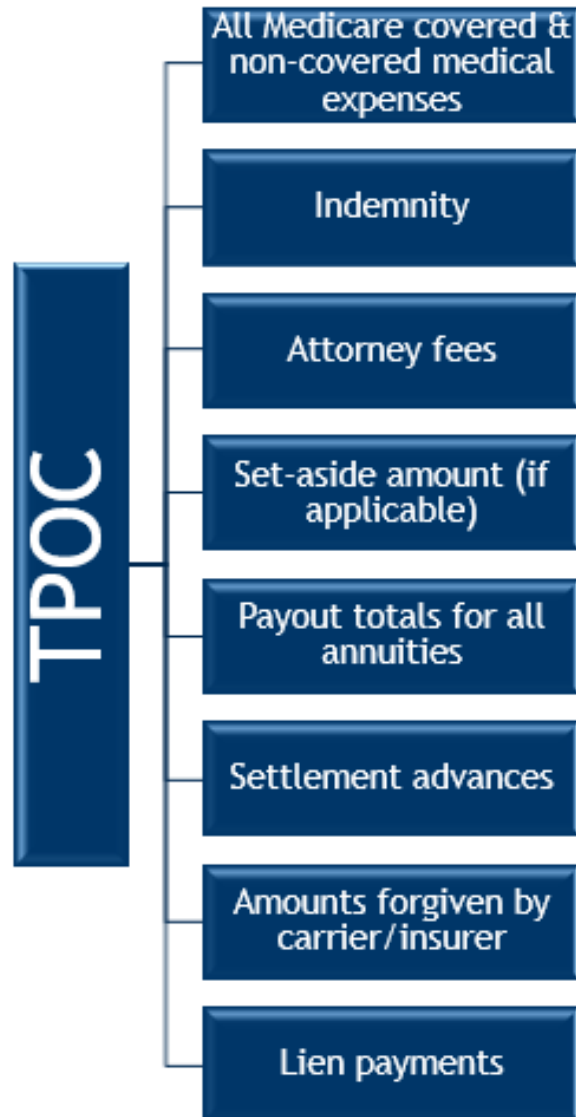


Questions & Answers

Why Accurate Reporting Matters



Total Payment Obligation to the Claimant (TPOC) Reporting



Indemnity Settlements

Sue settles her case for \$10,000 in lost wages

Sue's settlement for medical bills is pending

\$10,000 for lost wages is not reported as TPOC

Event Table

- Found in Section 6.6.4 of Chapter 4 of the NGHP User Guide
- Can help determine when, and how, to send records on the Claim Input File
- Covers a wide range of event scenarios

