MMSEA Section 111
Mandatory Insurer Reporting
Quick Reference Guide

The What, Why, and How of
MMSEA Section 111 Reporting
for Non-Group Health Plan (NGHP) Insurers

Version 1.2

Rev. 2014/6 October
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Revision History

Date	Version	Reason for Change
May 1, 2013	1.1	Branding changes for the Benefits Coordination & Recovery Center (BCRC).
October 6, 2014	1.2	Change Release (CR) 12373: The ICD-10 implementation date has been updated from 2014 to 2015. CR 12593: Checked to ensure that spouse references are gender-neutral according to DOMA. See changes in Chapter 1.

Confidentiality and Disclosure of Information

Section 1106 (a) of the Social Security Act as it applies to the Centers for Medicare & Medicaid Services (CMS) - (42 CFR Chapter IV Part 401 §§ 401.101 to 401.152) prohibits disclosure of any information obtained at any time by officers and employees of Medicare Intermediaries, Carriers, or Medicare Contractors in the course of carrying out agreements and/or contracts under Sections 1816, 1842, and 1874A of the Social Security Act, and any other information subject to Section 1106 (a) of the Social Security Act.

Section 1106 (a) of the Act provides in pertinent part that "Any person who shall violate any provision of this section shall be deemed guilty of a felony and, upon conviction thereof, shall be punished by a fine not exceeding $10,000 for each occurrence of a violation, or by imprisonment not exceeding 5 years, or both." Additional and more severe penalties are provided under Title XVIII (Medicare) USC Section 285 (unauthorized taking or using of papers relating to claims) and under Section 1877 of Title XVIII of the Act (relating to fraud, kickbacks, bribes, etc., under Medicare).

These provisions refer to any information obtained by an employee in the course of their performance of duties and/or investigations (for example, beneficiary diagnosis, pattern of practice of physicians, etc.).

The Electronic Correspondence Referral System (ECRS) contains IRS tax data. Any unauthorized inspection or disclosure of IRS return information in violation of any provision of Section 6103 may result in sanctions as described in IRC Sections 7431 and 7213, which include, but are not limited to, fines or imprisonment.

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Chapter 1: Summary of Version 1.2 Updates

The following updates have been made in Version 1.2 of the MMSEA Section 111 Mandatory Insurer Reporting Quick Reference Guide:

- The date of implementation for the International Classification of Diseases 10th Revision (ICD-10) has been changed from 2014 to 2015.
- The Department of Health & Human Services has adopted a policy treating same-sex marriages on the same terms as opposite-sex marriages to the greatest extent reasonably possible. Any same-sex marriage legally entered into in a U.S. jurisdiction that recognizes the marriage - including one of the 50 states, the District of Columbia, or a U.S. territory -- or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, will be recognized. Consistent with this policy and the purpose of the MSP provisions, effective January 1, 2015, the rules below apply with respect to the term “spouse” under the MSP Working Aged provisions. This is true for both opposite-sex and same-sex marriages as described herein.
  - If an individual is entitled to Medicare as a spouse based upon the Social Security Administration’s rules, that individual is a “spouse” for purposes of the MSP Working Aged provisions.
  - If a marriage is valid in the jurisdiction in which it was performed as described herein, both parties to the marriage are “spouses” for purposes of the MSP Working Aged provisions.
  - Where an employer, insurer, third party administrator, GHP, or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the “spouse” in question. If such an individual is reported as a “spouse” pursuant to MMSEA Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

Chapter 2: Introduction

About this Guide

The Centers for Medicare & Medicaid Services (CMS) refers to liability insurance (including self-insurance), no-fault insurance, and workers' compensation as Non-Group Health Plan (NGHP) insurance. This MMSEA Section 111 Quick Reference Guide has been developed to help NGHP insurers understand the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111 reporting requirements.

Specifically, this guide will:

- Explain MMSEA Section 111 reporting and how it may affect you,
- Help you determine if you are an MMSEA Section 111 Responsible Reporting Entity (RRE),
- Provide an overview on how to set up and begin reporting,
- Describe the various options you have for reporting,
- Outline the data "input and response" process, and
- Identify resources for additional instruction and information on how to access free computer-based training and other resources.

Note: This document was prepared by CMS for informational purposes only. All affected entities are responsible for following the instructions found in the MMSEA Section 111 NGHP User Guide, which is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.html on the CMS website.

What is MMSEA Section 111 Reporting?

