MMSEA Section 111
MSP Mandatory Reporting

GHP USER GUIDE

Version 2.0
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MMSEA Section 111 GHP User Guide

Revision History

Date	Version	Reason for Change
August 1, 2008	1.0	Initial Version
August 11, 2008	1.1	Various Changes - Unpublished
September 9, 2008	1.2	Various Changes - Unpublished
October 3, 2008	1.3	Incorporation of changes related to published website articles.
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December 17, 2008	2.0	Second Publication

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1 Summary of Version 2.0 Updates

The following updates have been made in Version 2.0 of the MMSEA Section 111 GHP User Guide:

- The explanation of Active Covered Individuals in Section 7.1.2 has been updated to exclude individuals covered by COBRA with one exception to this rule noted for individuals with ESRD.
- The age threshold used in the definition of Active Covered Individuals has been temporarily raised to 55 from 45 years old. The age threshold will be lowered back to 45 on January 1, 2011. The explanation of Active Covered Individuals in Section 7.1.2 has been updated for this change. Notations on this age threshold change have also been made in Sections 7.1.7, 7.2.1 and 7.2.9.1.
- Section 7.1.2.1 has been added to describe a "finder file" option as an alternative to using the age threshold requirement in the definition of an Active Covered Individual.
- Section 7.1.7 was updated to note the new compliance flags and add a special note about initial MSP Input File submissions for former VDSA/VDEA partners.
- Further clarification was added to Section 7.2.2 regarding the TIN Reference File. In particular, it has been noted that once the full TIN Reference File has been submitted, only new or changes records need to be sent on subsequent submissions rather than a full replacement file. Also, the file is to contain only one record per TIN/TIN Indicator combination.
- Section 7.2.2.1 "Special GHP Extension For Reporting Employer TINs" has been added to explain the temporary use of "pseudo-TINs" until January 1, 2010 when employer TINs are unavailable.
- Section 7.2.2.2 "TIN Validation" has been added to explain how employer and insurer TINs are validated on MSP Input and TIN Reference Files.
- A new paragraph was added to Section 7.2.6.1, "Changing Information Used to Determine Medicare Secondary Payer" to further clarify the use of update transactions. A similar explanation was added to Section 7.4.5.1 pertaining to the Non-MSP Input File process.
- Clarification was added regarding the Document Control Number (DCN) in Section 7.2.7. This number needs only be unique within the current file being submitted.
- Information was added on determining employer size to Section 7.2.7 and the description of Field 16 on the MSP Input File in Appendix A.
- Section 7.2.7 has been updated to explain reporting requirements regarding Flexible Savings Accounts (FSAs), Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), and stand-alone dental and vision care coverage.
- Section 7.2.8 has been changed to lengthen the extension for RREs to collect the SSNs for dependents whose initial GHP effective date is prior to January 1, 2009. RREs now have until January 1, 2011 (instead of 2010) to report on these specific individuals.

- A set of compliance flags have been added to the end of the MSP Response File record layout. A description of these fields is provided in Section 7.2.9.6. Compliance Code values used for these flags can be found in Appendix D.
- The reference to File Transfer Protocol (FTP) over the AT&T Global Network Services (AGNS) was removed from the description of the Connect:Direct file transmission method in Section 8.1.1. Note that Secure FTP (SFTP) is still an available option over the Internet. FTP over AGNS is not. Connect:Direct (NDM) must be used for the AGNS.
- The dataset naming conventions to be used for Connect:Direct were corrected in Section 8.1.1.
- Sections 8.1.2 and 8.1.3 were updated to note that the links to documentation related to SFTP and HTTPS listed there are only to be used for those transmitting via these methods prior to April 2009. These file transmission methods will be transitioned to the COB Secure Website at that time.
- Clarification was added in Section 9.1.2 to indicate that the limit on queries that can be submitted through BASIS is 200 per Section 111 Reporter ID per month.
- Section 12.3 “Contact Protocol for the Section 111 Data Exchange” has been added to explain how to elevate Section 111 data exchange issues at the COBC.
- The description of Field 8 Coverage Type on the MSP Input File in Appendix A has been updated with an explanation for Health Reimbursement Accounts.
- Clarification has been added to data element descriptions for the MSP Input File in Appendix A related to reporting by Third Party Administrators (TPAs), Self-Insured entities, and reporting on Taft-Hartley multi-employer plans.
- Updates have been made to the descriptions of SP Error Codes in Appendix D to further clarify their meaning and corrective actions. Some SP Error Codes originally marked as “RRE Responsible” have been changed to “COBC Responsible”.
- The description for disposition code ‘51’ was updated in Appendix D to include situations where neither a HICN nor SSN was submitted for the individual on an input record.
- The description of the ‘BY’ Disposition Code was updated in Appendix D.
- All header and trailer indicator fields have been changed to alphanumeric data types from alphabetic.

2 Introduction

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

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

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

3 MMSEA Section 111 Overview

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

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

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

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

4 Medicare Entitlement, Eligibility and Enrollment

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

Medicare is a health insurance program for:

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

Medicare has:

Part A Hospital Insurance - Most people receive premium-free Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance, or HI) helps cover inpatient care in hospitals and skilled nursing facilities (but not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance - Most people pay a monthly premium for Part B. Medicare Part B (Supplemental Medical Insurance, or SMI) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.

Part C Medicare Advantage Plan Coverage - Medicare Advantage Plans are health plan options (like HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called “Part C” or “MA plans.” These plans are an alternative to the fee-for-service Part A and Part B coverage and often provide extra coverage for services such as vision or dental care.

Prescription Drug Coverage (Part D) - Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Private companies provide the coverage. Beneficiaries choose the drug plan they wish to enroll in, and most will pay a monthly premium.

Exclusions - Throughout, Medicare has various coverage and payment rules which determine whether or not a particular item or service will be covered and reimbursed.

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

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

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

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

5 MSP Overview for GHP

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

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

Medicare Secondary Payer

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

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

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

Who does MSP affect?

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

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

Working Aged

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

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

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

or

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

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

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

People with Permanent Kidney Failure

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

Disabled People

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

individuals who have Medicare because of a disability if one or more of the employers in the GHP has 100 or more full and/or part-time employees.

Making MSP Work

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

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

Role of the Medicare Coordination of Benefits Contractor

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

Where to Find MSP Regulations

The sections of the Social Security Act known as the Medicare Secondary Payer (MSP) provisions were originally enacted in the early 1980s and have been amended several times, including by the MMSEA Section 111 mandatory reporting requirements. See section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b). See 42 CFR Part 411 for the applicable regulations. Medicare has been secondary to workers' compensation benefits from the inception of the Medicare program in 1965.

6 The GHP Process

6.1 Overview

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

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

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

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

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

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

6.2 GHP Reporting Options

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

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

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

6.2.1 Basic Reporting Option

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

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

MMSEA Section 111 Basic GHP Reporting Option Files

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

6.2.2 Expanded Reporting Option

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

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

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

MMSEA Section 111 Expanded GHP Reporting Option Files

File Type	Description
GHP MSP Input File	This is the data set transmitted from a MMSEA Section 111 responsible reporting entity (RRE) to the COBC that is used to report information regarding Active Covered Individuals.
GHP MSP Response File	This is the data set transmitted from the COBC to the MMSEA Section 111 RRE after the information supplied in the RRE's MSP Input File has been processed.
TIN Reference File	The TIN Reference File consists of a listing of each business entity's federal tax identification number (TIN) and the business mailing address that is linked to that particular TIN.
GHP Non-MSP Input File	This is the data set transmitted from a MMSEA Section 111 RRE to the COBC that is used to report information regarding the drug insurance coverage information of Inactive (e.g. not employed, retired) Covered Individuals.
GHP Non-MSP Response File	This is the data set transmitted from the COBC to the MMSEA Section 111 RRE after the information supplied in the Non-MSP Input File has been processed.
Query Only Input File	This is a query file used to obtain Medicare Part A entitlement and Parts B and C enrollment information of potential Medicare beneficiaries.
Query Only Response File	After the COBC has processed the Query Only Input File it will return the Query Only Response File with Medicare Parts A, B and C

File Type	Description
	coverage information for individuals identified as Medicare beneficiaries.

7 GHP Mandatory Reporting Requirements

7.1 General Reporting Requirements

7.1.1 Responsible Reporting Entities

7.1.1.1 Who Must Report

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

7.1.1.2 Use of Agents

See the discussion of "agents" with respect to GHP reporting in Appendix H.

GHP RREs may use agents to submit data on their behalf. An agent is a data services company, consulting company, or the like that can create and submit Section 111 files to the COBC on behalf of the RRE. Information on the use of agents is required as part of the Section 111 registration process. The RRE remains solely responsible and accountable for adhering to the requirements of the Section 111 program and for the accuracy of data submitted.

7.1.2 Active Covered Individuals

A GHP responsible reporting entity's first file submission must contain information for all individuals meeting the definition of an Active Covered Individual, as set forth below. Active Covered Individuals are to be reported on the RRE's Section 111 MSP Input File. In many cases the GHP coverage being reported will be primary to Medicare. Subsequent quarterly file submissions are to include only new or changed coverage information, using add, update, and delete transactions.

For purposes of Section 111 reporting, Active Covered Individuals are:

- Effective January 1, 2009 through December 31, 2010, all individuals covered in a GHP age 55 through age 64 who have coverage based on their own or a family

member's current employment status. Effective January 1, 2011 and subsequent, all individuals covered in a GHP age 45 through 64 who have coverage based on their own or a family member's current employment status.

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

An Active Covered Individual is someone who may be Medicare eligible and currently is employed, or the spouse or other family member of a worker who is covered by the employed individual's GHP and who may be eligible for Medicare. Medicare may be a secondary payer for these individuals. On the MSP Input File, CMS is requiring the RRE to include all of the individuals covered by the GHP for whom, if they had Medicare, Medicare would be a secondary payer of their GHP benefits. The COBC will determine if the active covered individual is a Medicare beneficiary and whether Medicare is the primary or secondary payer. The results of this determination are then provided to the submitter on the returned MSP Response File.

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

Note: The fact that an employer has less than 20 full and/or part-time employees is **NOT** a basis for excluding such employees from the Section 111 GHP reporting process if the employer is part of a multi-employer/multiple employer GHP. See, also, the section of this User Guide discussing the Small Employer Exception.

Note: The size of the employer is not relevant with respect to reporting for individuals who have been receiving kidney dialysis or have received a kidney transplant.

Note: The MSP provisions for the disabled apply to all employers in a multi-employer/multiple employer GHP if one or more of the employers has 100 or more full and/or part-time employees.

Note: The age threshold of 55 described above will be lowered to 45 for all MSP Input Files submitted January 1, 2011 and subsequent.

7.1.2.1 Finder File as an Alternative to the Age Threshold

As an alternative to using the age threshold requirements defined above, CMS is making a “finder file” option available to Section 111 GHP RREs. This option involves the RRE first sending a query file through which the COBC would identify any Medicare beneficiaries and return these positive identifications to the RRE. The RRE would then submit MSP Input File records for those identified Medicare beneficiaries. However, use of a “finder file” is not a foolproof method of identifying all Active Covered Individuals who are Medicare beneficiaries that should be reported. CMS believes that the use of a finder file is functionally less precise than routine reporting of all Active Covered Individuals as defined using the age threshold. Consequently, use of the “finder file” option may increase an RRE’s probability of underreporting all Active Covered Individuals who are Medicare beneficiaries, putting the RRE in jeopardy of noncompliance with the Section 111 reporting requirements. This possibility should be carefully weighed by any RRE considering the “finder file” reporting option.

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

7.1.3 Inactive Covered Individuals

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

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

7.1.4 File Format

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

Header, Detail and Trailer Records

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

7.1.5 Data Formatting Standards

Conventions for Describing Data Values

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

Data/Field Type	Formatting Standard	Examples
Numeric	Zero through 9 (0 to 9) Padded with leading zeroes	Numeric (5): “12345” Numeric (5): “00045”
Alpha	A through Z Left justified Non-populated bytes padded with spaces Alphabetic characters sent in lower case will be converted and returned in upper case.	Alpha (12): “TEST EXAMPLE” Alpha (12): “EXAMPLE “

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

7.1.6 Section 111 Registration

7.1.6.1 Purpose of the Registration Process

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

- Validate information provided by the RRE registrant
- Assign a Section 111 Reporter ID to each RRE
- Develop a Section 111 reporting profile for each entity including estimates of the volume and type of data to be exchanged for planning purposes
- Assign a production live date and ongoing file submission timeframe to each entity
- Establish the necessary file transfer mechanisms, and
- Assign a COBC Electronic Data Interchange Representative (EDI Rep) to each entity to assist with ongoing communication and data exchange.

7.1.6.2 Registration Timeframes

Current VDSA/VDEA Partners

GHP responsible reporting entities that currently have Voluntary Data Sharing Agreements (VDSAs) or Voluntary Data Exchange Agreements (VDEAs) in place with CMS and the COBC must complete the following **by October 31, 2008**:

- MMSEA Section 111 GHP RRE Registration Attachment for VDSA/VDEA Partners that can be found at www.cms.hhs.gov/MandatoryInsRep/Downloads/PaperRegistration.pdf
- the electronic file transmission information attachment for Connect:Direct (AGNS) in the same document named above.

Complete instructions are included in the attachment.

All Other GHP Responsible Reporting Entities

GHP RREs that do *not* currently exchange data with CMS under the VDSA/VDEA Program will register on the COB Secure Web site (COBSW) from April 1, 2009 through April 30, 2009 using a new, interactive, Web portal designed for this purpose. Details on how to complete the Section 111 registration process on the COBSW that starts in April 1, 2009, will be posted on the CMS Section111 Web page at www.cms.hhs.gov/MandatoryInsRep/. This User Guide will be updated accordingly. You may review the requirements for registration at www.cms.hhs.gov/MandatoryInsRep/Downloads/RegistrationOverview.pdf.