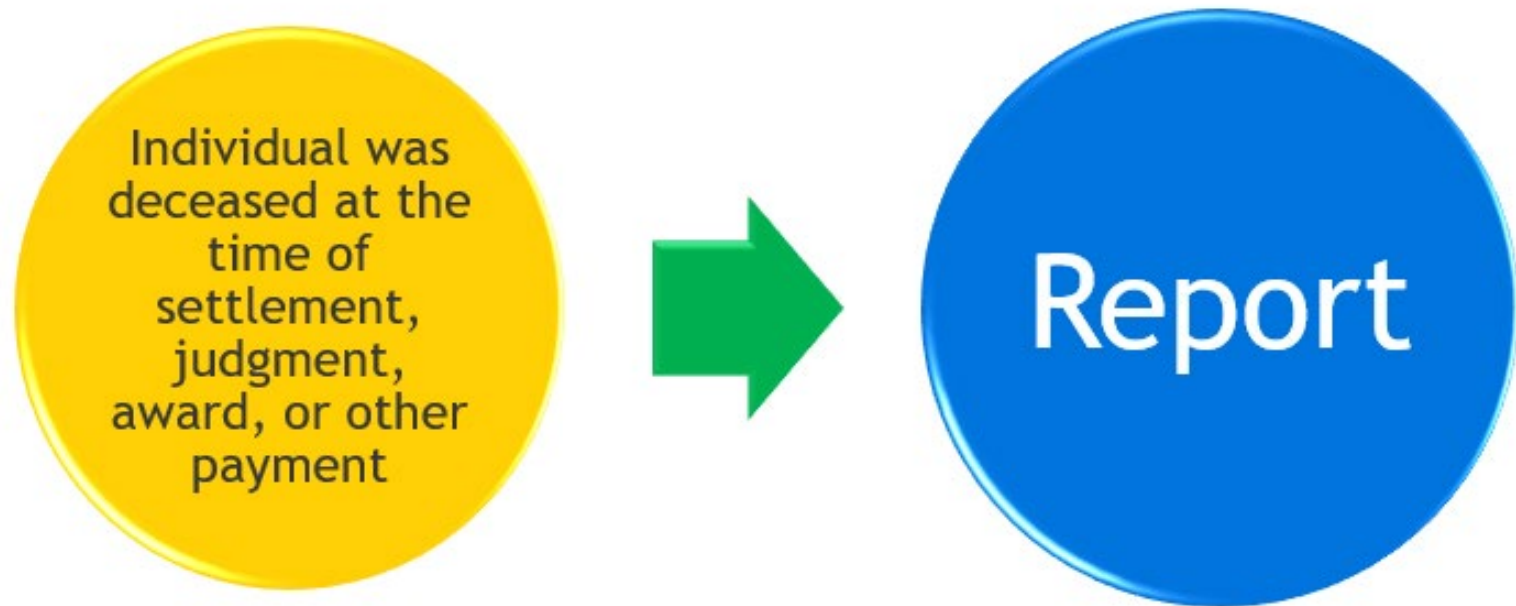
Event Table: Scenario One

Event	RRE Action
<p>ORM Ends for One Injury, Continues for Another</p> <ul style="list-style-type: none">• Claim previously submitted and accepted with ORM <p>Indicator (Field 78) = 'Y', non-zero ORM Termination Date (Field 79), multiple ICD Diagnosis Codes reflecting ORM assumed for multiple injuries</p> <ul style="list-style-type: none">• RRE's ORM subsequently ends for one or more injuries, but ORM <u>continues on</u> the claim for one or more other injuries	<p>Send Update Record</p> <ul style="list-style-type: none">• '2' in the Action Type• Same values previously reported for Injured Party SSN/Medicare ID (Fields 4/5)• CMS Date of Incident (Field 12)• Plan Insurance Type (Field 51)• 'Y' in ORM Indicator (Field 78)• Zeroes in the ORM Termination Date (Field 79)• ICD Diagnosis Codes reflecting injuries for which the RRE continues to have ORM (No ICD Diagnosis Codes related to injuries for which ORM ended)• Be sure to submit a valid value, not spaces, in ICD Diagnosis Code 1 (Field 18)• Same or updated information for all other fields• Note: Submit ORM Termination Date on subsequent update only when ORM ends for all alleged injuries for which the RRE assumed ORM

Event Table: Scenario Two

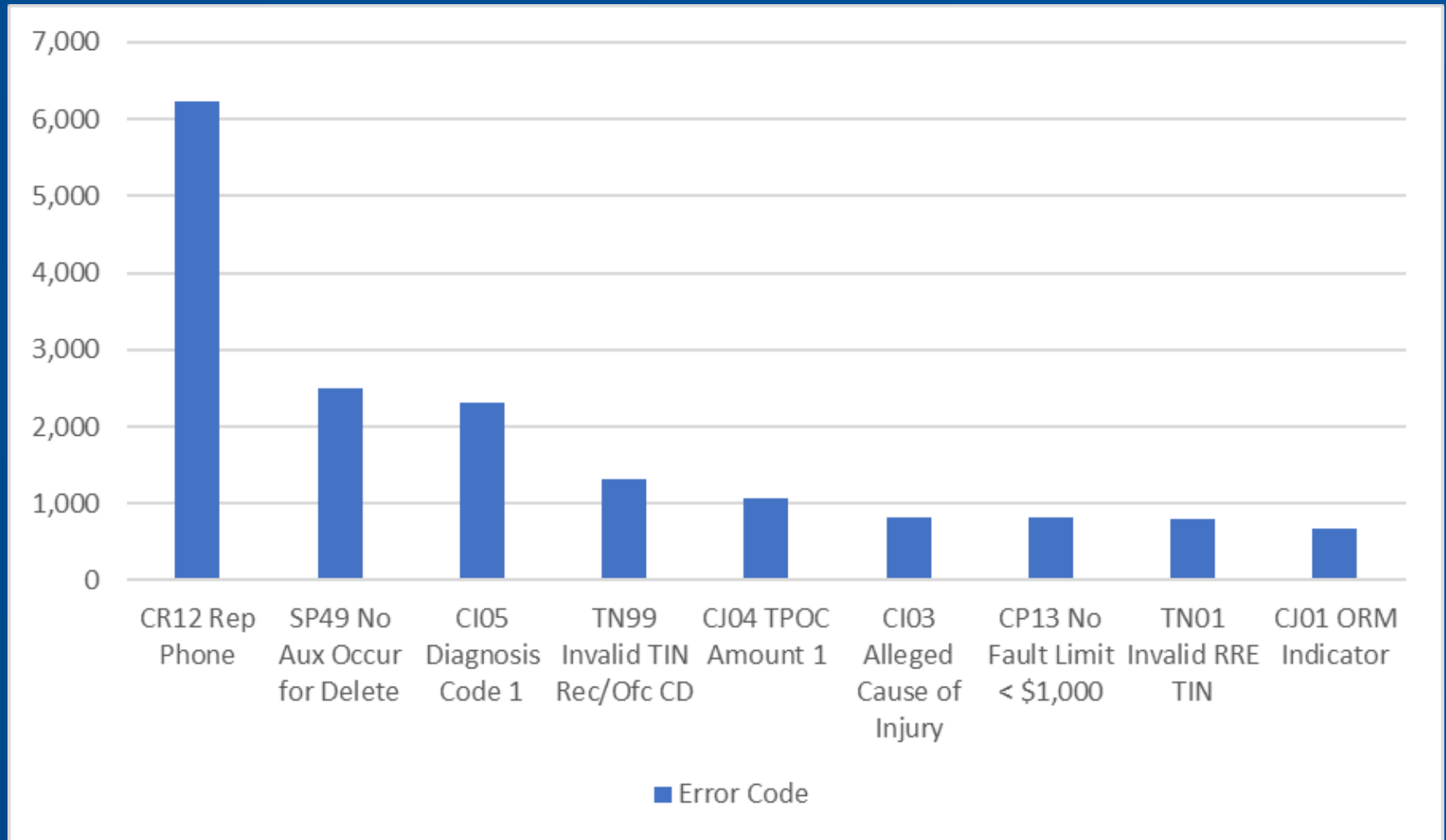
Event	RRE Action
<p>ORM Ends for One Injury Due to TPOC, Continues for Another</p> <ul style="list-style-type: none"> • Claim previously submitted and accepted with ORM Indicator (Field 78) = 'Y', non-zero ORM Termination Date (Field 79), multiple ICD Diagnosis Codes reflecting ORM assumed for multiple injuries • RRE's ORM subsequently ends for one or more injuries due to a <u>TPOC</u> but ORM <u>continues on the claim for one or more other injuries</u> 	<p>Send one Update Record, and Send one Add Record:</p> <p>First: Send Update Record:</p> <ul style="list-style-type: none"> • '2' in the Action Type • Same values previously reported for (SSN/MBI, CMS DOI, Plan Insurance Type, Policy #, 'Y' in ORM Indicator • Zeroes in the ORM Termination Date (Field 79) • ICD Diagnosis Codes reflecting injuries for which the RRE continues to have ORM (No ICD Diagnosis Codes for which resulted in the TPOC) <p>Second: Send Add Record for TPOC:</p> <ul style="list-style-type: none"> • '0' (add) in the Action Type • ICD Diagnosis describing all injuries claimed and/or released related to TPOC • 'N' in the ORM indicator • TPOC dates and amounts

Reporting Deceased Beneficiaries



Claimant Information can be supplied but is not required.

