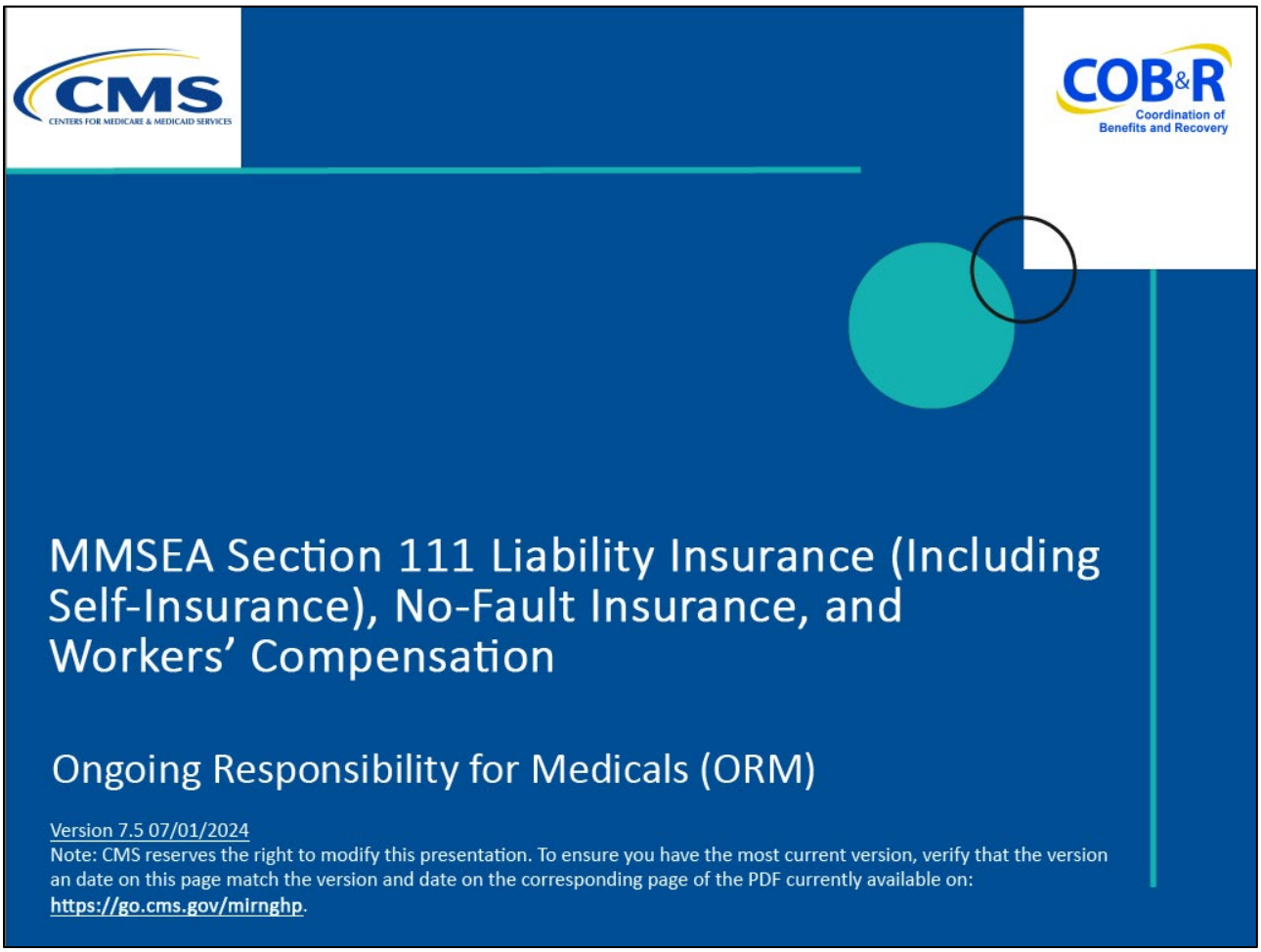
Ongoing Responsibility for Medicals (ORM) Introduction