7.1.6.3 Overview of the Registration Process

Current GHP VDSA/VDEA Partners

Current Insurer GHP VDSA/VDEA partners who are responsible reporting entities will complete and deliver their registration attachments to the COBC. Note that the COBC will implement an Internet-based Section 111 application on the COBSW on April 1, 2009. At that time, GHP VDSA/VDEA partners who previously registered for Section 111 by paper will be invited to confirm their registration, set up online accounts and register individual users for the site. This new application will provide additional options for submitting files to the COBC and allow users to monitor the status of test and production file processing for Section 111.

The COBC will process your registration and once it has been accepted, will send you an e-mail with your Section 111 profile report. This report summarizes the information you provided on your registration and provides important information you will need for your data file transmission. It will also contain your Section 111 Reporter ID that you will need to include on all files transmitted to the COBC. The profile report will also include your assigned production live date and file submission timeframe for MSP Input Files. You must sign a copy of your profile report and return it to the COBC in order for your registration to be complete. At that point you may begin testing your Section 111 files.

All Other Responsible Reporting Entities

All other entities responsible for complying with the Section 111 reporting requirements will register on the COBSW. An authorized company representative will complete and submit the registration for the RRE using a new Internet-based application on the COBSW. When a registration application is submitted, the information provided will be validated by the COBC. Once this is completed, the RRE will be invited to assign an Account Manager to return to the COBSW to complete account set up and obtain Login IDs for individual users associated with that account on the COBSW.

Once account set up has been completed and processed, a profile report will be sent to the RRE's authorized representative via e-mail. This report summarizes the information you provided on your registration and account set up and provides important information you will need for your data file transmission. It will also contain your Section 111 Reporter ID that you will need to include on all files transmitted to the COBC. The profile report will include your assigned production live date and file submission timeframe for MSP Input Files. The RRE's authorized representative must review, sign and return the profile report to the COBC. At that point you may begin testing your Section 111 files.

The Account Manager will be the administrative contact for the RRE and control the overall account profile. Users associated with the reporting entity's account will be able to submit test and production files, maintain account information and monitor the status of file processing using the COBSW.

Information Needed to Register

Each applicable, responsible reporting entity (RRE) must complete the registration process regardless of whether an agent will be submitting files on that entity's behalf. An agent cannot complete the registration form for you. See https://www.cms.hhs.gov/MandatoryInsRep/Downloads/RegistrationOverview.pdf for the information that will be collected.

Each RRE's registration must correspond with the manner in which it will submit files to comply with the Section111 requirements. A separate registration must be submitted for each file transmission set-up. For example, if an RRE is a company comprised of three subsidiaries with separate Group Health Plan (GHP) enrollment systems for which it intends to submit three separate sets of files, it must complete three separate registrations and will be assigned three separate Section 111 Reporter IDs. Alternatively, if that same company will be submitting one file that includes data for all three subsidiaries, then it must complete only one registration and will receive one Section 111 Reporter ID.

7.1.7 Differences Between VDSA/VDEA and Section 111 Files

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

- Each Section 111 RRE will be assigned a Section 111 Reporter ID number. This number will replace the partner's existing VDSA or VDEA ID number. The RRE Reporter ID will be entered in Field 2 of the Header and Trailer Files for the Section 111 GHP MSP, Non-MSP, and TIN Reference Input Files. The partner's previous VDSA or VDEA ID will no longer be valid or used in these files.

  NOTE: For the time being, a former VDSA or VDEA partner that uses the Query Only File labeled Section 111 Query Only Input File (ANSI X12 270/271 Entitlement Query Flat File Format) must continue to use its current VDSA or VDEA ID in Field 2 of the Query Only File Header and Trailer records. The Section 111 Query Only File will be modified at a later date to include the new Section 111 Reporter ID, and all RREs will be notified.

- Pseudo-TINs for employer EIN reporting will no longer be permitted for inclusion on the MSP Input File and TIN Reference File as of January 1, 2010. All former VDSA/VDEA partners who have transitioned to Section 111 RREs must provide valid TINs for employers on all file type submissions January 1, 2010 and subsequent. RREs must send correct employer TINs in an updated TIN Reference File with their First Quarter 2010 submissions or prior. RREs must also submit MSP Input File update records with valid employer TINs to correct previously submitted records with pseudo-TINs at that time. Valid insurer TINs must be submitted on the TIN Reference File starting January 1, 2009. Pseudo-TINs are not permitted under any circumstances for insurer TINs.

- Effective January 1, 2009 through December 31, 2010, on the MSP Input File, the age threshold for reporting individuals not otherwise known to be Medicare beneficiaries is 55 years of age and older. Effective with files submitted January 1, 2011 and subsequent, this age threshold for reporting individuals not otherwise known to be Medicare beneficiaries will be 45 years of age and older. For Section 111 reporting, adherence to these reporting age thresholds is a requirement.

- A "Small Employer Exception (SEE) HICN" field has been added; see Field 32 on the MSP Input File Detail Record. Data supplied in new Field 32 and existing Field 16 will be used in conjunction with records of previously approved small employer exception requests to ensure that we know when Medicare is primary for a particular beneficiary with the exception. A full explanation of the "Small Employer Exception" is provided in a later section of this guide.

- A "SEE Response Code" field has been added to the MSP Response File at Field 81. The full explanation of the "SEE Response Code" is provided in a later section of this guide.

- A "Late Submission Indicator" field has been added on the MSP Response File. It will be filled if the submitted record was not received within its required submission period. The “Late Submission Indicator” is at Field 82.

- Compliance Flag fields have been added on the MSP Response File in Fields 83-92. These flags are explained in a later section of this guide.

- For Section 111 production file exchange, each current VDSA or VDEA partner will be assigned a new file submission schedule. It will replace the file submission schedule a partner is using in the Voluntary program.

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

7.1.8 File Submission Timeframes

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

Note: Your MSP Input File receipt date will be set by the COBC system when the batch cycle runs. The COBC batch cycle runs nightly Monday-Friday, except holidays. RREs must send their files as close to the first day of their submission timeframe as possible in order to have the file receipt date fall within their submission timeframe. For example, if you submit a file on a Saturday, the COBC system will not mark the receipt date until the COBC batch cycle runs on Monday night. In addition, if the batch cycle runs past midnight, your file receipt date might not be set until Tuesday. The seven-day submission window is provided to account for this delay between file transmission and receipt date determination. It is not intended to allow you more time to submit your file. You should be ready to transmit your files to the COBC on the **first** day of your submission timeframe to be compliant with Section 111 reporting requirements.

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

Quarterly MSP Input File Submission Timeframes

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

7.2 MSP Input File Requirements

7.2.1 Overview

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

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

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

An MSP Response File will be sent back to you by the COBC for each MSP Input File you send. This is the data set transmitted from COBC to the GHP RRE after the information supplied on the MSP Input File has been processed. It consists of the same data elements in the Input File, with updates applied by the COBC based on Medicare's information for that individual, disposition and error codes which let you know what we did with the record, as well as applicable Medicare entitlement and enrollment information.

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

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

7.2.2 TIN Reference File

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

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

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

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

An RRE can have more than one TIN. For example, an insurer or TPA may have claims operations defined for various regions of the country. Because they are separate business operations, each could have its own TIN, and each TIN may be associated with a distinct business mailing address. (Note: The TIN is the same as the federal Employer ID Number, the EIN.) **The mailing address associated with each TIN on the TIN Reference File should be the address to which health care insurance coordination of benefits issues and recovery demands should be directed.** This mailing address will help CMS and others to direct correspondence to the most appropriate contact for the GHP RRE. If the RRE has more than one TIN, you may choose to report all records under one primary Insurer/TPA TIN or use different TINs on different records as you see fit.

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

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

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

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

NOTE: For Taft-Hartley multiple employer/multi-employer plans (plans using an "hours bank" arrangement) covering individuals who routinely work for multiple employers in a single Section 111 reporting period, RREs should submit the plan sponsor TIN rather than the actual employer TIN in the Employer TIN (Field 21) of the MSP Input File record. The name, address, and EIN/TIN of the plan sponsor should then be submitted on the corresponding TIN Reference File detail record. So that CMS can identify such situations, the RRE must place the designation of "(PS)" after the name of the plan sponsor in the Name (Field 2) of the TIN Reference File detail record.

7.2.2.1 Special GHP Extension For Reporting Employer TINs

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

Records for all Active Covered Individuals must be submitted per the Section 111 reporting requirements beginning with your initial MSP Input File submission. However, if the applicable Employer TIN is not available, RREs may submit the record with what is referred to as a "pseudo-TIN" in Field 21. A pseudo-TIN is a 9 digit number made up by the RRE to represent an employer in lieu of a valid employer TIN.

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

- Pseudo-TINs are allowed only for employer TINs on files submitted from January 1, 2009 through December 31, 2009.

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

7.2.2.2 TIN Validation

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

Employer TINs

- An employer TIN in Field 21 of the MSP Input File detail record must match a TIN on a current or previously submitted TIN Reference File record. The TIN Reference File record must have a TIN Indicator of 'E' or 'Y'.
- If no matching TIN Reference File record is found, the MSP Input record will be rejected with an 'SP' disposition code and errors associated with invalid employer information.
- If a match is found with a TIN Indicator of 'E' then the TIN must be a valid IRS-assigned tax ID. If the TIN is not valid, then the MSP Input record will be processed but a compliance flag will be set on the corresponding MSP Response File record.
- If a match is found with a TIN Indicator of 'y', then the TIN will be considered valid until January 1, 2010. With files submitted after January 1, 2010, the MSP Input record will be processed but a compliance flag will be set on the corresponding MSP Response File record.

Insurer TINs

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

7.2.3 Record Matching Criteria

7.2.3.1 Individuals

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

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

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

7.2.3.2 MSP Occurrences

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

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

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

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

7.2.4 Small Employer Exception (SEE)

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

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

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

<u>Multi-Employer GHPs & Medicare Entitlement Based Upon Disability or ESRD:</u>

If an employer participates in a multi-employer GHP and at least one participating employer has at least 100 full and/or part-time employees, the MSP rules apply to all

individuals entitled to Medicare on the basis of disability, including those associated with the employer having fewer than 100 full and/or part-time employees.

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

GHP RRE Section 111 Reporting with Respect to the SEE:

- If reporting on an active covered individual for whom a SEE has been granted, place the individual's HICN in MSP Input File Field 32, Small Employer Exception HICN. If the COBC can match this to its records using the SEE HICN, employer EIN, and insurer policy number, the insurance effective date from the submitted MSP file will be compared to the SEE start and end dates.

- If the insurance coverage period is entirely within the SEE start and end dates, no working-aged MSP occurrence will be created and the coverage will not be considered primary to Medicare. A disposition code of 'BY' (bypassed) and a SEE Response Code (field 81) of 'SA' (SEE Accepted) will be returned on the MSP Response File.

- If the insurance effective date is prior to the SEE start date, an MSP occurrence will be generated if the individual was covered by Medicare for that period. The MSP Effective Date will be set as the insurance effective date submitted on the MSP Input File. The MSP Termination Date will be 1 calendar day prior to the SEE start date. The appropriate disposition code for the updated record and a SEE Response Code of 'SP' (SEE Partial) will be returned on the MSP Response File record.

- If the insurance effective date is within the SEE effective period and the insurance end date is after the close of the SEE effective period, the MSP Effective Date will be set to 1 calendar day after the SEE termination date. The appropriate disposition code for the updated record and a SEE Response Code of 'SP' (SEE Partial) will be returned on the MSP Response File record.

- If an MSP occurrence is created because the insurance coverage period is outside of the SEE effective period, the appropriate disposition code for the updated record and a SEE Response Code of 'SN' (SEE Not Applicable) will be returned on the MSP Response File record.

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

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

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

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

7.2.5 Initial MSP Input File Submission

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

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

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

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

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

7.2.6 Quarterly Update MSP Input File Submissions

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

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

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

7.2.6.1 Add, Delete, Update Transactions

Add Transactions

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

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

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

Update Transactions

An "update" record or transaction is defined with a '2' in the Transaction Type (Field 7). An update transaction is sent when you need to change information on a record previously accepted and added as an MSP occurrence to the Medicare CWF or MBD by the COBC for which you received an '01' disposition code in your MSP Response File.

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

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

Delete Transactions

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

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

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

How to Report a Coverage Termination Date

If coverage for an Active Covered Individual previously sent and accepted by the COBC ends, you must send an update record with the Termination Date (Field 11). The COBC will update the MSP occurrence Termination Date and Medicare will become the primary payer after that date. **Do not send a delete transaction** in these cases. A delete transaction will remove the MSP occurrence entirely, as

though Medicare was always supposed to be the primary payer, and claims will be paid erroneously.

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

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

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

Changing Information Used to Determine Medicare Secondary Payer

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

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

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

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

Example: An add transaction was sent indicating that the Coverage Type was Hospital and Medical (a value of 'A' in Field 8). The Effective Date submitted was January 1 and the Termination Date was open-ended. The record was accepted and the COBC created an MSP occurrence and returned a disposition code of '01'. Effective June 1, the coverage for the individual changed to Hospital Only. In the next quarterly file submission, an update transaction should be sent with a Coverage Type value of 'A', Effective Date of January 1 and a Termination Date of May 31. In the same update file an add transaction should be sent with an Effective Date of

June 1, an open-ended Termination Date and a Coverage Type of 'J' reflecting the new Hospital Only coverage.