Top 10 Error Codes July 1 to Oct. 7, 2022



Resolving Errors



File

- Errors are returned in the Error Code fields on the response files
- Records will not be accepted



RRE

- Responsible for reviewing the response files for errors
- Must make corrections to the file and resubmit

Soft Edits



File

- Soft edits are returned in the Error Code fields on the Claim Response Files after all rejecting errors have been added to the response file
- Records will still be accepted



RRE

- Responsible for reviewing the response file for these edits
- Make corrections on their next quarterly file submission

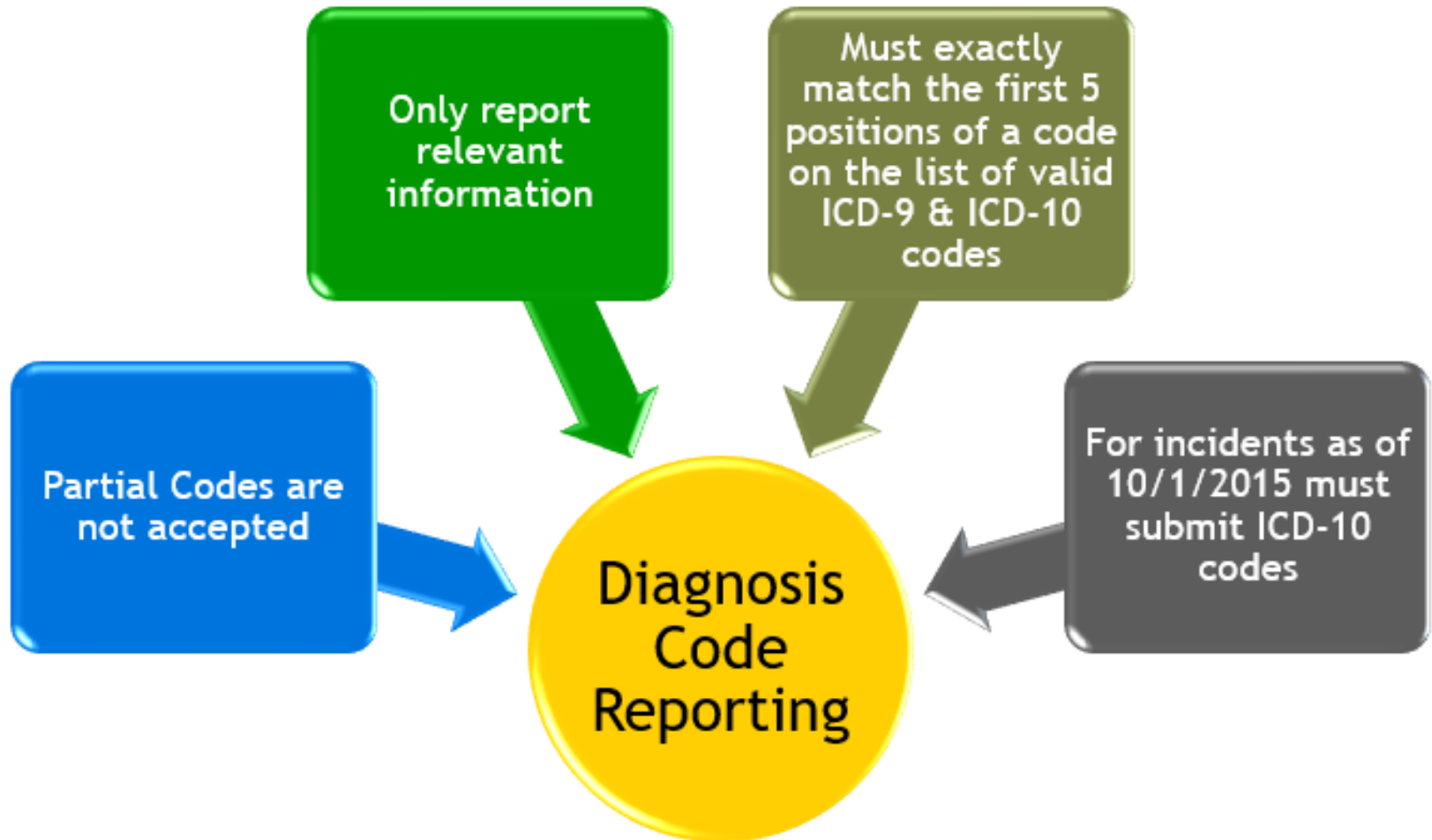
Upcoming Soft Edit Change to Note

Current CP13
No-Fault Error Code
\$1000



New CP13 No-Fault Error Code
effective January 2023
\$500

Diagnosis Code Reporting



ICD-10 Diagnosis Codes

S00.03XA

S12.400A

T17.900A

Diagnosis Codes Reporting Format



S00.03XA

S3XA

S12.400A

S12A

S124A

T17.900A

T17.90A

T179A

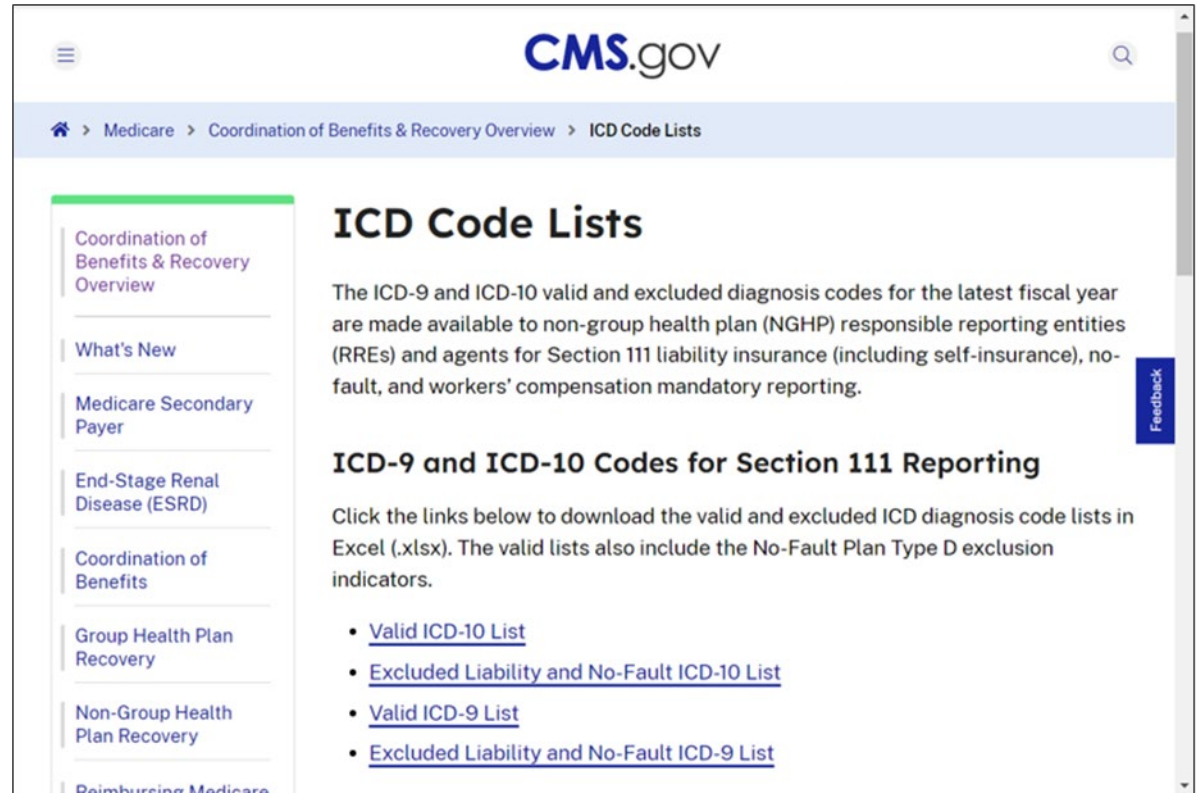


S0003XA

S12400A

T17900A

Diagnosis Code Lists



The screenshot shows the CMS.gov website interface. At the top, the CMS.gov logo is visible. Below it, a breadcrumb trail reads: Home > Medicare > Coordination of Benefits & Recovery Overview > ICD Code Lists. On the left side, there is a vertical navigation menu with the