Slide 1 of 34 - Ongoing Responsibility for Medicals (ORM) Introduction

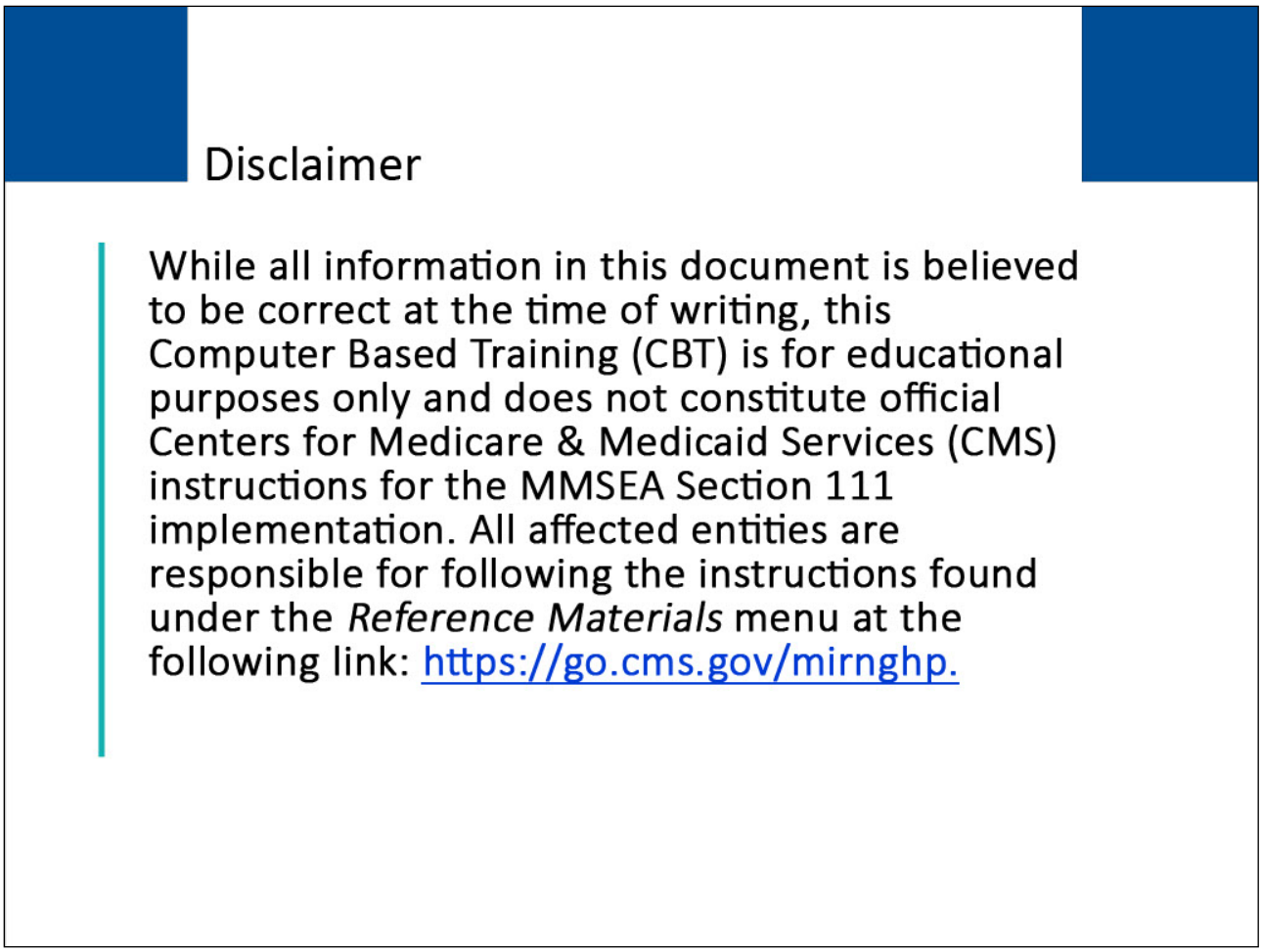


Slide notes

Welcome to the Ongoing Responsibility for Medicals (ORM) course.

Note: This module applies to Responsible Reporting Entities (RREs) that will be submitting Section 111 claim information via an electronic file submission as well as those RREs that will be submitting this information via Direct Data Entry (DDE).