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

7.2.7 MSP Input File Detailed Requirements

- MSP Input Files must contain properly formatted header, detail and trailer records as defined in Appendix A.
- MSP Input Files must be submitted on a quarterly basis, four times a year.
- Files must be submitted within your assigned, 7-day submission period each quarter. The receipt date of your file will be set to the date the COBC batch system processes it. The COBC runs batch processes nightly Monday – Friday excluding holidays. As batch processing may cross midnight, the receipt date may not be defined until the day after transmission by the Section 111 RRE. Files submitted on weekends will be held and not processed until the Monday night batch cycle. If your receipt date falls after your 7 day submission timeframe, your file will be processed but will be marked as late on subsequent compliance reports.
- Current GHP VDSA/VDEA partners must submit their initial production Section 111 MSP Input File during the First Quarter (January – March) of 2009 during their assigned submission timeframe. Current VDSA/VDEA partners must submit their registration form to the COBC by October 31, 2008 and complete testing in time to submit their production file as specified above.
- Section 111 responsible reporting entities who do not (or did not) have a VDSA/VDEA in place with CMS must submit their initial production Section 111 MSP Input File during the Third Quarter (July – September) 2009 during their assigned submission timeframe. They must register on the COB Secure Web site by April 30, 2009 and complete testing in time to submit their production file as specified above.
- RREs' initial file submissions must report on all Active Covered Individuals with coverage as of January 1, 2009, regardless of the assigned date for a particular RRE's first submission.
- The initial MSP Input File must contain records for all Active Covered Individuals who had open coverage under your GHP(s) as of January 1, 2009 even if it has since been terminated.
- A TIN Reference File must be submitted with the Initial MSP Input File containing records for each TIN or EIN submitted in Fields 21 and 22 of the MSP Input File.
- Subsequent MSP Input Files do not need to be accompanied by a TIN Reference File unless there are changes to previously submitted TIN information or new TINs have been added.
- All TINs (or EINs) on the MSP Input File records must have a corresponding TIN record on the TIN Reference File.

- The initial MSP Input File must contain records for all Active Covered Individuals who have active coverage under your plan as of the date of submission. However, if the GHP coverage effective date is within 45 days prior to the start of your 7-day file submission timeframe, you may submit that information on your next quarterly file (the following quarterly file submission period). This grace period allows you time to process the new enrollee information internally prior to submission for Section 111. Records not received on time will be processed but marked as late and used for subsequent compliance tracking.
- Subsequent quarterly update files must include records for any Active Covered Individual you have added to your plan since the last file submission. However, if the coverage effective date is within 45 days prior to the start of your 7-day file submission timeframe, then you may submit that information on your next quarterly file. This grace period allows you time to process the new enrollee information internally prior to submission for Section 111. For example, if an Active Covered Individual's GHP coverage effective date is May 1, 2010, and your file submission period for the second quarter of 2010 is June 1-7, 2010, then you may delay reporting that individual until your third quarter file submission during September 1-7, 2010. However, if the individual's GHP coverage effective date is April 1, 2010, then you must include this individual on your second quarter file submission during June 1-7, 2010. Records not received timely will be processed but marked as late and used for subsequent compliance tracking.
- Subsequent quarterly update files must include updates to any previously submitted record that has changed since the last submission.
- Quarterly update files must contain resubmission of any records found in error on the previous file (Disposition Code of SP) with corrections made. Please refer to the Processing Response Files section for more information.
- Quarterly update files must contain resubmission of any records that received the Disposition Codes 'ID', '51' or '55' on the previous response file, if the individual is still covered and an Active Covered Individual, with corrections applied as needed. Please refer to the Processing Response Files section for more information.
- If you have no new information to supply on a quarterly update file, you must submit an "empty" MSP Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count.
- E-mail notifications will be sent to the Section 111 responsible reporting entity contacts after a file has been initially processed and when a response file has been transmitted or is available for download.
- Each detail record on the MSP Input File must contain a unique Document Control Number (DCN) generated by the RRE. This DCN is required so that response records can be matched and issues with files more easily identified and resolved. It can be any format of the RREs choosing as long as it is not more than 15 text characters as defined in the record layout. The DCN only needs to be unique within the current file being submitted.
- Employer size (the number of full or part-time employees, not the number of covered lives under a particular GHP) is critical to determining primary vs. secondary payment responsibility. RREs must report all Active Covered Individuals for all employers who are part of a multiple/multi-employer GHP regardless of the number of full or part time employees for a particular employer. RREs must have employer size information for all of the employers in a multiple/multi-employer GHP. Employer size must be reported on each MSP

Input File record in Field 16. If the employer is part of a multi-employer plan, this field should reflect the size of the **largest** employer in the plan. Employer size must be calculated once per calendar year. Refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 for details on this calculation.

- A Flexible Savings Account (FSA) product is not considered to be GHP coverage for MSP purposes. RREs are not required to include FSA programs in Section 111 reporting.
- A Health Savings Account (HSA) is typically associated with a high deductible GHP product. Under current law, Medicare beneficiaries may not make further contributions to the savings portion of an HSA, although they retain access to previous contributions, both their own and those made by an employer. The CMS will not consider HSAs to be reportable under Section 111 as long as Medicare beneficiaries may not make a current year contribution to an HSA.
- The CMS considers a Health Reimbursement Account (HRA) to be a GHP product for MSP purposes. RREs are required to include HRA programs in Section 111 reporting.
- Routine dental services and dentures are not covered benefits in the Medicare program although Medicare does cover inpatient hospital services required in dental services. Routine vision care is also not a covered Medicare benefit, although Medicare does cover periodic eye exams to check for the presence of diabetic retinopathy and will pay for one pair of glasses after one particular type of cataract surgery. When offered as stand-alone products, dental and vision care GHP coverage are not to be included in Section 111 reporting. However, RREs are responsible for being aware of situations where dental or vision care services are covered by Medicare and pay primary to Medicare for all beneficiaries who have such stand-alone coverage when appropriate.

7.2.8 Special GHP Reporting Extension For Dependents

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

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

The extension is provided to all Section 111 GHP responsible reporting entities during 10/1/2008 to 12/31/2010. It is intended to allow you time to obtain the SSN or HICN of spouses and family members. ***It does not apply to reporting subscriber information under any circumstances.*** You must have the SSN or HICN for subscribers at the start of Section 111 reporting and submit coverage information for Active Covered Individuals who are subscribers on your initial and all subsequent update MSP Input Files.

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

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

7.2.9 Processing Response Files

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

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

7.2.9.1 Disposition Codes

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

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

- SSN

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

- MSP Effective and Termination Dates – start and end dates for the period of time your coverage overlaps Medicare coverage, your coverage is primary to Medicare and should pay first. Note that in some cases, the MSP Effective Date may reflect a future date based on an established Medicare entitlement date in the future.
- Medicare Part A, B, and C Coverage Dates
- End Stage Renal Disease (ESRD) information

- Records that are rejected with any other disposition code must be resubmitted on your next quarterly update file. As a rule, you should check these records for accuracy, update the information previously sent, as applicable, and resubmit.
- Note that since the age threshold for Active Covered Individuals is 55 (age 45 as of January 1, 2011) but most people are not entitled to Medicare until they are 65, you will receive a significant number of records back with disposition '51' each quarter. This is a completely acceptable situation and you should continue to send current information for these individuals with each quarterly submission until you receive an '01' disposition code, the GHP coverage is terminated or the individuals no longer fit the definition of Active Covered Individuals.

7.2.9.2 SP Error Codes

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

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

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

Special Consideration for the SP ES Error Code

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

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

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

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

Special Consideration for Non-Overlapping GHP and Medicare Coverage

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

This situation applies only to add records. If you receive a SP32/SP62 error on an update record you are sending to apply a termination date to a previously added MSP occurrence (your GHP coverage has ended), then you most likely have an error

in your system that needs to be addressed. Please see the description of SP error codes in Appendix D.

7.2.9.3 Rx Disposition and Rx Error Codes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    - MSP Effective and Termination Dates – start and end dates for the period of time your coverage is primary to Medicare and should pay first.
    - Medicare Part A, B, C and D Coverage Dates
    - End Stage Renal Disease (ESRD) information

- Records that are rejected with an Rx disposition code other than those listed above must be resubmitted on your next quarterly update file. As a rule, you should check these records for accuracy, update the information previously sent as applicable, and resubmit.

7.2.9.4 Expanded Option Only - Part D Eligibility and Enrollment Data

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

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

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

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

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

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

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

7.2.9.5 File Level and Threshold Errors

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

- 10% or more of the total records are delete transactions
- 20% or more of the total records failed with a disposition code of SP due to errors
- More than one MSP Input File was submitted during your defined quarter.

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

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

7.2.9.6 Late Submission and Compliance Flags

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

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

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

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

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

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

7.2.9.7 Split Entitlement Indicator – Multiple Response Records

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

7.2.9.8 End Stage Renal Disease (ESRD)

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

7.3 Query Only Input File Requirements

7.3.1 Overview

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

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

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

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

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

7.3.2 Query Only Input File Detailed Requirements

- Query Only Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set.
- Query Only Input Files may be submitted up to once per calendar month. These files do not have to be submitted during a specific submission timeframe.
- Only Medicare Part A, Part B and Part C coverage information will be supplied on the Query Only Response File. Part D coverage information will be added at a

later date but only provided to those reporting under the Expanded Reporting Option.

- Query Only Response Files will be returned to you within 14 days.
- The following edits will be applied to the Query Only Input File. Any failure of these edits will result in the file being placed in a severe error status. You will receive an e-mail notification and are to contact your EDI Rep to address the identified errors. Files failing for these errors must be corrected before they can be processed.
    - File does not contain a header record
    - Header record does not contain a valid Section 111 Reporter ID
    - File does not contain a trailer record.
- E-mail notifications will be sent to the Section 111 responsible reporting entity contacts after the file has been received and when a response file has been transmitted or is available for download.
- Query Only Response Files will be returned with NO header and trailer records.

7.4 Non-MSP Input File Requirements

7.4.1 Overview

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

CMS uses the information in the Non-MSP File to determine GHP coverage that is secondary to Medicare Part D for Medicare beneficiaries, which is then used for proper claims payment and the calculation of the beneficiary's True Out of Pocket (TrOOP) drug costs. If the individual reported is a Medicare beneficiary enrolled in Part D and it is determined that your prescription drug coverage is secondary or supplemental to Medicare Part D, the COBC sets up a supplemental Part D record on the Medicare Beneficiary Database (MBD). Part D supplemental records have start and end dates based on the beneficiary's Medicare entitlement, enrollment in Part D, and your coverage dates. A supplemental Part D record will have an open end date if both your coverage and Medicare coverage are active. An end date is applied when either your or Medicare coverage ends.

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

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

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

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

7.4.2 Action Types

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

7.4.2.1 N – Query Records

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

7.4.2.2 D – Supplemental Prescription Drug Coverage Records

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

the individual as well as information about whether the supplemental drug record was accepted and posted by the COBC on the MBD.

7.4.2.3 S – RDS Retiree File Records

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

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

7.4.3 Record Matching Criteria

7.4.3.1 Individuals

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

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

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

7.4.3.2 Supplemental Prescription Drug Records

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

- HICN
- Supplemental Coverage Effective Date
- Coverage Type (network drug only, comprehensive hospital/medical/drug, etc.)

- Patient Relationship Code (self, spouse, dependent, etc.) and
- Section 111 Reporter ID

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

7.4.4 Initial Non-MSP Input File Submission

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

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

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

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

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

N and D records can be mixed together on one "logical" file between the same header and trailer records. S records must be submitted on their own logical file with their own header and trailers. S records cannot be mixed in the same logical file as N/D records. RREs may send in retiree files for multiple plan sponsors (employers) for multiple RDS applications. The RDS application number goes on the header record of the Non-MSP Input File. So if you are submitting retiree files for multiple plan sponsors, you must put the S records associated with each application number in separate logical files

separated by the corresponding header and trailer records. All of these logical files can either be submitted separately or be concatenated together and submitted in one ”physical” file as shown below. However, only one logical Non-MSP Input File with N/D records will be accepted per month. Multiple Non-MSP Files with S records will be accepted and are to be sent on the frequency required by the RDS Center. If you are not using the Non-MSP File to submit RDS retiree files, then one Non-MSP File can be submitted per month with a mixture of N and D records.

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

7.4.5 Update Non-MSP Input File Submissions

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

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

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

7.4.5.1 Add, Delete, Update Transactions

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

Add Transactions

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

Update Transactions

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

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

Delete Transactions

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

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

How to Report a Coverage Termination Date

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

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

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

Changing Coverage Information on a Supplemental Drug Record

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

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

7.4.6 Detailed Non-MSP Input File Requirements

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

- The initial Non-MSP Input File must contain D records for all Inactive Covered Individuals who had open prescription drug coverage under your GHP(s) as of January 1, 2009 even if it has since been terminated.
- The initial Non-MSP Input File should contain D records for all Inactive Covered Individuals who have active prescription drug coverage under your plan as of the date of submission.
- The subsequent, update files should include D records for any Inactive Covered Individual you have added to your plan since the last file submission.
- The subsequent update files must include updates to any previously submitted D and S records that have changed since the last submission.
- Update files must contain resubmission of any records found in error on the previous file (Disposition Codes SP) with corrections made. Please refer to the Processing Response Files section for more information.
- Update files must contain resubmission of any records that received Disposition Codes 'ID', '51' or '55' on the previous file submission response with corrections applied as needed. Please refer to the Processing Response Files section for more information.
- E-mail notifications will be sent to the Section 111 responsible reporting entity contacts when the file has been received and when a response file has been transmitted or is available for download.

7.4.7 Processing Response Files

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

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

7.4.7.1 Part D Eligibility and Enrollment Data

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

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

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

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

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

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

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

7.4.7.2 Processing "D" Response Records

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

- Records marked in error with a 'SP' D/N disposition code must be corrected and resent on your next submission. Error codes are provided in Fields 44 – 47 on the Non-MSP Response File record. An explanation of the error codes is in Appendix D.
- If a record was rejected with a N/D disposition code of 'ID', '51' or '55' which indicate the Inactive Covered Individual could not be matched to a Medicare Beneficiary you must continue to resend **current information** for the individual in subsequent file submissions until it is accepted, your coverage for this individual is terminated, or the individual no longer meets the definition of an Inactive Covered Individual (e.g. returns to work).
- An N/D disposition code of '51' will also be returned if neither a HICN nor SSN was submitted on the input record. You must obtain a valid HICN or SSN for the individual and resubmit the record in your next file submission.
- Records accepted with an '01' N/D disposition code have been added by the COBC as drug coverage supplemental to Medicare on the MBD and will be used in Medicare Part D claims processing. The following fields may contain updated information from the COBC based on Medicare data and could be used to update your internal files:

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

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

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

7.4.7.3 Processing "N" Response Records

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

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

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

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

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

7.4.7.4 Processing "S" Response Records

Please refer to the RDS Retiree File Submission section.