following items: Coordination of Benefits & Recovery Overview (highlighted with a green bar), What's New, Medicare Secondary Payer, End-Stage Renal Disease (ESRD), Coordination of Benefits, Group Health Plan Recovery, Non-Group Health Plan Recovery, and Reimbursing Medicare. The main content area features the heading 'ICD Code Lists' and a paragraph explaining that ICD-9 and ICD-10 valid and excluded diagnosis codes for the latest fiscal year are available to non-group health plan (NGHP) responsible reporting entities (RREs) and agents for Section 111 liability insurance. Below this, a sub-heading reads 'ICD-9 and ICD-10 Codes for Section 111 Reporting', followed by a paragraph instructing users to click links to download valid and excluded ICD diagnosis code lists in Excel (.xlsx) format. A list of four links is provided: Valid ICD-10 List, Excluded Liability and No-Fault ICD-10 List, Valid ICD-9 List, and Excluded Liability and No-Fault ICD-9 List. A 'Feedback' button is located on the right side of the page.

ICD Code Lists

The ICD-9 and ICD-10 valid and excluded diagnosis codes for the latest fiscal year are made available to non-group health plan (NGHP) responsible reporting entities (RREs) and agents for Section 111 liability insurance (including self-insurance), no-fault, and workers' compensation mandatory reporting.