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 is usually referred to as MMSEA Section 111 reporting (or simply Section 111). This law added mandatory reporting requirements for liability insurers (including self-insurers), no-fault insurers, and workers' compensation insurers providing coverage to Medicare beneficiaries. These NGHP insurers are obligated to notify Medicare about "settlements, judgments, awards, or other payment from liability insurers (including self-insurers), no-fault insurers, and workers' compensation" received by or on behalf of Medicare beneficiaries. The reporting requirements for NGHP insurers under MMSEA Section 111 first became effective on May 1, 2009.

The MMSEA Section 111 reporting requirements are an addition to the already existing Medicare Secondary Payer (MSP) law and corresponding regulations.

What is MSP?

MSP is the term used to describe situations where another insurer has primary payment responsibility for care provided to a Medicare beneficiary.

Until 1980, Medicare was a primary payer for covered beneficiaries in almost all cases except those involving workers' compensation (and black lung disease). Starting in 1980, the addition of the MSP provisions of the Social Security Act required that when the injured party is a Medicare beneficiary, Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

Why is There an MSP Law?

The MSP provisions of the Social Security Act were enacted so that some of the costs of caring for Medicare beneficiaries could be borne by other types of insurance. Spreading payment for healthcare coverage costs across multiple insurers is helping to extend the life of the Medicare Trust Fund and is helping to ensure that Medicare beneficiaries have adequate access to care.

For more information and guidance about MSP issues, please refer to Chapter I "Introduction and Overview" of the NGHP User Guide.

Chapter 3: Getting Started on MMSEA Section 111 Reporting

I May Be an "NGHP" Insurer. Do I Need to Report Under MMSEA Section 111?

You most likely will need to report under MMSEA Section 111 if you are "an applicable plan" – meaning that you are a liability insurer (including a self-insurer), an insurer providing "no-fault" coverage, or a workers' compensation plan. These are the main categories of NGHP insurance types. In all cases, you provide insurance coverage or payments for medical expenses for someone who is a Medicare beneficiary. Please see Chapter III "Policy Guidance" of the NGHP User Guide for a comprehensive discussion of the types of insurers that must report.

If you have determined you need to report under MMSEA Section 111, you are the entity responsible for complying and will be referred to as the RRE.

Who Do I Report To?

Insurers are to report coverage to the CMS, the federal agency that manages the Medicare program. Since the start of MMSEA Section 111 reporting, almost 30,000 RREs are now sending MMSEA Section 111 data to the CMS.

To manage the huge volume of MMSEA Section 111 data and other Coordination of Benefits (COB) work that Medicare handles, the CMS has engaged the Benefits Coordination & Recovery Center (BCRC) to manage the technical aspects of the Section 111 data exchange process for all Section 111 RREs. The RREs (or their data management agents) transmit information electronically to the CMS BCRC.

I Have Determined that I Need to Comply with the MMSEA Section 111 Reporting Requirements. How Do I Sign Up for It?

Insurers that need to report under MMSEA Section 111 become RREs by registering on the Section 111 COB Secure Website (COBSW), a website established by the CMS and managed by the BCRC. RREs are required to register on the COBSW to notify the BCRC of their intent to report data in compliance with Section 111.

To begin the registration process, visit the Section 111 COBSW at http://www.section111.cms.hhs.gov on the CMS website, and click the **I Accept** link at the bottom of the page. When the Section 111 COBSW Login page displays, click **Step 1 - New Registration**. You will be required to enter specific data and submit your registration. Once you have registered and completed your account setup (i.e., **Step 2 – Account Setup**) for MMSEA Section 111 reporting on the Section 111 COBSW, you become a registered RRE. For more information on the registration process, visit https://www.section111.cms.hhs.gov/MRA/help/how_to/GetStarted.htm.to see the "How to Get Started" document.

What Information Do I Report? What Will I be Sending to the BCRC?

Section 111 requires RREs to report claim information for Medicare beneficiaries after the insurer has assumed the Ongoing Responsibility for Medicals (ORM) or after paying the Total Payment Obligation to the Claimant (TPOC) in the form of a settlement, judgment, award, or other payment.

RREs must report evidence of insurance coverage or applicable settlements, judgments, awards, or other payments regardless of whether there is admission or determination of liability. Some of the required data that must be reported includes: the identity of the claimant (their Medicare Health Insurance Claim Number [HICN] or Social Security Number [SSN], the first letter of their first name, the first six letters of their last name, their date of birth, and gender); the RRE Taxpayer Identification Number (TIN); RRE address information; and other information related to the claimant, such as the International Classification of Diseases 9th (or 10th) Revision (ICD-9 or ICD-10) diagnosis codes and TPOC dates and amounts.