7.4.7.5 Non-MSP Input File Level and Threshold Errors

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

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

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

7.4.7.6 End Stage Renal Disease (ESRD)

In order to allow Section 111 RREs to better coordinate benefits for Medicare beneficiaries related to End Stage Renal Disease (ESRD), the COBC will provide ESRD data fields on your Non-MSP Response File for Inactive Covered Individuals. These fields are the ESRD Coverage Period Effective and Termination Dates, the First (oldest) Dialysis Date, the Self-Training Date, the most recent Kidney Transplant Date, and the most recent Kidney Transplant Failure Date. Please refer to fields 55-60 in the Non-MSP Response File specifications in Appendix C.

For an individual with ESRD there is a 30-month coordination of benefits period for ESRD where the patient's GHP coverage may be primary to Medicare. Subsequent to that 30-month period, Medicare becomes the primary payer regardless of the patient's other GHP coverage. There are conditions that must be met in order for a patient to receive Medicare benefits and coverage for an ESRD diagnosis. Refer to http://www.cms.hhs.gov/ESRDGeneralInformation/

http://www.cms.hhs.gov/OrigMedicarePartABEligEnrol/06_PartAEligibilityforEnd-StageRenalDisease(ESRD).asp and http://www.cms.hhs.gov/EmployerServices/04_endstagerenaldisease.asp for more information related to the coordination of benefits with Medicare for ESRD.

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

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

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

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

7.4.9 RDS Retiree File Submission

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

You may use Section 111 reporting as an alternative method of providing retiree drug subsidy enrollment files to the RDS Center. After enrollment with the RDS program, a Plan Sponsor can use Section 111 for its necessary data transfer and management of retiree files with the RDS Center. Plan Sponsors wishing to receive the Part D Retiree Drug Subsidy for retiree drug coverage must submit an initial application to the RDS Center, a requirement separate from the Section 111 process. For more information and complete requirements related to the retiree drug subsidy please visit: http://rds.cms.hhs.gov/.

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

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

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

The COBC essentially acts as a pass through and will send S records directly to the RDS Center for processing. The RDS Center will determine whether the covered individuals included on S records are eligible for the Subsidy (Part D eligible, but not enrolled in Part D). On the response records, the RDS Center will indicate whether a covered individual was accepted (eligible to be included as part of the plan sponsor's subsidy population) or rejected by putting a 'Y' or 'N' in the RDS Determination Indicator (Field 54). If the covered individual is not accepted for the subsidy or the record is in error, corresponding reason/error codes will be posted in the RDS Reason Code (Field 53). The COBC will populate the S response record with Medicare Part A, B, C and D coverage information as applicable. The COBC will then return the S records to the Section 111 reporter on a Non-MSP Response File.

Splits – Multiple S Response Records

Because periods of eligibility can be interrupted, or a retiree is not eligible for the subsidy for the entire year, you may get more than one S response record for a given submitted S record for a beneficiary/retiree. If this is the case, the RDS Split Indicator (Field 52) will be set to 'Y' and the RDS Start and End Dates in Fields 50-51 will

reflect the split periods on each of the response records. Each response record will contain your original DCN (document control number) in the response Field 21. Each response record will contain the RDS Determination and Reason Codes that apply to the date span specified. For example, if the S record was sent to claim the subsidy for 1/1/2009 through 12/31/2009 but the retiree is not entitled to Medicare until 4/1/2009, one response record will include RDS Start and End Dates for 01/01/2009 through 03/31/2009 with a RDS Determination Indicator of N and a RDS Reason Code of 11 (person is not yet eligible for Medicare). The second response record will have dates 04/01/2009 through 12/31/2009 covering the remainder of the plan year with an RDS Determination Indicator of 'Y' and a blank RDS Reason Code.

RDS Determination and Reason Codes

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

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

Converting an "S" Record to a "D" Record

Prior to transmitting the Non-MSP Response File back to you, when the COBC receives S record responses from the RDS Center, it will screen those responses for covered individuals who do not qualify to be counted in the Plan Sponsor's drug subsidy because they are enrolled in Part D. These individuals will then be considered to have other drug coverage supplemental to their Part D coverage. Accordingly, using the information you sent on the S record the COBC will add a supplemental drug coverage record to the MBD (as it would with a standard D record). You will receive one response record with a D in the Action Type Field 24 and S in the Original Action Type Field 23. The RDS Determination and Reason Codes in Fields 53 and 54 will indicate why the record was rejected for the subsidy, Field 29 will have the COBC disposition code for the S record, and the D/N Disposition in Field 48 will indicate the results of posting the record as a supplemental drug record. The response record will contain your original DCN (document control number) in Field 21. You will be expected to submit updates and/or deletes to maintain this supplemental drug record going forward on your subsequent Non-MSP Input Files with D record action types.

Unsolicited RDS Response Files or Records

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

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

RDS Reason Code	**Description**
10	*Enrolled in Part D*. The retiree cannot be covered under the RDS program because (s)he is/was enrolled in Medicare Part D during the coverage period provided by the Plan sponsor.
11	*Not eligible for Medicare*. The retiree cannot be covered under the RDS program because (s)he is/was not enrolled/entitled to Medicare during the coverage period provided by the Plan sponsor.
12	*Beneficiary is deceased*.
20	*Beneficiary attempted to enroll in Part D and received an initial rejection*. The retiree tried to enroll in Medicare Part D when (s)he was already covered under the RDS program and as a result this initial attempt to enroll in Part D was denied. The Plan Sponsor may counsel the beneficiary that they have equal or better prescription drug coverage through the RDS program. The Plan Sponsor will not be able to claim the subsidy for the beneficiary if (s)he overrides the denial and enrolls in Part D.
21	*New Medicare information has been received – resend record*. After an initial rejection of the retiree's record, the RDS Center has now been notified of a change in the retiree's Medicare enrollment/entitlement status. The Plan sponsor should resubmit the retiree data on its next monthly update to determine if the retiree is now eligible for RDS program coverage.

7.5 Testing the Section 111 Reporting Process

All Section 111 GHP responsible reporting entities must test both file transmission and processing for all applicable file types prior to submitting production files. For the initial Section 111 GHP reporting process implementation, testing will be performed in the same manner as was done for the earlier voluntary data sharing program. For April 2009, the COBC will modify the testing requirements and add testing and tracking functionality to the COB Secure Web site. This guide will be updated for the new testing requirements at a later date.

Overview of the Testing Process

Before transmitting your first "live" (full production) input file to the COBC, you must thoroughly test the file transfer process. Prior to submitting your initial MSP Input File, you will submit a test initial MSP Input File, including a test TIN Reference File. If you have chosen the Expanded Reporting Option, you will also send a test initial Non-MSP Input File. The COBC will return a test initial MSP Response File and a test initial Non-MSP Response File. The response files will indicate what errors were found and the COBC will work with you to correct them. You must continue to submit your initial test files until these errors are corrected. Following a successful submission of your initial files, you will send test update MSP and Non-MSP Input Files. Testing will be completed when you have successfully added new enrollees using test update MSP and Non-MSP Input Files and you and the COBC agree all testing has been satisfactorily performed.

Detailed Testing Process

You and the COBC will begin testing as soon your registration form has been processed, you receive your profile report via e-mail, and you return your signed profile report to the COBC. All administrative and technical arrangements for sending and receiving test files will be made during the registration process.

The population size of a test file may not exceed 100 records.

You will be assigned a COBC Electronic Data Interchange Representative (EDI Rep) during registration. Your EDI Rep will be your main point of contact for testing Section 111 reporting with the COBC and will help you with questions and issues throughout the process. Your profile report will contain contact information for your assigned EDI Rep.

You must test each applicable file type you will be exchanging before submitting any production files. Basic Reporting Option submitters must test the MSP Input File and, optionally, the Query Only Input File. Expanded Reporting Option submitters must test the MSP Input File, Query Only Input File (optional) and the Non-MSP Input File.

Testing for the MSP Input File should be completed first. If you choose not to use the Query Only File in production, you do not have to perform testing for it. However, if you do not perform successful testing of the Query Only Input File you will not be allowed to submit it in production.

Testing MSP and Non-MSP Input Files: The test file record layouts used will be the standard MSP and Non-MSP record layouts found in the appendices of this guide. Data provided in test files will be kept in a test environment by the COBC, and will not be used to update the Medicare CWF or MBD.

You will submit an initial test file with all add transactions. You will submit a test TIN Reference File with your initial test MSP Input File. Upon completion of its review of your initial test file, the COBC will provide you with a response for every record found on it usually within a week after receipt of the test file. After receiving the initial test response file in return, you will take the steps necessary to correct the problems that were reported on it and resubmit the initial test file as necessary.

After the initial test files are successfully processed, you must create and submit an update test file for each file type. The update test file should contain new add records as well as updates and deletes for records sent and accepted on the initial test file. Your update test MSP Input File should be accompanied by a full TIN Reference File as needed. Upon completion of its review of the update test file, the COBC shall provide you a test response file within a week after receipt of the test file. After receiving the update test response file in return, you will take the steps necessary to correct problems that were reported on it and resubmit the update test file as necessary.

MSP and Non-MSP Input Test Files must be limited to 100 records.

After all file transmission testing has been completed to the satisfaction of both you and the COBC, you may begin submitting your regular production files.

Testing Query Only Input Files: You will provide the COBC a test file of the data elements in Appendix B for the Query Only Input File. The HIPAA mandates that you must be able to transmit and receive the Query Only Files in the ANSI X12 270/271 (Health Care Medicare Entitlement/Benefit Inquiry and Information Response) transaction code set rules and standards. The COBC will provide you with a copy of the HIPAA Eligibility Wrapper (HEW) software if requested or you may use your own ANSI X12 translator.

The Query Only Input Test File shall contain a maximum of 100 records of actual data on covered individuals. The Test File will allow the COBC to review the data prior to receiving your first Query Only File submission and identify any defects. You may provide a test Query Only File to the COBC as soon as possible after the registration process has been completed.

After processing the Test File, the COBC will provide you a test Query Only Response File identifying those covered individuals that have Medicare coverage, and those individuals not found to be Medicare beneficiaries. The COBC will return the Response File to you within a week of receipt of the Test File. The COBC will request that you submit another Query Only Input Test File if we find it necessary. After both you and the COBC are satisfied with the results of the testing, you may begin submitting regular production files.

Former VDSA/VDEA Partners Only: Since this file is in the same format as that used for the VDSA/VDEA data exchange, if you have successfully tested with it in the

past, you are not required to re-test this file for your initial Section 111 data submission.

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

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

- Complete your registration including file transmission information. Current VDSA partners must submit the registration found on www.cms.hhs.gov/MandatoryInsRep and submit it to the COBC by October 31, 2008. All others are to complete registration on the COB Secure Web site (COBSW) between April 1, 2009 and April 30, 2009.
- Receive your profile report via e-mail indicating your registration was accepted by the COBC.
- Verify, sign and return your profile report to the COBC.
- Complete your file transmission set up. If you choose SFTP/HTTPS, set up your CMS mailbox. If you already have a mailbox for VDSA/VDEA, you will use that and will not need a new one. If you choose Connect:Direct (AGNS) establish a connection to AGNS, if you don't have one yet, and create transmission jobs and datasets.
- Review file specifications, develop software to produce Section 111 files, and schedule your internal quarterly submission process.
- Test your file transmission method with the COBC.
- Test each Section 111 file type you will be submitting with the COBC.
    - Basic Reporting Option Submitters – MSP and optional Query Only Files.
    - Expanded Reporting Option Submitters – MSP, Non-MSP, and optional Query Only Files.
- Submit your initial MSP Input File with all Active Covered Individuals by your assigned production live date.
- If you are an Expanded Reporting Option submitter, submit your initial Non-MSP File with all Inactive Covered Individuals after your assigned production live date.
- Submit your Query Only File as needed but no more than monthly ongoing.
- Submit your quarterly MSP Input File ongoing during your assigned submission periods.
- Submit your monthly or quarterly Non-MSP Input File ongoing.
- VDSA/VDEA partners: When the Section 111 application is implemented on the COB Secure Web site (COBSW) in April 2009, you will be notified. At that time, establish your account on the site as directed and register users. You will then be able to monitor your Section 111 processing and compliance on the COBSW.

8 Electronic Data Exchange

8.1 File Transmission Methods

Currently, there are three separate methods of data transmission that Section 111 responsible reporting entities may utilize. As part of your registration for Section 111, you will indicate the method you will use and submit the applicable transmission information. In April 2009, the COBC will add functionality for Section 111 to transmit files via SFTP and HTTPS using the COB Secure Web site (COBSW). This guide will be updated with that information as it becomes available.

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

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

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

Using this method, responsible reporting entities must first establish an AGNS account in order to send files directly to the COBC over AGNS. Section 111 responsible reporting entities that currently do not have an existing AGNS account and plan to send and receive information using this telecommunications link should contact one of the well-established resellers of AT&T services to obtain a dedicated or a dial-up access line to the AGNS VAN. ***You are encouraged to do this as soon as possible since this set up can take a significant amount of time.***

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

Production Files

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

Test Files

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

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

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

8.1.2 Secure File Transfer Protocol (SFTP)

At the current time, files transmitted via SFTP are actually sent over the Internet to the CMS Data Center; CMS then forwards them to the COBC. The responsible reporting entity's SFTP mailbox is located on a CMS server. Using SFTP permits automated data transmission and management. At a later date, this transmission method will be available on the COBSW.

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

If you are new to this method and do not currently have a CMS SFTP/HTTPS mailbox for COBC data file exchange, your EDI Rep will contact you regarding the process to set up your mailbox after your registration has been processed.

If you have already been using SFTP (or HTTPS) for your voluntary data sharing program file exchange, then you will use the same CMS SFTP/HTTPS Mailbox (organization number) and IACS (Individuals Authorized Access to the CMS Computer Services) user IDs (UIDs or GUIDs). You will, however, need to use new file names for Section 111. **The file naming conventions are documented in Appendix F of this guide. Files transmitted via SFTP should be compressed and sent as .zip files.**

Please refer to the following documentation on the CMS Web site. This documentation pertains only to those registering and transmitting **files prior to April 2009**. All new GHP RREs registering in April 2009 will utilize the COBSW. Documentation for SFTP via the COBSW will be provided at a later date.