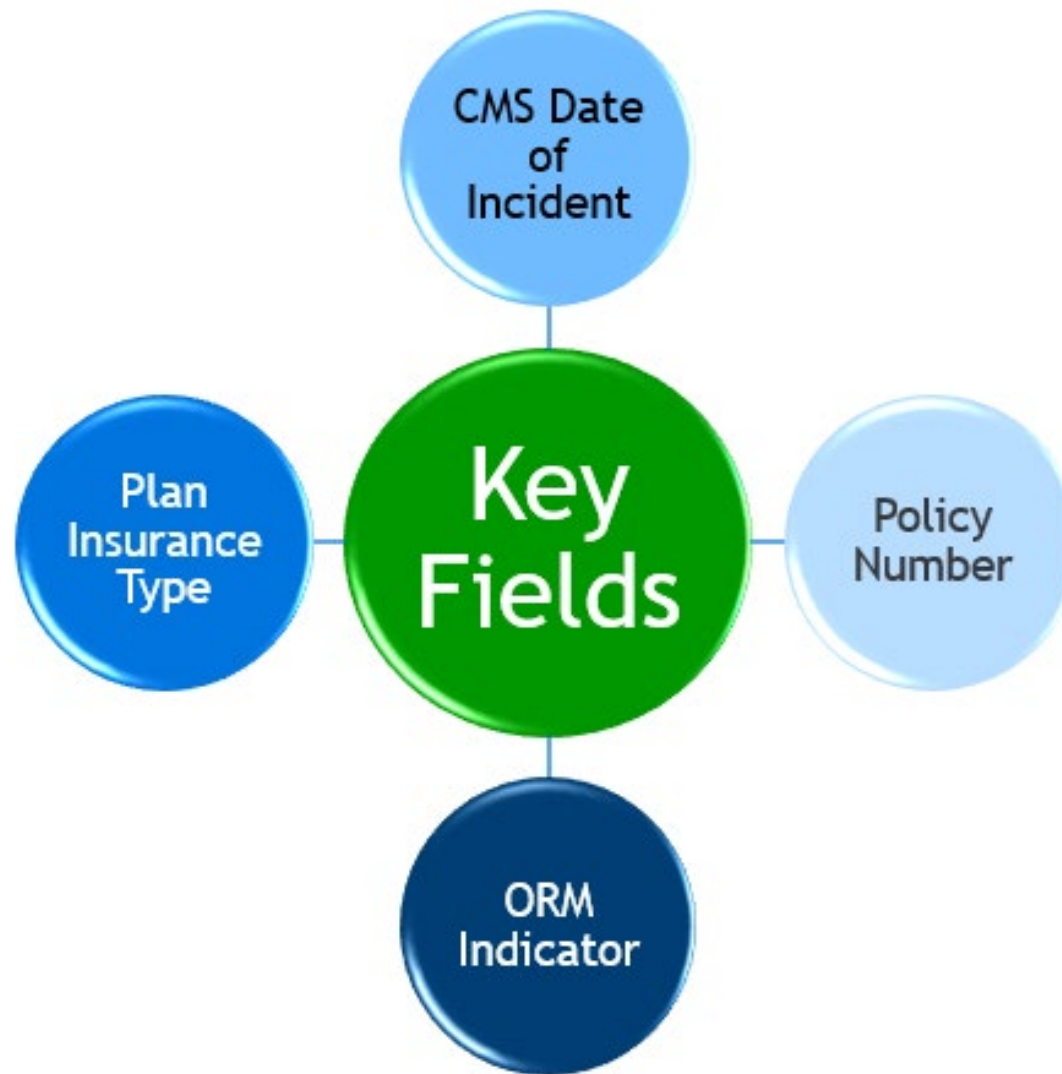
ICD-9 and ICD-10 Codes for Section 111 Reporting

Click the links below to download the valid and excluded ICD diagnosis code lists in Excel (.xlsx). The valid lists also include the No-Fault Plan Type D exclusion indicators.

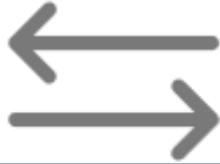
- [Valid ICD-10 List](#)
- [Excluded Liability and No-Fault ICD-10 List](#)
- [Valid ICD-9 List](#)
- [Excluded Liability and No-Fault ICD-9 List](#)

<https://www.cms.gov/medicare/coordination-benefits-recovery-overview/>

Key Fields



Updating Key Fields



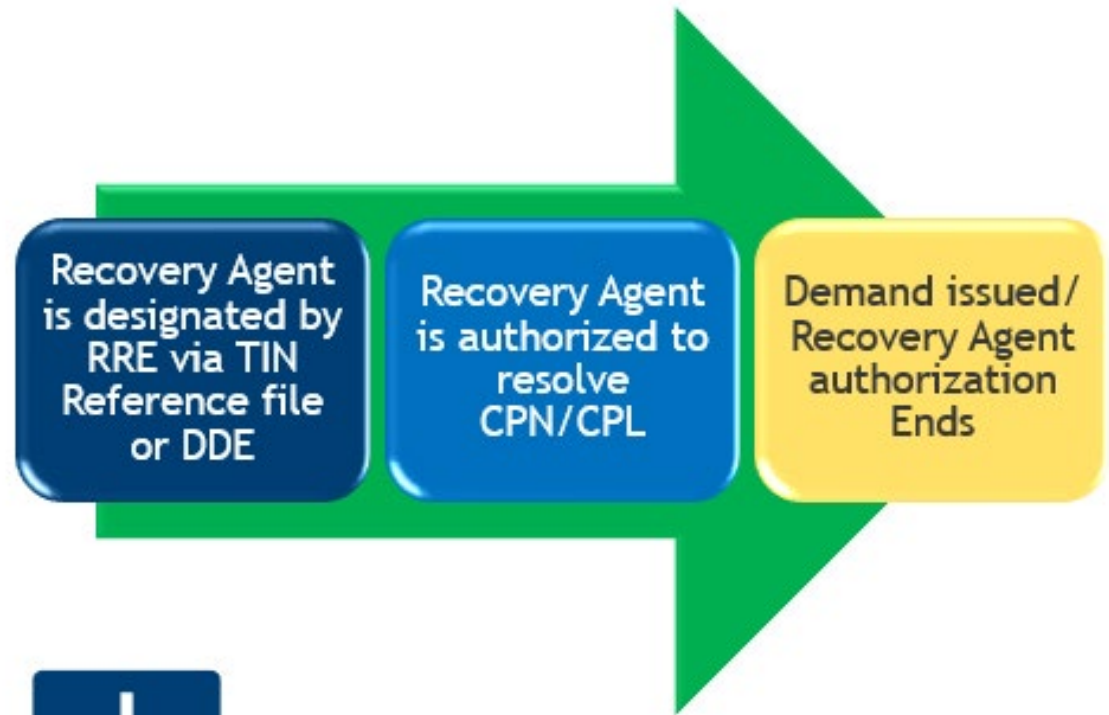
Claim Input Method

- Follow “Delete-Add” process
- Chapter 4, Section 6.6 of the NGHP User Guide

Direct Data Entry Method

- Delete claim in question
- Re-add with the appropriate updates

Recovery Agents



Recovery Agents do NOT have the right to file an appeal without proper authorization as outlined in the Code of Federal Regulations Title 42 - § 405.910 - Appointed representatives.

Changing Reporting Agents

Scenario 1: RRE moves NEW business to a new Third-Party Administrator (TPA) and is leaving all existing claims with the current TPA.