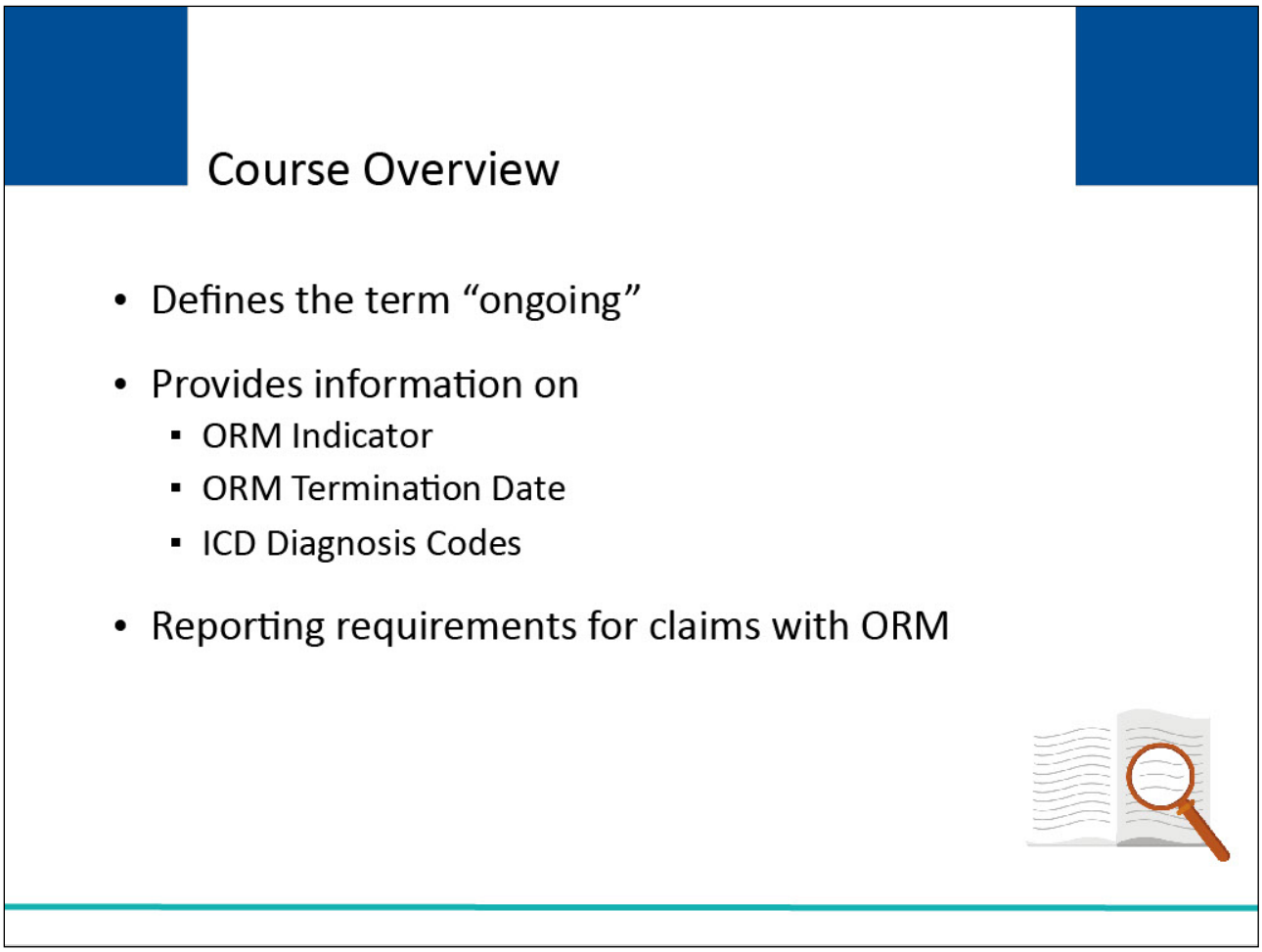
Slide 2 of 34 - Disclaimer



Slide notes

While all information in this document is believed to be correct at the time of writing, this Computer Based Training (CBT) is for educational purposes only and does not constitute official Centers for Medicare & Medicaid Services (CMS) instructions for the MMSEA Section 111 implementation. All affected entities are responsible for following the instructions found at the following link: CMS NGHP Website.

Slide 3 of 34 - Course Overview



Slide notes

This learning module begins by defining the term “ongoing” and providing information on some of the fields used in reporting ORM:

- ORM Indicator
- ORM Termination Date
- International Classification of Diseases (ICD) Diagnosis codes

It also clarifies what is meant by the assumption of ORM and discusses the reporting requirements for claims where ORM has been assumed.

Note: Liability insurance (including self-insurance), no-fault insurance, and workers’ compensation are sometimes collectively referred to as “non-group health plan” or “NGHP.” The term NGHP will be used in this CBT for ease of reference.

Slide 4 of 34 - PAID Act

PAID Act

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act also known as the PAID Act requiring that CMS provide Non-Group Health Plans with a Medicare beneficiary's Part C and Part D enrollment information for the past 3 years.