- CMS Connect: Enterprise Secure Client (SFTP) Gentran Internet Option Manual - www.cms.hhs.gov/mmahelp/downloads/SecureFTPInternet.pdf

- CMS Data Exchange Preparation Procedures - http://www.cms.hhs.gov/mmahelp/downloads/Data_Exchange_Preparation_Procedures_20070407.pdf

- IACS User Guide - http://www.cms.hhs.gov/MMAHelp/downloads/IACS_UserGuide_8.1.pdf

- IACS User Guide Attachment C – Coordination of Benefits - http://www.cms.hhs.gov/MMAHelp/downloads/IACS_User_Guide_Attachment_C_v8_20061220.pdf

Files submitted via SFTP to the COBSW should utilize an ASCII format. Fields within the records are length delimited and all records are fixed length.

8.1.3 Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)

Files uploaded via HTTPS are sent over the Internet to the CMS Data Center and then CMS forwards them to the COBC. The responsible reporting entity's HTTPS mailbox is located on a CMS server. There is no additional cost associated with using this method as long as the Internet Explorer (IE) browser is used. However, use of HTTPS does not permit automated data management and is only recommended for entities with a relatively small amount of data to submit. At a later date, this transmission method will be available on the COBSW.

If you are new to this method and do not currently have a CMS SFTP/HTTPS mailbox for your COBC data file exchange, your EDI Rep will contact you regarding the process to set up your mailbox after your registration has been processed

If you are already using HTTPS (or SFTP) for your voluntary data sharing program file exchange, then you will use the same CMS SFTP/HTTPS Mailbox (organization number) and IACS user IDs (UIDs or GUIDs). You will however need to use new file names for Section 111. **The file naming conventions are documented in Appendix F of this guide. Files transmitted via HTTPS should be compressed and sent as .zip files.**

Please refer to the following documentation on the CMS Web site. This documentation pertains only to those registering and transmitting files **prior to April 2009**. All new GHP RREs registering in April 2009 will utilize the COBSW. Documentation for HTTPS via the COBSW will be provided at a later date.

- CMS Data Exchange Preparation Procedures - http://www.cms.hhs.gov/mmahelp/downloads/Data_Exchange_Preparation_Procedures_20070407.pdf

- IACS User Guide - http://www.cms.hhs.gov/MMAHelp/downloads/IACS_UserGuide_8.1.pdf

- IACS User Guide Attachment C – Coordination of Benefits - http://www.cms.hhs.gov/MMAHelp/downloads/IACS_User_Guide_Attachment_C_v8_20061220.pdf

- HTTPS User Guide - http://www.cms.hhs.gov/COBAgreement/Downloads/HTTPSGuide.pdf

Files submitted via HTTPS to the COBSW should utilize an ASCII format. Fields within the records are length delimited and all records are fixed length.

9 Querying for Medicare Coverage Information

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

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

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

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

9.1 How to Obtain Medicare Coverage Information

9.1.1 File Transmission

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

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

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

9.1.2 Beneficiary Automated Status and Inquiry System (BASIS)

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

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

In overview, BASIS operates as follows:

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

   Social Security Number
   Last Name
   First Initial
   Date of Birth
   Gender

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

10 Data Use Agreement

As part of the Section 111 registration process, each Section 111 responsible reporting entity will be asked to sign a copy of the following Data Use Agreement. Data exchanged for Section 111 is to be used solely for the purposes of coordinating health care benefits for Medicare beneficiaries between Medicare and Section 111 responsible reporting entities who provide other health insurance coverage. Measures must be taken by both parties to secure all data exchanged and ensure it is used properly.

SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

I, the undersigned Authorized Representative of the Responsible Reporting Entity defined above, certify that the information contained in this Registration Form is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS to verify this information. I agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged for the purposes of complying with the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The Responsible Reporting Entity shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. I agree that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the Responsible Reporting Entity is in compliance with the security requirements specified above. Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and Responsible Reporting Entity employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized under Section 111 of the MMSEA of 2007. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

11 COB Secure Web Site

A new application will be developed on the Medicare COB Secure Web site (COBSW) to support Section 111 reporting. The functionality for this application will be implemented at a later date and this guide and the Section 111 informational page at www.cms.hhs.gov/MandatoryInsRep/ will be updated with information on that as it becomes available. The initial functionality is slated to be available starting in April 2009.

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

- Complete the registration process. All information will be collected through an interactive Web application.
- Obtain Login IDs and assign users for Section 111 COBSW accounts.
- Exchange files via HTTPS or SFTP directly with the COBC data center without going through the CMS data center.
- View and update Section 111 reporting account profile information such as contacts and company information.
- View the status of current file processing such as when a file was marked as received and whether a response file has been created.
- View statistics related to previous file submission and processing.
- View statistics related to compliance with Section 111 reporting requirements such as whether files and records have been submitted on a timely basis.

12 Customer Service and Reporting Assistance

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

12.1 EDI Representative

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

12.2 Customer Service Center

The Coordination of Benefits Contractor's trained staff will help you with your general Medicare COB and MSP questions. Customer Service Representatives are available to provide you with quality service Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines:1-800-999-1118 or TTY/TDD: 1-800-318-8782 for the hearing and speech impaired. The COBC EDI Department may be reached directly at 646-458-6740.

Please visit the COB Web page on the CMS Web site at www.cms.hhs.gov/COBGeneralInformation/.

12.3 Contact Protocol for the Section 111 Data Exchange

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

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

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

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

13 Training and Education

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

- The Section 111 CMS Web page at www.cms.hhs.gov/MandatoryInsRep will contain links to all CMS publications regarding the MSP Mandatory Reporting Requirements under Section 111 of the MMSEA of 2007. In order to be notified via e-mail of updates to this page, click on the "For e-mail updates and notifications" link and add your e-mail address to the distribution list for these updates.
- CMS and the COBC will be conducting a series of teleconferences that will provide information regarding Section 111 reporting requirements. The schedule for these calls will be posted on the Section 111 Web page at www.cms.hhs.gov/MandatoryInsRep.
- CMS and the COBC will make available a curriculum of computer-based training (CBT) courses to Section 111 RREs. These courses will provide overviews of Medicare and MSP in addition to in-depth training on Section 111 reporting requirements, file transmission, file formats, and file processing. Instructions on how to sign up for these courses will be posted on www.cms.hhs.gov/MandatoryInsRep when available.

Appendix A – MSP File Specifications

Section 111 GHP MSP Input File

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

Section 111 GHP MSP Input File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
1.	HIC Number (HICN)	12	1-12	Alpha-Numeric	Active Covered Individual's/Beneficiary's Health Insurance Claim (Medicare ID) Number (HICN). **Required if SSN not provided**. **Required if the Active Covered Individual is under 45 years of age and is eligible for Medicare due to ESRD or a disability.** Populate with spaces if unavailable.
2.	Beneficiary Surname	6	13-18	Text	Active Covered Individual's/Beneficiary's Last Name – **Required**.
3.	Beneficiary First Initial	1	19-19	Alpha	Beneficiary's First Initial – **Required**.
4.	Beneficiary Date of Birth	8	20-27	Date	Beneficiary's DOB (CCYYMMDD) – **Required**.
5.	Beneficiary Sex Code	1	28-28	Numeric	Beneficiary's Sex – **Required**. Valid Values: 0 = Unknown 1 = Male 2 = Female
6.	DCN	15	29-43	Text	Document Control Number; assigned by the Section 111 GHP RRE. **Required**. Each record within the current file must have a unique DCN.
7.	Transaction Type	1	44-44	Numeric	Type of Transaction – **Required**. Valid Values: '0' = Add Record

Section 111 GHP MSP Input File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					'1' = Delete record '2' = Update/Change record
8.	Coverage Type	1	45-45	Alpha-Numeric	Type of Insurance – **Required**. Basic Reporting Option includes Hospital and/or Medical Coverage. Expanded Reporting Option includes all Coverage Types. Valid Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical (non-network Rx) 'W' = Comprehensive Coverage –Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Prescription Drug Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage –Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx) When reporting coverage under an HRA, use the code most applicable to the reimbursable services. For example, if the HRA covers only medical services, use a value of 'K'. If the HRA covers only non-network prescription drugs, use a value of 'Z'.

Section 111 GHP MSP Input File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
9.	Beneficiary Social Security Number	9	46-54	Numeric	Active Covered Individual's/Beneficiary's SSN – **Required if HICN not provided**. Populate with 9 spaces if unavailable.
10.	Effective Date	8	55-62	Date	Start Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). **Required**.
11.	Termination Date	8	63-70	Date	End Date of Covered Individual's GHP Coverage. CCYYMMDD, **Required**. ***Use all zeros if open-ended.***
12.	Relationship Code	2	71-72	Numeric	Covered Individual's Relationship to Policy Holder – **Required**. Valid values: '01' = Self; Covered Individual is Policy Holder or Subscriber '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other
13.	Policy Holder's First Name	9	73-81	Text	Employee or Subscriber's First name – **Required.**
14.	Policy Holder's Last Name	16	82-97	Text	Employee or Subscriber's Last Name – **Required**.
15.	Policy Holder's SSN	9	98-106	Numeric	Employee or Subscriber's SSN – **Required**.
16.	Employer Size	1	107	Numeric	Valid Values: '0' = 1 to 19 employees* '1' = 20 to 99 employees* '2' = 100 or more employees If no employer size is provided, the COBC will default this field to a value of '2'.

Section 111 GHP MSP Input File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					*Employer Size Rule for Multi-Employer Plans: If the employer is part of a multi-employer plan, this field should reflect the size of the **largest** employer in the plan. Enter '1' if employer has fewer than 20 full or part-time employees but is part of a multi-employer plan (a group of plans) and another employer in that group has 20 or more employees. Enter '2' if employer has fewer than 100 full or part-time employees but is part of a multi-employer plan where another employer in that group has 100 or more employees. Employer size must be calculated once per calendar year. Refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 for details on this calculation. **Required**.
17.	Group Policy Number	20	108-127	Text	Policy Number Assigned by GHP Payer. If no group number exists as in the case of a self-insured RRE, this field may be set to any valid text value as a default. For use when Coverage Type is V, Z, 4, 5, and 6.
18.	Individual Policy Number	17	128-144	Text	Individual Policy Number; GHP's unique individual identifier for the Active Covered Individual (beneficiary) reported on this record. For self-insured

Section 111 GHP MSP Input File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					RRE's, covered person's member ID or other unique ID used to identify individuals covered by the plan. **Required for Coverage Types V, Z, 4, 5, and 6**. **Required when submitting a record for the Small Employer Exception (SEE).**
19.	Employee Coverage Election	1	145	Numeric	Who the Policy Covers – **Required.** '1' = Policyholder/Subscriber Only. '2' = Policyholder/Subscriber & Family. '3' = Policyholder/Subscriber & Dependents, but not Spouse.
20.	Employee Status	1	146	Numeric	'1' = Active/Currently Employed during GHP effective period reported. '2' = Not Active/Not Currently Employed during GHP effective period reported. This value should only be used for individuals with ESRD. **Required**.
21.	Employer TIN	9	147-155	Numeric	Employer Tax Identification Number (EIN) – **Required**. A matching record must be (or have been) submitted on the TIN Reference File. For Taft-Hartley multiple employer/multi-employer plans (plans using an "hours bank" arrangement) covering individuals who routinely work for multiple employers in a single Section 111

Section 111 GHP MSP Input File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					reporting period, submit the plan sponsor TIN rather than the actual employer TIN.
22.	Insurer/TPA TIN	9	156-164	Numeric	Insurer/TPA Tax Identification Number for the RRE – **Required**. A matching record must be (or have been) submitted on the TIN Reference File. If the RRE is a TPA, report the TIN of the TPA entity. If the RRE is a self-insured employer/plan sponsor entity, then the TIN of the self-insured employer/plan sponsor RRE is to be used.
23.	National Health Plan	10	165-174	Filler	National Health Plan Identifier – (Future Use). **Fill with spaces**.
24.	Rx Insured ID Number	20	175-194	Text	Insured's Identification Number for prescription drug coverage. Applies to drug coverage information reported when using the Expanded Reporting Option. **Required for Coverage Types U, W, X, & Y.**
25.	Rx Group Number	15	195-209	Text	Group Number for prescription drug coverage. Applies to drug coverage information reported when using the Expanded Reporting Option. For use when Coverage Type is V, Z, 4, 5, and 6.
26.	Rx PCN	10	210-219	Text	Rx Processor Control Number. Applies to drug coverage information reported when using the Expanded Reporting Option.