- RRE will need to setup a new RRE ID for the new TPA to use for reporting new claim data
- Current TPA will use existing RRE ID for reporting of existing claims
- New TPA will use new RRE ID for reporting of NEW claims
- No Section 111 update is required for existing claims

Changing Reporting Agents cont.

Scenario 2: RRE moving NEW business and existing claims to a new TPA (takeover).

- RRE will transfer existing RRE ID to new TPA as part of the takeover; no new RRE ID is required
- Delete records will need to be submitted for the prior report and match on the key fields (CMS DOI, Plan Insurance Type, original Policy Number, and ORM Indicator)
- Add records will need to be submitted and include the NEW Policy Number

Changing Reporting Agents Example

ACME moved their business from ABC TPA to XYZ TPA on 01/01/2021.

- ABC TPA reported claim to Medicare via Section 111 with their Policy Number
- ACME transfers RRE ID to XYZ TPA and contacts EDI Rep to update account information
- XYZ TPA submits delete records for claims with the ABC TPA Policy Number
- XYZ TPA submits add records for claims with the XYZ TPA Policy Number

Additional Resources

The EDI Department is available for assistance at (646) 458-6740.

For additional information, please also see the following resources:

- [Section 111 NGHP User Guide](#)
- [Section 111 NGHP Training Materials](#)

[Section 111 Mailbox](#)

(PL110-%20173SEC111-comments@cms.hhs.gov)

Questions & Answers



Slide 0: Non-Group Health Plan (NGHP) Section 111 Reporting Webinar

Slide 1: Presentation Overview

During this presentation we want to go over some Section 111 reminders and best practices and remind you of some additional resources that are available. Lastly, we will open the call up for questions and answers.

Slide 2: Why Accurate Reporting Matters

We want to start today by talking about why the accuracy of Section 111 reporting is so important.

The purpose of Section 111 reporting is to allow CMS to pay appropriately for Medicare-covered items and services furnished to Medicare beneficiaries. Section 111 NGHP reporting of applicable liability insurance (including self-insurance), no-fault insurance, and workers' compensation claim information helps CMS determine when other insurance coverage is primary to Medicare, meaning that it should pay for the items and services first, before Medicare considers its payment responsibilities.

This essentially means that the more accurate your S111 reporting is, the more accurate the recovery will be. So, let's walk through a few tips and reminders to help you have the most accurate reporting possible.

Slide 3: Total Payment Obligation to the Claimant (TPOC) Reporting

Total Payment Obligation to Claimant (TPOC) and its calculation tends to be a topic we often get questions about.

The TPOC Amount refers to the dollar amount of a settlement, judgment, award, or other payment in addition to or apart from Ongoing Responsibility for Medicals (ORM). A TPOC generally reflects a "one-time" or "lump sum" settlement, judgment, award, or other payment intended to resolve or partially resolve a claim. It is the dollar amount of the total payment obligation to, or on behalf of, the injured party. Individual reimbursements paid for specific medical claims submitted to a Responsible Reporting Entity or RRE, paid due the RRE's ORM for the claim, do not constitute separate TPOC amounts.

It is important to remember that the computation of the TPOC amount includes, but is not limited to:

- All Medicare covered and non-covered medical expenses related to the claim(s)
- Indemnity (lost wages, property damages, etc.)
- Attorney fees
- Set-aside amount (if applicable)
- Payout totals for all annuities rather than cost or present values
- Settlement advances
- Lien payments (including repayment of Medicare conditional payments)
- Amounts forgiven by the carrier/insurer

Slide 4: Indemnity Settlements

Another question we get often about the TPOC calculation is around indemnity. As we just mentioned the TPOC computation definition includes indemnity. However, an indemnity-only settlement should not be reported.

We are often asked if, when a claim settlement releases medicals at a later date, after an indemnity-only settlement, should the computation of the TPOC releasing medicals include the prior "indemnity-only" settlement? Or is the TPOC computation specific only to the payment issued when medicals are released?

And the answer is that a TPOC includes all payments included in the settlement, including indemnity payments. However, if an indemnity-only settlement is made prior to the release of medicals, and it truly is for indemnity-only, then it is not reported. If, in that case, the rest of the settlement occurs which does release medicals, then the original indemnity-only settlement is not added back in or otherwise aggregated.

An easy way to determine if an indemnity-only settlement must be reported is to question whether that settlement released, or had the effect of releasing, medicals, even if through a general release.

As an example, if Sue settles her case for \$10,000 in lost wages but her settlement for her medical bills is still pending, the \$10,000 is indemnity only and should not be reported, either upon the indemnity settlement or included when reporting TPOC for medicals.

Slide 5: Event Table

The Event Table which is found in Section 6.6.4 of Chapter 4 of the NGHP User Guide is to be used by RREs and their agents to help determine when, and how, to send records on the Claim Input File.

Oftentimes we receive questions on scenarios that are covered by the event table. The table covers many common scenarios and spells out both the event as well as what action the RRE should take in detail. So, we want to remind everyone that it is a very useful tool, and it is there to help you so be sure to reference it first if you have question because in most cases you will find what you need there.

The most common scenarios we get asked about are when ORM ends for one injury, due to termination or TPOC, and continues for another. While these are covered in the Event Table, we did want to take a moment to break them down here.

Slide 6: Event Table: Scenario One

The first scenario when ORM terms for one injury and continues for another can be addressed by the RRE by sending an update record where:

- The Action Type should be '2'
- The same values should be used that were previously reported for Injured Party SSN/Medicare ID (Fields 4/5)
- Enter the CMS Date of Incident (Field 12)
- Enter the Plan Insurance Type (Field 51)
- The ORM Indicator should be 'Y' (Field 78)
- Enter zeroes for the ORM Termination Date (Field 79)

- Enter the ICD Diagnosis Codes reflecting injuries for which the RRE continues to have ORM and no ICD Diagnosis Codes related to injuries for which ORM has ended
- Be sure to enter a valid value, not spaces, in ICD Diagnosis Code 1 (Field 18)
- Enter the same or any updates to information in the remaining fields.
- Also note that you should only submit an ORM Termination Date on a subsequent update when ORM ends for all alleged injuries for which the RRE assumed ORM.