This information will be provided on the COBSW S111/MRA and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

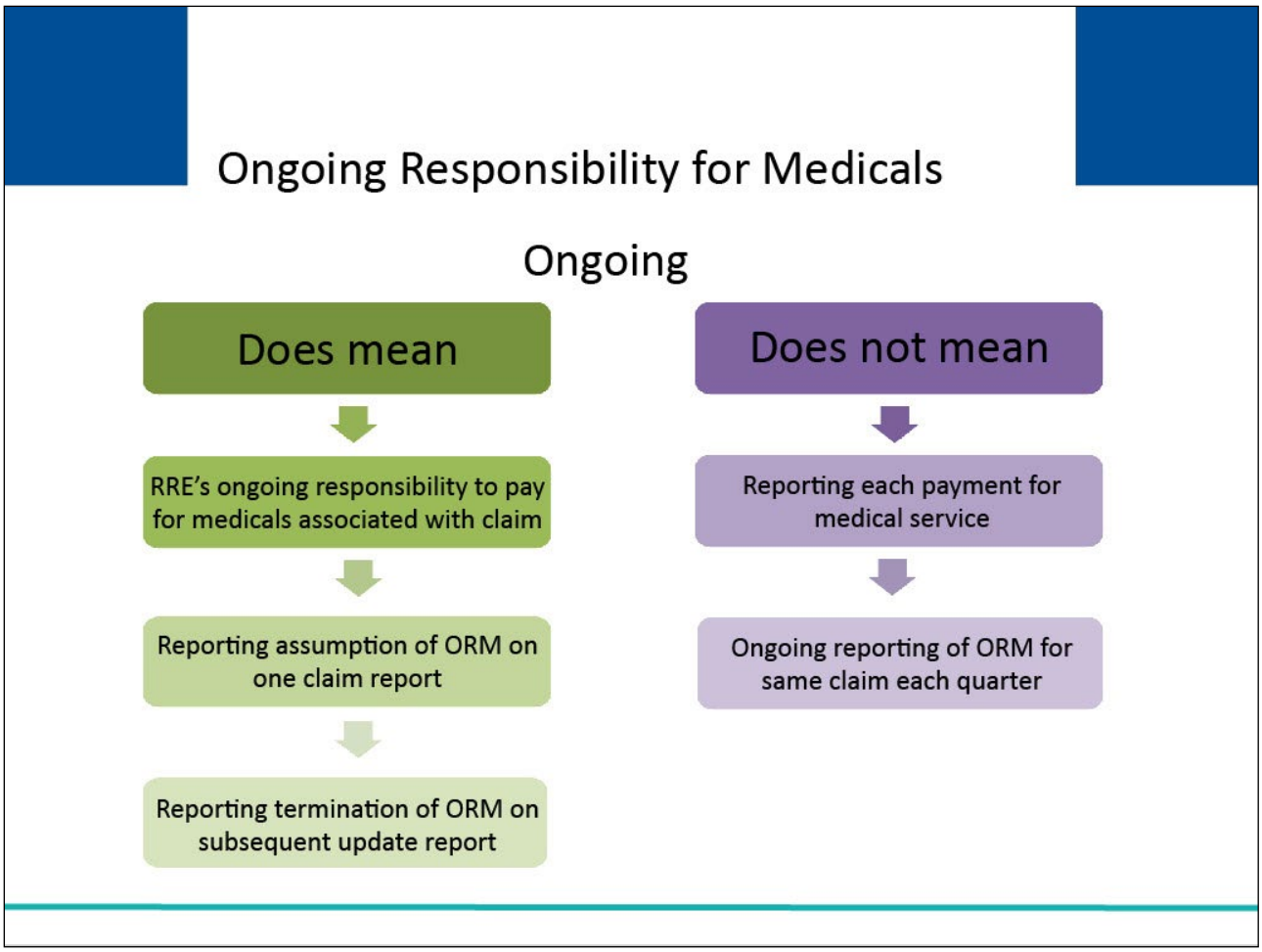
Slide notes

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act also known as the PAID Act requiring that CMS provide Non-Group Health Plans with a Medicare beneficiary's Part C and Part D enrollment information for the past three years.

This information will be provided on the S111/MRA and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

Note: To support the PAID Act, the Query Response File will be updated to include Contract Number, Contract Name, Plan Number, Coordination of Benefits (COB) Address, and Entitlement Dates for the last three years (up to 12 instances) of Part C and Part D coverage. The updates will also include the most recent Part A and Part B entitlement dates.