Section 111 GHP MSP Input File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					Required if available.
27.	Rx BIN Number	6	220-225	Text	Benefit Identification Number for Rx processing. Applies to drug coverage information reported when using the Expanded Reporting Option. **Required for Coverage Types U, W, X, & Y.**
28.	Rx Toll Free Number	18	226- 243	Text plus "(" and ")"	Prescription Drug/Pharmacy Benefit Information Toll Free Number. Applies to drug coverage information reported when using the Expanded Reporting Option.
29.	Person Code	3	244-246	Text	Person code the plan uses to identify specific individuals on a policy. The values are established by the insurer. May also known as a Dependent Code.
30.	Reserved	10	247-256	Alpha-Numeric	Reserved for COBC use. **Fill with spaces only.**
31.	Reserved	5	257-261	Alpha-Numeric	Reserved for COBC use. **Fill with spaces only.**
32.	Small Employer Exception HICN	12	262-273	Alpha-Numeric	Beneficiary's Health Insurance Claim Number if exception has been approved for a small employer. Fill with spaces if there is no approval.
33.	Filler	152	274-425	Alpha-Numeric	Unused Field. **Fill with spaces only.**

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

Section 111 GHP MSP TIN Reference File

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

Section 111 GHP MSP TIN Reference File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
1.	TIN	9	1-9	Numeric	Tax identification number of the entity, or cross-reference number to TIN field in the detail records. Must be unique – only one record per TIN will be processed and saved by the COBC. If multiple records for the same TIN are submitted on the TIN Reference File, only the information for the last record will be used. Corresponds to either Field 21 or 22 of the MSP Input File. The TIN indicator field identifies which has been used. **Required.**
2.	Name	32	10-41	Text	Name of the entity. If the TIN on this record reflects a plan sponsor of a Taft-Hartley multi-employer plan, then place the notation “(PS)” after the name of the plan sponsor in this field. **Required.**

Section 111 GHP MSP TIN Reference File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
3.	Address Line 1	32	42-73	Text	Address Line 1. The mailing address associated with each TIN should be the address to which health care insurance coordination of benefits issues should be directed. This mailing address will help CMS and others to direct correspondence to the most appropriate contact at the GHP responsible reporting entity, employer, or plan sponsor. **Required.**
4.	Address Line 2	32	74-105	Text	Address Line 2.
5.	City	15	106-120	Text	City. **Required.**
6.	State	2	121-122	Alpha	State – Must be a valid USPS state abbreviation. **Required.**
7.	Zip Code	9	123-131	Alpha-Numeric	Zip Code. **First 5 positions required.**
8.	TIN Indicator	1	132	Alpha	Used to indicate whether the TIN is for an insurer/TPA or employer. Values: E = The TIN field contains a valid TIN (EIN) for an Employer. I = The TIN field contains a valid TIN for an Insurer/TPA. Y = The TIN field contains a "pseudo-TIN" for an employer. Valid employer TIN/EIN is not available. **Required.** *If a "pseudo-TIN" number is contained in the TIN field place a*

Section 111 GHP MSP TIN Reference File Detail Record – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					value of 'Y' in this field to indicate that the TIN field is only to be used as a cross-reference to the name/address fields. The TIN field does not contain an actual TIN. A value of 'Y' will not be accepted after 1/1/2010.
9.	Filler	293	133-425	Text	Future use – **Fill with spaces**.

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

Section 111 GHP MSP Response File

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

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

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
6.	Beneficiary Sex Code	1	32	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Field will contain either the value supplied or the **corrected** value from COBC database.
7.	COBC DCN	15	33-47	Document Control Number assigned by the COBC. COBC supplied.
8.	Disposition Code	2	48-49	Response Disposition Code from COBC (via the Medicare CWF). See GHP Disposition Code Table for values.
9.	Transaction Type	1	50	Type of Transaction: '0' = Add Record '1' = Delete record '2' = Update record Transaction Type applied by COBC.
10.	Reason for Medicare Entitlement	1	51	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Value returned if individual is entitled. COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
11.	Coverage Type (insurer type/policy type)	1	52	Type of Insurance: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only - network Rx 'V' = Drug with Major Medical - non-network Rx 'W' = Comprehensive Coverage - Hosp/Med/Drug - network Rx 'X' = Hospital and Drug - network Rx 'Y' = Medical and Drug - network Rx 'Z' = Health Reimbursement Account - non-network Rx '4' = Comprehensive Coverage - Hosp/Med/Drug - non-network Rx '5' = Hospital and Drug - non-network Rx '6' = Medical and Drug - non-network Rx Field will contain value supplied on input.
12.	Insurer Name	32	53-84	Insurer name. Field will contain value supplied on TIN Reference File.
13.	Insurer Address 1	32	85-116	Insurer's Address Line 1. Field will contain value supplied on TIN Reference File.
14.	Insurer Address 2	32	117-148	Insurer's Address Line 2. Field will contain value supplied on TIN Reference File.
15.	Insurer City	15	149-163	Insurer's City. Field will contain value supplied on TIN Reference File.
16.	Insurer State	2	164-165	Insurer's State. Field will contain value supplied on TIN Reference File.
17.	Insurer Zip Code	9	166-174	Insurer's Zip Code. Field will contain value supplied on TIN Reference File.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
18.	Beneficiary SSN	9	175-183	Beneficiary's SSN. Field will contain either the SSN matched or the **corrected** SSN based on a HICN match.
19.	MSP Effective Date	8	184-191	Start date of Beneficiary's Primary GHP Coverage (CCYYMMDD). Effective date of the MSP occurrence posted on the Medicare CWF or MBD. Medicare is the secondary payer between the MSP Effective Date and MSP Termination Date. The MSP Effective Date may be set to a future date since Medicare entitlement/enrollment information is often established in advance. COBC supplied.
20.	MSP Termination Date	8	192-199	End date of Beneficiary's Primary GHP Coverage (CCYYMMDD). End date of the MSP occurrence posted on the Medicare CWF or MBD. *All zeros if open-ended. Medicare is the secondary payer between the MSP Effective Date and MSP Termination Date. COBC supplied.
21.	Relationship Code	2	200-201	Covered Individual's Relationship to Active Employee: '01' = Covered Individual is Active Employee '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other Default is '01'
22.	Policy Holder's First Name	9	202-210	Active Employee's First Name. Field will contain value supplied on input.
23.	Policy Holder's Last Name	16	211-226	Active Employee's Last Name. Field will contain value supplied on input.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
24.	Policy Holder's SSN	12	227-238	Active Employee's SSN. (9 digits, left justified.) Field will contain value supplied on input.
25.	Employer's Name	32	239-270	Employer Providing Coverage. Field will contain the value supplied on the TIN Reference File.
26.	Employer's Address Line 1	32	271-302	Employer's Street Address, line 1. Field will contain value supplied on TIN Reference File.
27.	Employer's Address Line 2	32	303-334	Employer's Street Address, line 2. Field will contain value supplied on TIN Reference File.
28.	Employer's City	15	335-349	Employer's City. Field will contain value supplied on TIN Reference File.
29.	Employer's State	2	350-351	Employer's State Code. Field will contain value supplied on TIN Reference File.
30.	Employer's Zip Code	9	352-360	Employer's Zip Code. Field will contain value supplied on TIN Reference File.
31.	Group Policy Number	20	361-380	Group Policy Number. Field will contain value supplied on input.
32.	Individual Policy Number	17	381-397	Individual's Policy Number. Field will contain value supplied on input.
33.	Last Query Date	8	398-405	Last Date Sent to Medicare CWF (Common Working File) (CCYYMMDD). COBC supplied.
34.	Current Disposition Code	2	406-407	Result from Most Current CWF Transmission (same as Field #8). COBC supplied.
35.	Current Disposition Date	8	408-415	Date of Most Current CWF Transmission (CCYYMMDD). COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
36.	Previous Disposition Code	2	416-417	Result from Previous CWF Transmission. COBC supplied.
37.	Previous Disposition Date	8	418-425	Date of Previous CWF Transmission (CCYYMMDD). COBC supplied.
38.	First Disposition Code	2	426-427	Result from First CWF Transmission. COBC supplied.
39.	First Disposition Date	8	428-435	Date of First CWF Transmission (CCYYMMDD). COBC supplied.
40.	Error Code 1	4	436-439	SP Error Code 1 See SP Error Code Table for values. COBC or CWF supplied.
41.	Error Code 2	4	440-443	SP Error Code 2 See SP Error Code Table for values. COBC or CWF supplied.
42.	Error Code 3	4	444-447	SP Error Code 3 See SP Error Code Table for values. COBC or CWF supplied.
43.	Error Code 4	4	448-451	SP Error Code 4 See SP Error Code Table for values. COBC or CWF supplied.
44.	Split Entitlement Indicator	1	452	Entitlement Split Indicator: ‘Y’ = yes ‘N’ or blank = no COBC supplied.
45.	Original Reason for Medicare Entitlement	1	453	Original Reason for Medicare Entitlement: ‘A’ = Aged ‘B’ = ESRD ‘G’ = Disabled COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
46.	Original Coverage Effective Date	8	454-461	The original GHP coverage effective date sent. This gets populated if a SP31 error occurs (CCYYMMDD). Field will be the value supplied on input.
47.	Original Coverage Termination Date*	8	462-469	The original GHP coverage termination date sent. This gets populated if a SP32 error occurs (CCYYMMDD). Field will be the value supplied on input. *All zeros if open-ended.
48.	RRE Assigned DCN	15	470-484	The Document Control Number assigned by the Section 111 GHP responsible reporting entity. It is moved here so we can provide our own unique COBC DCN in Field 7. Field will be the value supplied on input.
49.	Current Medicare Part A Effective Date	8	485-492	Effective Date of Medicare Part A Coverage (CCYYMMDD). COBC supplied.
50.	Current Medicare Part A Termination Date*	8	493-500	Termination Date of Medicare Part A Coverage (CCYYMMDD). COBC supplied. * All zeros if open-ended.
51.	Current Medicare Part B Effective Date	8	501-508	Effective Date of Medicare Part B Coverage (CCYYMMDD). COBC supplied.
52.	Current Medicare Part B Termination Date*	8	509-516	Termination Date of Medicare Part B Coverage (CCYYMMDD). COBC supplied. * All zeros if open-ended.
53.	Medicare Beneficiary Date of Death	8	517-524	Medicare Beneficiary Date of Death (CCYYMMDD). COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
54.	Current Medicare Part C Plan Contractor Number	5	525-529	Contractor Number of the current Medicare Part C Plan in which the beneficiary is enrolled. COBC supplied.
55.	Current Medicare Part C Plan Enrollment Date	8	530-537	Effective Date of coverage provided by current Medicare Part C Plan (CCYYMMDD). COBC supplied.
56.	Current Medicare Part C Plan Termination Date*	8	538-545	Termination Date of coverage provided by current Medicare Part C Plan (CCYYMMDD). COBC supplied. * All zeros if open-ended (i.e., if coverage is not terminated).
57.	Current Medicare Part D Plan Contractor Number	5	546-550	Contractor Number of the current Medicare Part D Plan in which the beneficiary is enrolled. COBC supplied. **Only provided to Expanded Reporting Option Section 111 reporters.**
58.	Current Part D Plan Enrollment Date	8	551-558	Effective Date of coverage provided by current Medicare Part D Plan (CCYYMMDD). COBC supplied. **Only provided to Expanded Reporting Option Section 111 reporters.**
59.	Current Medicare Part D Plan Termination Date*	8	559-566	Termination Date of coverage provided by current Medicare Part D Plan (CCYYMMDD). COBC supplied. * All zeros if open-ended (i.e., if coverage is not terminated). **Only provided to Expanded Reporting Option Section 111 reporters.**

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

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
70.	Rx Disposition Date	8	667-674	Date Rx Disposition Code was generated (CCYYMMDD). Code supplied by the COBC.
71.	Rx Error Code 1	4	675-678	Rx Error Code 1. Refer to GHP Rx Error Codes for values. COBC supplied.
72.	Rx Error Code 2	4	679-682	Rx Error Code 2. Refer to GHP Rx Error Codes for values. COBC supplied.
73.	Rx Error Code 3	4	683-686	Rx Error Code 3. Refer to GHP Rx Error Codes for values. COBC supplied.
74.	Rx Error Code 4	4	687-690	Rx Error Code 4. Refer to GHP Rx Error Codes for values. COBC supplied.
75.	ESRD Coordination Period Start Date	8	691-698	The start date for the 30-month coordination period in which GHP coverage is considered primary to Medicare because the beneficiary has a diagnosis of End Stage Renal Disease (CCYYMMDD). COBC supplied.
76.	ESRD Coordination Period End Date	8	699-706	The ending date for the 30-month coordination period in which GHP coverage is considered primary to Medicare because the beneficiary has a diagnosis of ESRD. A corresponding GHP coverage will no longer be considered an MSP record after the 30-month coordination period is terminated (CCYYMMDD). COBC supplied.
77.	First Dialysis Date	8	707-714	A date that indicates when the ESRD Dialysis first started (CCYYMMDD). Value will be zero if not applicable. COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
78.	ESRD Self-Training Date	8	715-722	A date that indicates when the beneficiary participated in ESRD Self - Care Training (CCYYMMDD). Value will be zero if not applicable. COBC supplied.
79.	Transplant Date – Most Recent	8	723-730	A date that indicates when a Kidney Transplant Operation occurred (CCYYMMDD). Value will be zero if not applicable. COBC supplied.
80.	Transplant Failure Date – Most Recent	8	731-738	A date that indicates when a Kidney Transplant failed. Last occurrence will be reported (CCYYMMDD). COBC supplied.
81.	SEE Response Code	2	739-740	Small Employer Exception (SEE) Response Code. (Spaces): Not applicable. SEE HICN not provided SA – SEE HICN accepted SN – SEE HICN not accepted SP – SEE HICN partially accepted (SEE HICN period does not cover entire MSP period) COBC supplied.
82.	Late Submission Indicator	1	741-741	Indicates that the submitted record was not received on schedule. The GHP effective date was more than 45 calendar days older than the start date of the scheduled Section 111 submission. COBC supplied.
83.	Compliance Flag 1	2	742-743	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. COBC supplied.
84.	Compliance Flag 2	2	744-745	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than one issue found. COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
85.	Compliance Flag 3	2	746-747	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than two issues found. COBC supplied.
86.	Compliance Flag 4	2	748-749	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than three issues found. COBC supplied.
87.	Compliance Flag 5	2	750-751	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than four issues found. COBC supplied.
88.	Compliance Flag 6	2	752-753	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than five issues found. COBC supplied.
89.	Compliance Flag 7	2	754-755	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than six issues found. COBC supplied.
90.	Compliance Flag 8	2	756-757	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than seven issues found. COBC supplied.
91.	Compliance Flag 9	2	758-759	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than eight issues found. COBC supplied.

Section 111 GHP MSP Response File Detail Record - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
92.	Compliance Flag 10	2	760-761	Alphanumeric code indicating compliance issue found with record. See Compliance Code Table for values. Used when more than nine issues found. COBC supplied.
93.	Filler	39	762-800	Unused field. Space filled.