For more information on the specific data required, please see Chapter IV "Technical Information" and Chapter V "Appendices" of the NGHP User Guide.

Note: The International Classification of Diseases 10th Revision (ICD-10) will be implemented in 2015.

How Do I Know or Determine if I'm Insuring a Medicare Beneficiary?

Most Medicare beneficiaries are at least age 65; however, an individual of almost any age may be enrolled in the Medicare program. Medicare is a health insurance program for:

- People age 65 or older,
- People of any age who have certain designated disabilities, and
- People of any age who have End-Stage Renal Disease (ESRD) — permanent kidney failure.

When an individual is eligible for coverage and enrolls in Medicare, he or she is issued a Medicare HICN, which is better known as the Medicare ID. The Medicare HICN/ID is derived from the individual's SSN. All Medicare beneficiaries will have a Medicare HICN and an SSN.

You will know if an individual is a Medicare beneficiary if you have been given the person's Medicare HICN. The easiest way to check for eligibility is to simply ask individuals for their Medicare HICN. If you are unable to readily determine Medicare beneficiary status, CMS provides a query process (search mechanism) as part of the Section 111 reporting process to assist you. To use the query process, you must be a registered RRE. Once registered, RREs must have and use a process to determine whether the claimant is a Medicare beneficiary or if the claimant anticipates receiving Medicare benefits in the future.

How Do I Send the Required Information to the BCRC?

MMSEA Section 111 reporting information can be exchanged with the BCRC using any one of the following four methods. The first three methods involve the submission of electronic files.

- **Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)** – Using HTTPS, an RRE can transmit files via the Internet directly to the Section 111 COBSW and receive response

files in the same manner. This method is recommended for RREs sending less than 24,000 records on a regular basis.

- **Secure File Transfer Protocol (SFTP)** – Using SFTP software, an RRE can transmit files via the Internet directly to the BCRC. The RRE will have a dedicated "mailbox" on the BCRC's Section 111 SFTP Server, where the RRE will send input files and retrieve response files. This method can handle large amounts of data.
- **Connect:Direct** – This system provides a direct file transmission connection to the BCRC mainframe using the CMS Extranet Network and CMS' private CMSNet. This is the most costly transmission method, but it is the most efficient for RREs that will be exchanging very large amounts of MMSEA Section 111 data with CMS.
- **Direct Data Entry (DDE)** – Using DDE, an RRE will manually enter claim information using an interactive application that will be accessed directly from the Section 111 COBSW. DDE can only be used by small reporters.

For more information on any of these data submission methods, please see Chapter IV "Technical Information" of the NGHP User Guide.

Should I Use DDE?

DDE is the simplest method of reporting MMSEA Section 111 data. DDE reporting is done through the Section 111 COBSW. DDE is designed for smaller RREs that do not expect to report much claim information under Section 111 (e.g., less than 500 claim reports per year). RREs using the DDE reporting option will manually key claim information into pages (screens) on the Section 111 COBSW. Once the claim is submitted and the BCRC has completed its processing, a response will be sent to the RRE via the Section 111 COBSW. For more information on the DDE process, please see the Section 111 COBSW User Guide, which is available for download from the Section 111 COBSW under the "Reference Materials" menu option. You must be logged into the Section 111 COBSW to gain access to the Section 111 COBSW User Guide.

Here are some important facts about DDE:

- An RRE can make, correct or update an MMSEA Section 111 claim report at any time,
- Although a separate query function is not available to DDE submitters, the initial step in the DDE process provides the same functionality,
- RREs using DDE can submit no more than 500 records a year,
- All new DDE submissions for any purpose (even those where the Injured Party is not identified as a Medicare beneficiary) count against this annual limit,
- Updates or deletes to a previously submitted and accepted claim report do count toward this limit, and
- Corrections to a previously submitted, but not yet accepted claim report due to errors, do not count against this limit.

How Often Do I Submit My Claim Information?

RREs submitting electronic files must submit new or changed information on a quarterly basis during the RREs assigned seven-day file submission timeframe unless the RRE has nothing to

report for a particular quarter. RREs using DDE to report must submit claim information one claim report at a time as soon as the conditions related to the claim require reporting under Section 111.

How Do I Know if What I sent Was OK?

When the BCRC receives a Claim Input File (or a DDE claim report), it will edit the data and determine whether the submitted information identifies the injured party as a Medicare beneficiary. When this processing is complete or the prescribed time for response file generation has elapsed, the BCRC will electronically transmit a response file (for file submitters) or a response record (for DDE submitters).