Slide 7: Event Table: Scenario Two

The second scenario we see a lot of question on is when ORM ends for one injury because of TPOC and continues for another. In this scenario the RRE needs to send one update record and one add record.

First the RRE should send an update record. For this record:

- The action type should be '2'.
- Use the same values that were used previously for SSN/MBI, CMS DOI, Plan Insurance Type, Policy #, and a 'Y' for ORM Indicator.
- Zeros should be entered in the ORM Termination date (Field 79).
- ICD Diagnosis Codes should be entered reflecting the injuries for which the RRE continues to have ORM and No ICD Diagnosis Codes for that which resulted in the TPOC.

Second the RRE will need to send an Add Record for the TPOC. For this record:

- The Action Type should be '0'.
- ICD Diagnosis Codes should be entered describing all injuries claimed and/or released related to the TPOC.
- Enter 'N' in the ORM indicator.
- Enter the TPOC dates and amounts.

Slide 8: Reporting Deceased Beneficiaries

Another topic we continue to see come up is regarding deceased beneficiaries.

This is a reminder that RREs are expected to report information about Medicare beneficiaries, including deceased beneficiaries, if the individual was deceased at the time of the settlement, judgment, award, or other payment.

This is also a reminder that Claimant Information can be supplied, but is not required, in Fields 84-98 on the Claim Input File Detail Record in the case of a deceased beneficiary/injured party and the claimant is the beneficiary's estate or another individual/entity.

Slide 9: Top 10 Error Codes July 1 to Oct. 7, 2022

We have seen some trends when it comes to error codes recently. We hope that by pointing these out the BCRC will see fewer of them in the future and your files will process more smoothly. Each error code begins with a two-letter prefix, which helps you to quickly determine what the error code is related to. For example, if you see an error code that begins with CI it is referencing claim injury information while an error code beginning with CJ is referring to ORM or TPOC information.

Let's look in more detail at the top error codes last quarter.

- CR 12 - Rep Phone Soft Edit Record will be accepted, and RRE should correct the error on their next submission. Most common cause is that they populated field 64 Injured party Representative indicator field but failed to provide valid numeric data in this field. Most common is that they put non-numeric data in the field.
- SP49 - Delete Transaction failed - The record with the key fields that the RRE is trying to delete does not exist or has already been deleted. One of the reasons that it could have been already deleted is that the record that was causing the issue with the beneficiaries claims and the bene or their insurance company called the customer service (CSRs) to delete the record.
- CI05 - Diagnosis Code 1 - More will be mentioned in the other slide but this is a required field and the most common reason RRE receive this is that they leave this field blank.
- TN99 - Invalid TIN - This is caused by the RRE putting a TIN/office code combination that was not defined in the TIN reference file. Every TIN/office code combination that the RRE uses in the claim records must correspond to an accepted TIN/office code combo in the TIN reference file. Another common cause is that RRE leaves this blank or sends in all zeros or 9s. RRE needs to define the TIN record in the TIN reference file and resend the claim record in the claim file.
- TN01 - Invalid RRE TIN - The TIN was found on the TIN reference file, but the TIN was not accepted due to a number of reasons. The reasons can be found on the error codes in the TIN reference response file. The most common rejection reason for TIN was rejected on the TIN reference file includes RRE sending invalid addresses. RRE needs to correct the TIN record in the TIN reference file and resend the claim record in the claim file.
- CJ04 - TPOC amount - The TPOC amount is zero when the ORM indicator is N or the TPOC amount is zero when the TPOC date field has a valid date.
- CI03 - Alleged Cause - Most common cause is that RRE sends invalid ICD codes in the Alleged Cause field. RREs can avoid this error if they do not send this field as it is not a required field. They can leave it blank. This is a soft edit meaning the record will not reject and will be accepted and RRE should correct the error in their next submission and again the simplest fix is to leave the Alleged Cause field blank.
- CP13 - Low Policy Amount - Soft edit that warns the RRE that they are sending a Low Policy Amount (≤ 1000). The record will still be accepted. On an upcoming slide we will discuss a change to this soft edit.
- CJ01 - ORM indicator - The most common cause of this error is the field is left blank. The ORM indicator field is a required field and cannot be left blank and must be either a Y or N.

Slide 10: Resolving Errors

Now that we have looked at the common error codes it is also important to understand the difference between errors that will cause a file to reject and soft edits which do not.

Some errors cause the rejection of a file submission and for the records to not be accepted. Some errors result in rejection of TIN Reference File Detail Records can also cause rejection of associated Claim Input File Detail Records. When an RRE receives errors on the response file, they must make the appropriate corrections and resubmit the files.

In the list of most common errors that we reviewed on the previous slide the following will all cause a file to reject.

- SP49 – Delete failed
- CI05 – Diagnosis Code 1
- CJ05 – Funding Delayed Beyond TPOC Start Date
- TN99 – TIN Office / Code does not match
- CJ04 – TPOC Amount
- CI03 – Alleged Cause of Injury
- TN01 – TIN
- CJ01 – ORM Indicator

These errors must be corrected by the RRE and the file resubmitted. There is a full breakdown of all error codes, their meanings and how to resolve them in Chapter 5 of the NGHP User Guide.

An RRE can also always reach out to their EDI representative if they have additional questions about the errors they receive and how to resolve them.

Slide 11: Soft Edits

Now that we talked about errors, we wanted to also remind everyone about soft edits. As of April of last year changes were made to Claim Input File edits to no longer reject records for certain errors.