Appendix B – Query Only HEW Input/Output File Specifications

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

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

Section 111 Query Only Input File Header Record – 38 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Header Indicator	2	1-2	Must be: 'H0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC (previously known as "Plan Number").
3.	Contractor Number	5	7-11	'11106' - Insurer '11105' – Employer '11112' – BCBS
4.	File Type	4	12-15	'IACT' – Inactive.
5.	Cycle Date	8	16-23	File date (CCYYMMDD).
6.	Filler	15	24-38	Unused Field.

Section 111 Query Only Input File Detail Record – 38 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number (if available).
2.	Last Name	6	13-18	Surname of Covered Individual.
3.	First Initial	1	19-19	First Initial of Covered Individual.
4.	DOB	8	20-27	Covered Individual's Date of Birth (CCYYMMDD).
5.	Sex Code	1	28-28	Covered Individual's Gender: 0 = Unknown 1 = Male 2 = Female
6.	SSN	9	29-37	Social Security Number of the Covered Individual.
7.	Filler	1	38	Filler.

Section 111 Query Only Input File Trailer Record – 38 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Trailer Indicator	2	1-2	Must be: 'T0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC (previously known as "Plan Number").
3.	Contractor Number	5	7-11	'11106' – Insurer '11105' – Employer '11112' – BCBS
4.	File Type	4	12-15	'IACT' – Inactive.
5.	Cycle Date	8	16-23	File date (CCYYMMDD).
6.	Record Count	9	24-32	Number of individual query records in this file. Do not include the Header and Trailer Records in the Record Count.
7.	Filler	6	33-38	Unused Field.

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

Section 111 Query Only Response File Record – 116 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number.
2.	Surname	6	13-18	Surname of Covered Individual.
3.	First Initial	1	19-19	First Initial of Covered Individual.
4.	DOB	8	20-27	Covered Individual's Date of Birth (CCYYMMDD).
5.	Sex Code	1	28-28	Covered Individual's Gender: 0 = Unknown 1 = Male 2 = Female
6.	SSN	9	29-37	Social Security Number of the Covered Individual.
7.	Entitlement Reason (Medicare reason)	1	38	Reason for Medicare Entitlement: A = Aged B = ESRD G = Disabled

Section 111 Query Only Response File Record – 116 Bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
8.	Current Medicare Part A Effective Date	8	39-46	Effective Date of Medicare Part A Coverage (CCYYMMDD).
9.	Current Medicare Part A Termination Date*	8	47-54	Termination Date of Medicare Part A Coverage (CCYYMMDD). * Blank if ongoing.
10.	Current Medicare Part B Effective Date	8	55-62	Effective Date of Medicare Part B Coverage (CCYYMMDD).
11.	Current Medicare Part B Termination Date*	8	63-70	Termination Date of Medicare Part B Coverage (CCYYMMDD). *Blank if ongoing.
12.	Medicare Beneficiary Date of Death	8	71-78	Beneficiary Date of Death (CCYYMMDD).
13.	Current Medicare Part C Plan Contractor Number	5	79-83	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. COBC supplied value.
14.	Current Medicare Part C Plan Enrollment Date	8	84-91	Effective Date of coverage provided by the beneficiary's current Medicare Part C Plan (CCYYMMDD).
15.	Current Medicare Part C Plan Termination Date*	8	92-99	Termination Date of the coverage provided by the beneficiary's current Medicare Part C Plan (CCYYMMDD). *Blank if ongoing.
16.	Disposition Code	2	100-101	01 = Record Accepted. Individual was found to be a Medicare Beneficiary. 51 = Individual was not found to be a Medicare beneficiary.
17.	CMS Document Control Number	15	102-116	VDSA ID (102-105), Julian Date (106-110), Sequence Counter (111-116).

Appendix C – Non-MSP File Specifications

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

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

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
1.	Beneficiary Social Security Number	9	1-9	Numeric	Inactive Covered Individual's Social Security Number. **Required if HICN field (below) not populated.** Fill with spaces if SSN is not available.
2.	HIC Number (HICN)	12	10-21	Alpha-Numeric	Inactive Covered Individual's Health Insurance Claim Number (Medicare ID number). **Required if SSN field (above) not populated.** Populate with spaces if not available.
3.	Covered Individual's Surname	6	22-27	Text	Inactive Covered Individual's Last Name – **Required**.
4.	Covered Individual's First Initial	1	28-28	Alpha	Inactive Covered Individual's First Initial – **Required.**
5.	Covered Individual's Middle Initial	1	29-29	Alpha	Inactive Covered Individual's Middle Initial – Optional.
6.	Covered Individual's Date of Birth	8	30-37	Numeric Date	Inactive Covered Individual's DOB (CCYYMMDD). **Required.**
7.	Covered Individual's Sex Code	1	38-38	Numeric	Inactive Covered Individual's Sex – Valid values: 0 = Unknown 1 = Male 2 = Female **Required.**

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
8.	Group Health Plan (GHP) Number	20	39-58	Text	GHP Number assigned by Payer for Action Type D, or, Unique Benefit Option Identifier assigned by Payer for Action Type S. For use with Action Types D and S. **Required for Action Type S when Coverage Type is V, Z, 4, 5 or 6.**
9.	Individual Policy Number	17	59-75	Text	Unique Identifier assigned by the payer to identify the covered individual. For use with Action Types D and S. **Required for Action Type D when Coverage Type is V, Z, 4, 5, and 6.**
10.	Effective Date	8	76-83	Numeric Date	Start Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). **Required for Action Types D and S.**
11.	Termination Date**	8	84-91	Numeric Date	End Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). For use with Action Types D and S. **Required for Action Type S.** **All zeros if open-ended.
12.	National Health Plan	10	92-101	Filler	National Health Plan Identifier. *(Future Use.)*
13.	Rx Insured ID Number	20	102-121	Text	Insured's Rx Identification Number. For use with Action Types D and S. **Required for Action Type D when Coverage Type = U, W, X, or Y.**

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
14.	Rx Group Number	15	122-136	Text	Rx Group Health Plan Number assigned by Payer for Action Type D, or, Unique Benefit Option Identifier, as defined by the RDS Center, and assigned by Payer for Action Type S. **Required with Action Type S when Coverage Type = U, W, X, or Y.**
15.	Rx PCN	10	137-146	Text	Rx Processor Control Number for Medicare Beneficiaries. For use with Action Type D and S when Coverage Type = U, W, X, or Y. **Required if available.**
16.	Rx BIN Number	6	147-152	Text	Benefit Identification Number for Rx processing - Medicare Beneficiaries. For use with Action Types D and S. **Required for Action Type D when Coverage Type = U, W, X, or Y.**
17.	Rx Toll Free Number	18	153-170	Text plus "(" and ")"	Toll Free Number Pharmacist can use to contact Rx Insurer. For use with Action Types D and S.
18.	Relationship Code	2	171-172	Numeric	Covered Individual's Relation to Policy Holder: Valid values: '01' = Covered Individual is Policy Holder '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other Or spaces. **Required for Action Types**

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
					D and S.
19.	DCN	15	173-187	Text	Document Control Number; assigned by the Section 111 GHP RRE. **Required.** Each record within the current file must have a unique DCN.
20.	Action Type	1	188	Alpha	Type of Record: Valid values: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record **Required.**
21	Transaction Type	1	189	Alpha-Numeric	Type of Transaction: Valid values: '0' = Add Record '1' = Delete record '2' = Update record Fill with space for Action Type N. **Required for Action Types D or S.**
22.	Coverage Type	1	190	Alpha-Numeric	Type of Coverage: 'U' - Drug Only - network Rx 'V' - Drug with Major Medical - non-network Rx 'W' - Comprehensive Coverage - Hosp/Med/Drug - network Rx 'X' - Hospital and Drug - network Rx 'Y' - Medical and Drug - network Rx 'Z' - Health Reimbursement Account - non-network Rx '4' = Comprehensive Coverage - Hosp/Med/Drug - non-network Rx '5' = Hospital and Drug - non-

Section 111 GHP Non-MSP Input File Detail Record – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
					network Rx '6' = Medical and Drug - non-network Rx **Required for Action Types D or S.**
23.	Person Code	3	191-193	Text	Person Code the plan uses to identify specific individuals on a policy. For use with Action Types D and S.
24.	Reserved	10	194-203	Internal use	Reserved for COB internal use; **Fill with spaces only.**
25.	Reserved	5	204-208	Internal use	Reserved for COBC internal use; **Fill with spaces only.**
26.	Reserved	1	209	Internal use	Reserved for COBC internal use; **Fill with spaces only.**
27.	Insurer Name	32	210-241	Text	Name of Insurance company providing Prescription Drug coverage. For use with Action Types D and S.
28.	Filler	59	242-300	Filler	Unused field.

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

Section 111 GHP Non-MSP Response File

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

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Filler	4	1-4	COBC use.
2.	SSN	9	5-13	Beneficiary's SSN. Included for Action Types D, S, and N. Field will contain either the SSN matched, or a **corrected** SSN based on a HICN match.
3.	HIC Number	12	14-25	Beneficiary's Medicare Health Insurance Claim Number (HICN). Included for Action Types D, S, and N. Field will contain either the HICN matched, or a **corrected** HICN based on a SSN match. Store this HICN in your system for future updates and deletes.
4.	Covered Individual's Surname	6	26-31	Beneficiary's Last Name. Included for Action Types D, S, and N. Field will contain either the name supplied or a **corrected** name from COBC database.
5.	Beneficiary First Initial	1	32	Beneficiary's First Initial. Included for Action Types D, S, and N. Field will contain either the value supplied or a **corrected** value from COBC database.
6.	Beneficiary Middle Initial	1	33	Beneficiary's Middle Initial. Included for Action Types D, S, and N. Field will contain the value supplied.
7.	Beneficiary Date of Birth	8	34-41	Beneficiary's DOB (CCYYMMDD). Included for Action Types D, S, and N. Field will contain either the value supplied or a **corrected** value from COBC database.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
8.	Beneficiary Sex Code	1	42	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Included for Action Types D, S, and N. Field will contain either the value supplied or a **corrected** value from COB database.
9.	Group Health Plan Number	20	43-62	GHP Number assigned by Payer for Action Type D, or, Unique Benefit Option Identifier, as defined by the RDS Center, and assigned by Payer for Action Type S. Included for Action Types D and S. Field will contain the value supplied on input.
10.	Individual Policy Number	17	63-79	Policy Number. Included for Action Types D and S. Field will contain the value supplied on input.
11.	Effective Date	8	80-87	Start Date of Beneficiary's Supplemental Drug Insurance Coverage (CCYYMMDD). Included for Action Types D and S. Field will contain the effective date applied to the supplemental drug coverage record.
12.	Termination Date	8	88-95	End Date of Beneficiary's Supplemental Drug Insurance Coverage (CCYYMMDD). **All zeros if open-ended or non-applicable. Included for Action Types D and S. Field will contain the term date applied to the supplemental drug coverage record.
13.	National Health Plan ID	10	96-105	National Health Plan Identifier. For Action Types D and S. (*Future Use*).