Note: Each submitted record will receive a response. The response will include a disposition code that will give the RRE the results of the processing. The response will also include any error codes or compliance flags, which will identify any problems found with the data. The RRE must take the appropriate action, if any, based on the information received. If errors were received, they must be corrected and resubmitted in the RRE's next quarterly claim submission (file submitters) or as soon as the error has been corrected (DDE submitters).

Do I Have to do this Reporting Myself? Can I Hire a Commercial Data Management Firm to Do it for Me?

Once an RRE has registered, the RRE can delegate reporting responsibility to another entity, such as a "data reporting agent" (e.g., a third-party administrator or vendor) to manage the RRE's MMSEA Section 111 data exchanges with the BCRC. If an RRE uses an agent to manage its MMSEA Section 111 reporting, here are some important points to keep in mind:

- You, the RRE, are the Responsible Reporting Entity, not your agent. You cannot assign your responsibility to report to your agent. The RRE is ultimately responsible for the reporting and will be held liable for non-compliance,
- You, the RRE, are responsible for the content of the data and its validity, not your agent,
- Your agent may not use any MMSEA Section 111 reporting data other than to report for Section 111. The data belongs to the RRE and to the CMS, not to the agent,
- Your agent may use any data exchange transmission method acceptable to CMS, and
- CMS does not make any recommendations about any potential reporting agents.

What MMSEA Section 111 Reporting Resource Materials are Available?

- **MMSEA Section 111 Mandatory Insurer Reporting (NGHP) Website**: The most important online resource is the official MMSEA Section 111 Mandatory Insurer Reporting (NGHP) website located at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html on the Medicare tab of the CMS website under Coordination of Benefits &Recovery>Mandatory Insurer Reporting (NGHP). The updated NGHP Section 111 User Guide and Section 111 Alerts can be found on this website.
- **Free Computer-Based Training (CBT) Courses**: CMS has made available a curriculum of CBT courses to Section 111 RREs. These courses are offered free of charge and provide in-depth training on Section 111 registration, reporting requirements, using the Section 111

COBSW, data transmission, file formats, file processing, DDE, and general MSP topics. You may access these courses from the Mandatory Insurer Reporting (NGHP) website mentioned above.

- **Section 111 Town Hall Teleconferences**: From time to time, CMS holds national Section 111 Town Hall Teleconferences that you may participate in. During these calls, CMS addresses many of the questions and comments it receives through the Section 111 mailbox. Information about upcoming Town Hall Teleconferences is posted on the official MMSEA Section 111 Mandatory Insurer Reporting (NGHP) website mentioned above.
- **Electronic Data Interchange (EDI) Representative**: Once an RRE has registered, they will be assigned their own EDI Representative to assist them in managing all aspects of the Section 111 reporting process, from answering the simplest questions to helping them address the most complex problems.

Can I Contact CMS Directly with Questions or Comments?

If you have questions or concerns and you want to communicate to the CMS directly, you can use the dedicated Section 111 Mailbox at: PL110-173SEC111-comments@cms.hhs.gov.

We hope this Section 111 Mandatory Insurer Reporting Quick Reference Guide has been useful. If you have comments, questions on subjects not covered here, or suggestions about how this Quick Reference Guide can be improved, please feel free to send them to the dedicated Section 111 Mailbox at: PL110-173SEC111-comments@cms.hhs.gov. Please put “Quick Reference Guide” in the Subject line.

Appendix A: Acronyms

Table A-1: Acronyms

Term/Acronym	Definition
BCRC	Benefits Coordination & Recovery Center
CBT	Computer Based Training
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBSW	Coordination of Benefits Secure Website
CR	Change Release
DDE	Direct Data Entry
ECRS	Electronic Correspondence Referral System
EDI	Electronic Data Interchange
ESRD	End Stage Renal Disease
HICN	Health Insurance Claim Number
HTTPS	Hypertext Transfer Protocol over Secure Socket Layer
ICD-9	International Classification of Diseases 9th Revision
ICD-10	International Classification of Diseases 10th Revision
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
MSP	Medicare Secondary Payer
NGHP	Non-Group Health Plan
ORM	Ongoing Responsibility for Medicals
RRE	Responsible Reporting Entity
SCHIP	State Children's Health Insurance Program
SSN	Social Security Number
SFTP	Secure File Transfer Protocol
TIN	Tax Identification Number
TPOC	Total Payment Obligation to the Claimant

Appendix B: Previous Version Updates

Version 1.1

The following updates have been made in Version 1.1 of the MMSEA Section 111 Mandatory Insurer Reporting Quick Reference Guide:

- Branding changes for the Benefits Coordination & Recovery Center (BCRC).