Some errors are considered soft edits and incoming records are not rejected due to these errors. These soft edits, like CR12 – Representative Phone and CP13 – No Fault Insurance Limit, are returned in the Error Code fields on the Claim Response Files after all the errors that would cause an error to be rejected have been added to the response file.

While records with these soft edits will be accepted, RREs are still responsible for reviewing the response file for these edits and should make corrections on their next quarterly file submission.

Again, full details on all these codes can be found in Chapter 5 of the NGHP User Guide.

Slide 12: Upcoming Soft Edit Change to Note

We also wanted to point out an upcoming soft edit change so RREs can make note of it before it goes into effect in January 2023.

The CP13 error indicates that the No-Fault insurance limit submitted via the Claim Input file is less than \$1,000. However, it has been determined that in some instances, especially with motorcycle policies, the limit is often less than \$1,000.

To address this, the CP13 policy limit is being changed in January to trigger when the policy limit is at, or below, \$500 instead of the current amount of \$1,000. This will reduce the number of claims that trigger the CP13 policy limit edit inappropriately.

Remember this is a soft edit and will not cause a file to reject but RREs should still review to make sure they are reporting the correct policy limit.

Slide 13: Diagnosis Code Reporting

We also wanted to mention some best practice tips for reporting diagnosis codes. In order to accurately identify claims for recovery purposes and to prevent Medicare from paying primary in the case of ORM, it is critical to submit all diagnosis codes that pertain to the injury but not codes for pre-existing or unrelated conditions. The more accurate your reporting of diagnosis codes, the more accurate the recovery process will be.

With that in mind:

Only report relevant injury information. As previously mentioned, you should not report diagnosis codes for pre-existing conditions if included in the initial ER visit.

Be sure to submit ICD diagnosis codes that exactly match the first 5 positions of a code on the list of valid ICD-9 and ICD-10 codes. Partial codes are not accepted.

Remember, for incidents as of 10/1/2015, RREs must submit ICD-10 codes.

Slide 14: ICD-10 Diagnosis Codes

You should also be sure to:

Retain leading and trailing zeroes but do not add leading or trailing zeroes if they are not shown for the code.

Do not include the decimal point but be sure to include any digits that may follow the decimal point. So, for example, ICD-10 Code S00.03XA would be S0003XA.

Slide 15: Diagnosis Code Lists

The lists of valid ICD-9 and ICD-10 codes as well as the list of excluded codes are now available on CMS.gov.

Slide 16: Key Fields

Next, let's talk about key fields. Medicare stores information on claims submitted previously using certain fields that identify the beneficiary as well as the following key fields:

- CMS Date of Incident
- Plan Insurance Type (Liability, No-Fault, Workers' Compensation)
- Policy Number
- ORM Indicator

This information is used for beneficiary record matching purposes. It is important that the key fields stay up to date and are updated correctly.

Slide 17: Updating Key Fields

To update key fields:

- RREs submitting a Claim Input File should follow the "Delete-Add" process as outlined in Chapter 4, Section 6.6, of the NGHP User Guide.

- Direct Data Entry (DDE) RREs should delete the claim in question and re-add it with the appropriate updates.

Slide 18: Recovery Agents

Some NGHP RREs use Recovery Agents to perform or assist with tasks related to Medicare Secondary Payer (MSP) demands or potential demands.

For purposes of Section 111 NGHP submission of Recovery Agent information only, CMS uses the designation of an agent, and submission of that agent's name and address on the TIN Reference File or DDE submission, as an authorization by the RRE for the agent to resolve the Conditional Payment Notice (CPN) and Conditional Payment Letter (CPL) related to claim submissions. The Recovery agent's authorization ends once a Demand is issued.

Recovery Agents do not have the right to file an appeal without proper authorization as outlined in the Code of Federal Regulations Title 42 - Section § 405.910 - Appointed representatives. For Recovery Agents to take action post demand, the Applicable Plan must submit written authorization to the Commercial Repayment Center (CRC).

When you are using a Recovery Agent to assist with MSP recovery it is important to correctly report the Recovery Agent information.

RREs should submit Recovery Agent information in dedicated Recovery Agent fields (Fields 16-22) on the TIN Reference File.

Slide 19: Changing Reporting Agents

Now we would like to talk about instances when changes to reporting agents need to be made by an RRE. Over the next few slides, we will talk through two scenarios and an example.

Scenario one is when an RRE is moving NEW business to a new Third-Party Administrator or TPA and is leaving existing claims with their current TPA.

In this instance, the RRE will need to set up a new RRE ID for reporting of new claim data by the new TPA. The current TPA will use the existing RRE ID for reporting of existing claims. The NEW TPA will use the new RRE ID for reports of new claims. No Section 111 update is required for existing claims.

Slide 20: Changing Reporting Agents (Continued)

Scenario two is when an RRE is moving NEW business and existing claims to a new TPA (in a takeover situation).

The RRE will transfer the existing RRE ID to the TPA meaning no new RRE ID is required. Delete records will need to be submitted and match on the key fields as previously noted (CMS DOI, Plan Insurance Type, original Policy Number, and ORM indicator). Then Add records will need to be submitted and include the new Policy Number.

Slide 21: Changing Reporting Agents Example

Let's look at scenario two, a takeover situation, in more detail with the following real-life example.

- ACME moved their business from ABC TPA to XYZ TPA on January 1, 2021.

- ABC TPA had previously reported to Medicare via Section 111 with their Policy Number.
- ACME transfers their existing RRE ID to XYZ TPA. XYZ TPA submits a delete record for claims with the ABC TPA Policy Number, ensuring to match on the other Key Fields.
- XYZ TPA then submits add records for claims with the XYZ TPA Policy Number.

Slide 22: Additional Resources

Before we end the presentation and start the Q&A section of the call, we want to remind you of other resources available to you.

Slide 23: Question & Answers