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
14.	Rx Insured ID Number	20	106-125	Insured's Rx Identification Number. Included for Action Types D and S. Field will contain the value supplied on input.
15.	Rx Group Number	15	126-140	Rx Group Health Plan Number assigned by payer for Action Type D or Unique Benefit Option Identifier assigned by payer for Action Type S. Included for Action Types D and S. Field will contain the value supplied on input.
16.	Rx PCN	10	141-150	Rx Processor Control Number. Included for Action Types D and S. Field will contain the value supplied on input.
17.	Rx BIN Number	6	151-156	Benefit Identification Number for Rx processing. Included for Action Types D and S. Field will contain the value supplied on input.
18.	Rx Toll Free Number	18	157-174	Pharmacy benefit Toll Free Number. Included for Action Types D and S. Field will contain the value supplied on input.
19.	Person Code	3	175-177	Person Code the Plan uses to identify specific individuals on a policy. Included for Action Types D and S. Defaults to '001' for D records if not provided on input.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
20.	Relationship Code	2	178-179	Beneficiary's Relationship to active employee: '01' = Beneficiary is Policy Holder '02' = Spouse or Common Law Spouse '03' = Child '20' – Domestic Partner '04' = Other Included for Action Types D and S. Field will contain the value supplied on input.
21.	RRE Assigned DCN	15	180-194	The Document Control Number assigned by the Section 111 GHP RRE. Included for Action Types D, S, and N. Field will contain the value supplied on input.
22.	COBC DCN	15	195-209	COBC Document Control Number. Included for Action Types D, S, and N. Field will contain the DCN created for this record by the COBC.
23.	Original Action Type	1	210	Type of Record: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for Action Types D, S, and N. Field will contain value supplied on input.
24.	Action Type	1	211	Type of Record applied by COBC (COBC may change an S action to a D if RDS rejects the record due to Part D enrollment): 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for Action Types D, S and N. COBC supplied value.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
25.	Transaction Type	1	212	Type of Transaction: '0' = Add Record '1' = Delete record '2' = Update record Included for Action Types D and S. Field will contain value supplied on input.
26.	Coverage Type	1	213	Type of Coverage: 'U' = Drug Only - network Rx 'V' = Drug with Major Medical - non-network Rx 'W' = Comprehensive Coverage - Hosp/Med/Drug - network Rx 'X' = Hospital and Drug - network Rx 'Y' = Medical and Drug - network Rx 'Z' = Health Reimbursement Account - non-network Rx '4' = Comprehensive Coverage - Hosp/Med/Drug - non-network Rx '5' = Hospital and Drug - non-network Rx '6' = Medical and Drug - non-network Rx Included for Action Types D and S. Field will contain the value supplied on input.
27.	Filler	1	214	Unused Field.
28.	Reason for Medicare Entitlement	1	215	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Included for Action Types D and N. COBC-supplied value.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
29.	S Disposition Code	2	216-217	Cross-walked result from RDS processing to COBC disposition codes. Included for records submitted with 'S' Action Type. RDS-supplied value converted to Section 111 GHP specific S Disposition Code. Refer to Field 53 (RDS Reason Code) and Field 54 (RDS Determination Indicator) for actual codes supplied by the RDS Center.
30.	S Disposition Date	8	218-225	Date S Disposition determined (CCYYMMDD). Included for records with an original S Action Type. RDS Center supplied value.
31.	Current Medicare Part A Effective Date	8	226-233	Effective Date of Medicare Part A Coverage (CCYYMMDD). Included for all Action Types. COBC supplied value.
32.	Current Medicare Part A Termination Date*	8	234-241	Termination Date of Medicare Part A Coverage (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.
33.	Current Medicare Part B Effective Date	8	242-249	Effective Date of Medicare Part B Coverage (CCYYMMDD). Included for all Action Types. COBC supplied value.
34.	Current Medicare Part B Termination Date*	8	250-257	Termination Date of Medicare Part B Coverage (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
35.	Part D Eligibility Start Date	8	258-265	Earliest date that beneficiary is eligible to enroll in Part D – Refer to Field 42 for the Part D Plan Enrollment Date (CCYYMMDD). Included for all Action Types. COBC supplied value.
36.	Part D Eligibility Stop Date*	8	266-273	Date the beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 43 for the Part D Plan Termination Date (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.
37.	Medicare Beneficiary Date of Death*	8	274-281	Medicare Beneficiary Date of Death (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if not applicable.
38.	Current Medicare Part C Plan Contractor Number	5	282-286	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. Included for all Action Types. COBC supplied value.
39.	Current Medicare Part C Plan Enrollment Date	8	287-294	Effective Date of coverage provided by the Beneficiary's current Medicare Part C Plan (CCYYMMDD). Included for all Action Types. COBC supplied value.
40.	Current Medicare Part C Plan Termination Date*	8	295-302	Termination Date of the coverage provided by the Beneficiary's current Medicare Part C Plan (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
41.	Current Medicare Part D Plan Contractor Number	5	303-307	Contractor Number of the current Medicare Part D Plan in which the Beneficiary is enrolled. Included for all Action Types. COBC supplied value.
42.	Current Medicare Part D Plan Enrollment Date	8	308-315	Effective Date of coverage provided by the Current Medicare Part D Plan (CCYYMMDD). Included for all Action Types. COBC supplied value.
43.	Current Medicare Part D Plan Termination Date*	8	316-323	Termination Date of coverage provided by the current Medicare Part D Plan (CCYYMMDD). Included for all Action Types. COBC supplied value. * All zeros if open-ended or not applicable.
44.	Error Code 1	4	324-327	Error Code 1 – May contain SP or RX error codes from COBC or RDS processing if applicable. See SP and Rx Error Code Tables for values. COBC supplied value for D/N records. RDS supplied value for S records.
45.	Error Code 2	4	328-331	Error Code 2 – May contain SP or RX error codes from COBC or RDS processing if applicable. See SP and Rx Error Code Tables for values. COBC supplied value for D/N records. RDS supplied value for S records.
46.	Error Code 3	4	332-335	Error Code 3 – May contain SP or RX error codes from COBC or RDS processing if applicable. See SP and Rx Error Code Tables for values. COBC supplied value for D/N records. RDS supplied value for S records.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
47.	Error Code 4	4	336-339	Error Code 4 – May contain SP or RX error codes from COBC or RDS processing if applicable. See SP and Rx Error Code Tables for values. COBC supplied value for D/N records. RDS supplied value for S records.
48.	D/N Disposition Code	2	340-341	Result from processing of an Action Type D or N record. This will also be used to provide a disposition for D records converted from S records – in such case, the S Disposition (Field 30) will also be populated. See GHP Disposition Code Table for values. Code supplied by the COBC.
49.	D/N Disposition Date	8	342-349	Processing date associated with the D/N Disposition Code (CCYYMMDD). Supplied by the COBC.
50.	RDS Start Date	8	350-357	Start date for the RDS subsidy period (CCYYMMDD). RDS-supplied value.
51.	RDS End Date	8	358-365	End date for RDS subsidy period (CCYYMMDD). RDS-supplied value.
52.	RDS Split Indicator	1	366	Indicates multiple subsidy periods within the plan year. Expect multiple records. Values: 'Y' if applicable. Space if not applicable. RDS-supplied value.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
53.	RDS Reason Code*	2	367-368	Spaces = Accepted 01=Application deadline missed 02=Invalid Application Number 03=Invalid Last Name 04=Invalid First Name 05=Invalid Date of Birth 06=Invalid Gender 07=Invalid Coverage Effective Date 08= Invalid Coverage Termination Date 09= Invalid Benefit Option Identifier 10= Enrolled in Part D 11= Not eligible for Medicare 12= Beneficiary is deceased 13= Invalid HICN or SSN 14=Termination Date less than Effective Date 15= Missing Trailer Record 16= Not a valid Medicare beneficiary 17= No coverage period exists for delete transaction 18= Invalid Action Type 19= Invalid Relationship Code 20= Beneficiary attempted to enroll in Part D and received an initial rejection. 21= New Medicare information has been received – resend record. *RDS Center-supplied codes.
54.	RDS Determination Indicator	1	369	Y = Yes, the retiree qualifies for the RDS subsidy. N = No, the retiree does not qualify for the RDS subsidy. *This indicator may be blank on records in unsolicited RDS response files.* RDS supplied value.
55.	ESRD Coverage Period Effective Date	8	370-377	The date on which the beneficiary is entitled to Medicare in some part because of a diagnosis of End Stage Renal Disease (CCYYMMDD). Last coverage period will be reported if multiple coverage periods exist. Supplied by the COBC.

Section 111 GHP Non-MSP Response File Detail Record - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
56.	ESRD Coverage Period Term Date	8	378-385	The date on which the beneficiary is no longer entitled to Medicare under ESRD Provisions (CCYYMMDD). Last coverage period will be reported if multiple coverage periods exist. Supplied by the COBC.
57.	First Dialysis Date	8	386-393	A date that indicates when the beneficiary first started ESRD Dialysis (CCYYMMDD). Supplied by the COBC.
58.	ESRD Self-Training Date	8	394-401	A date that indicates when the beneficiary participated in ESRD Self Care Training (CCYYMMDD). Supplied by the COBC.
59.	Transplant Date – Most Recent	8	402-409	A date that indicates when a Kidney Transplant Operation Occurred (CCYYMMDD). Last occurrence will be reported. Supplied by the COBC.
60.	Transplant Failure Date – Most Recent	8	410-417	A date that indicates when a Kidney Transplant failed (CCYYMMDD). Last occurrence will be reported. Supplied by the COBC.
61.	Filler	83	418-500	Unused Field. Filled with spaces.

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

Appendix D – Disposition, Error and Compliance Codes

Section 111 GHP Disposition Codes

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

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

Section 111 GHP SP Error Codes

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

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

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

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

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

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

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

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

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

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

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

Section 111 GHP Rx Error Codes

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

Error Code	Error Description
RX 01	Missing RX ID
RX 02	Missing RX BIN
RX 03	Missing RX Group Number
RX 04	Missing Group Policy Number
RX 05	Missing Individual Policy Number
RX 06	Missing/Invalid Retiree Drug Subsidy Application Number
RX 07	Beneficiary does not have Part D enrollment
RX 09	Invalid Action Code
RX 10	Record not found for delete
RX 11	Record not found for update
RX 12	Invalid Supplemental Type

Section 111 SEE (Small Employer Exception) Response Codes

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

Section 111 Compliance Flag Codes

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

Appendix E – MMSEA Section 111 BASIS Request Attachment

MMSEA Section 111 BASIS Request

Section 111 Reporter ID: _____

Date: _____

Section 111 Reporter Company Name: _____

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

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

SECTION II: AUTHORIZATION

Administrative Contact Name: _____

Administrative Contact E-Mail Address: _____

Administrative Contact Phone Number: _____

_____

Administrative Contact Signature

SECTION III: FOR COBC USE ONLY

Date Received: _____

Date Completed: _____

Date Plan Notified: _____

Method of Notification: _____

Processor Name:_____

Processor Signature: _____ Date: _____

Appendix F – MMSEA Section 111 HTTPS/SFTP Incoming File Naming Conventions

Files sent to the Enterprise File Transfer Facility GENTRAN mailboxes at the CMS Data Center should follow the naming convention below.

File name IN ALL CAPITAL LETTERS

Example: GUID.RACFID.MIR.X.UNIQUEID.FILETYPE.W.ZIP

Incoming File Name Convention:

File Node	Description
GUID	7 character Alphanumeric user ID generated by the Individuals Authorized Access to CMS Computer Services (IACS).
RACFID	4-character RACF user ID. **Note: If you do not have RACF ID for the CMS Data Center, insert NONE.**
MIR	Always use the value of 'MIR' for Section 111 files.
X	Frequency of file transmission M – MONTHLY Q – QUARTERLY
UNIQUEID	This is the letter R followed by the last 7 digits of your Section 111 Reporter ID. If your Section 111 Reporter ID is 000001234 then this node should be R0001234.
FILETYPE	Code exactly as shown for the applications listed below:

	• MRMSP for MSP Input File • MRTIN for TIN Reference File • MRNMSP for Non-MSP Input File • MRQRY for Query Only Input File
W	Code T for Test Data Code P for Production Data
ZIP	Only used when file compression is used and automatically added to the file name by the ZIP application, e.g., WINZIP or PKZIP. Note: WINZIP version 9 or higher is required to support long file names.
. (Periods)	Delineators

GENTRAN Outgoing File Naming Conventions (GENTRAN Back to Section 111 Responsible Reporting Entity)

The filename created by the application will be sent unchanged to the mailbox. GENTRAN will then append a unique identifier to the end of the file. When downloading the file from your organizational mailbox, you may change the file name in accordance with your organizational naming requirements. Gentran file names are listed below. Please note the third or fourth node in the filename, which is represented as 'rrrrrrrr', will be unique for each business partner.

UNIQUEID = The letter R followed by the last 7 digits of your Section 111 Reporter ID. If your Section 111 Reporter ID is 000001234 then this node should be R0001234.
pn = Sequentially assigned number

Test Response Filenames

Description	Mailbox Filename
Dataset name for MSP Response File	**T.UNIQUEID.MRMSP.Dyymmdd.Thhmmsst.pn**
Dataset name for Non-MSP Response File	**T.UNIQUEID.MRNMSP.Dyymmdd.Thhmmsst.pn**
Dataset name for Query Only Response File	**T.UNIQUEID.MRQRY.Dyymmdd.Thhmmsst.pn**

Production Response Filenames

Description	Mailbox Filename
Dataset name for MSP Response File	**P.UNIQUEID.MRMSP.Dyymmdd.Thhmmsst.pn**
Dataset name for Non-MSP Response File	**P.UNIQUEID.MRNMSP.Dyymmdd.Thhmmsst.pn**
Dataset name for Query Only Response File	**P.UNIQUEID.MRQRY.Dyymmdd.Thhmmsst.pn**

HTTPS File Size Limitation

There is a HTTP file size limit of 1.0GB, with or without compression.

CRLF Considerations

The CRLF (carriage return line feed) characters will be handled by Gentran.

ZIP Utility Software

At the present time GENTRAN cannot support multiple files within a single compressed file name. However, it is recommended that files be compressed and can be sent with the .zip extension.

GENTRAN Access Requirements

To access GENTRAN, please use your GUID that was provided by the IACS system. This should be your 7-character user ID.

Section 111 Responsible Reporting Entities may only have **4 users associated with their mailboxes**. Designated users are identified by the reporting entity and approved by the COBC.

HTTPS GENTRAN Mailbox Access and System Requirements

Internet URL – https://gis.cms.hhs.gov:3443/mailbox

HTTP Screen Shot User Guides are available under the download section at http://www.cms.hhs.gov/COBAgreement/.

Trading Partner Firewall

Port 3443 is used for connectivity to the GENTRAN facility (do not use the typical Port 80 for HTTP or Port 443 for HTTPS).

Browser Requirements:

Microsoft Internet Explorer 5.x or later

CMS does recommend that EFT users/Business Partners use a Microsoft Operating Systems that is currently supported by Microsoft and at the appropriate Service Pack Levels.

To eliminate the HTTPS Security Pop-up after you have downloaded the GENTRAN Certificate, the end user may need to update his/her VeriSign Class 3 Certificate. Instructions are available from the CMMS Helpdesk at 1-800-927-8069.

FTP SSH Client GENTRAN Mailbox Access and System Requirements

CMS has experience with the Sterling FTP client. If you have another client that you would like to use, you just have to make sure it has SSH version 2.

To configure your client you will need the following information:

Host Name/IP Address: GIS.CMS.HHS.GOV

Port Number: 10022

Trading Partner Firewall

TCP Port 10022 for SFTP with SSH is used for the SFTP sessions.

Sterling FTP Client Minimum Requirements (Sterling Commerce)

Operating System	Requirements
UNIX	RAM 512MB
	OS AIX 5.3
	Solaris 9
	HPUX 11i
	Suse Linux 8.2
	Red Hat Linux 9
Microsoft Windows	RAM 512 MB
	OS Windows NT 4 SP6
	Windows 2000 Pro
	Windows XP SP1

Mailbox File Retentions

Section 111 files will be retained in your mailbox for up to 6 days, including weekends.

Appendix G – MMSEA Section 111 Statutory Language

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

SECTION 111 – MEDICARE SECONDARY PAYOR

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

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

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

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

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

(B) ENFORCEMENT-

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

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

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

(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

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

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

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

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

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

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

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

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

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) ENFORCEMENT-

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

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

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

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

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

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

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

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

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

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

Appendix H – MMSEA Section 111 Definitions and Reporting Responsibilities

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

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

THIRD PARTY ADMINISTRATOR (TPA)
For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), a TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of GHPs (as defined at 42 U.S.C. 1395y(b)(1)(A)(v)), the plan sponsor(s) or the plan insurer. A TPA may perform these services for, amongst other entities, self-insured employers, unions, associations, and insurers/underwriters of such GHPs. If a GHP is self-funded and self-administered for certain purposes but also has a TPA as defined in this paragraph, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(7)
Agents are NOT Responsible Reporting entities (RREs). However, for purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7), agents may submit reports on behalf of:

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

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

CMS provides information on the method of identifying agents for reporting purposes in Section 6.1.1.2 of this User Guide.