Slide 5 of 34 - Ongoing Responsibility for Medicals



Slide notes

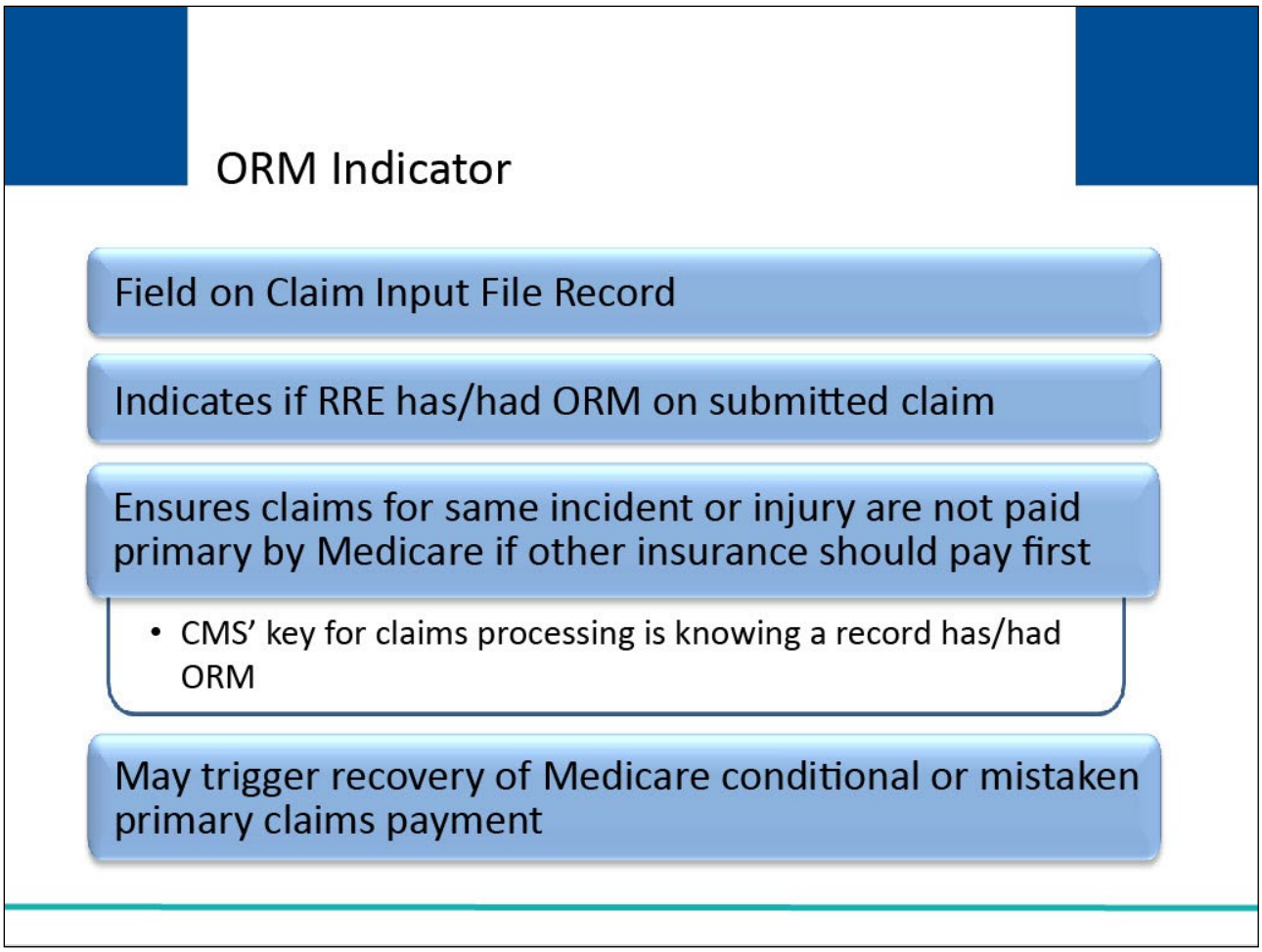
The reference to ongoing, in the term Ongoing Responsibility for Medicals, means the RRE's ongoing responsibility to pay for the injured party's/Medicare beneficiary's medicals associated with the claim.

For Section 111, this generally means the reporting of the assumption of ORM on one claim report and the termination of the ORM on a subsequent update report, where appropriate.

It does not mean the reporting of each payment for a medical service for the injured party, nor does it mean the ongoing reporting of ORM for the same claim each quarter.

Instead, it is a report of the fact that ORM has been assumed for a particular claim for a particular period of time.

Slide 6 of 34 - ORM Indicator



Slide notes

The ORM Indicator is a field on the Claim Input File Detail Record. It indicates if the RRE has or had ORM on the submitted claim.

The Benefits Coordination & Recovery Center (BCRC) posts these records for Medicare claims processing use, so that claims for the same incident or injury are checked and not paid primary by Medicare if there is other insurance that should pay first.

CMS' key for claims processing actions related to these records is knowing a record has or had ORM - hence, the ORM Indicator is key to Section 111 processing.

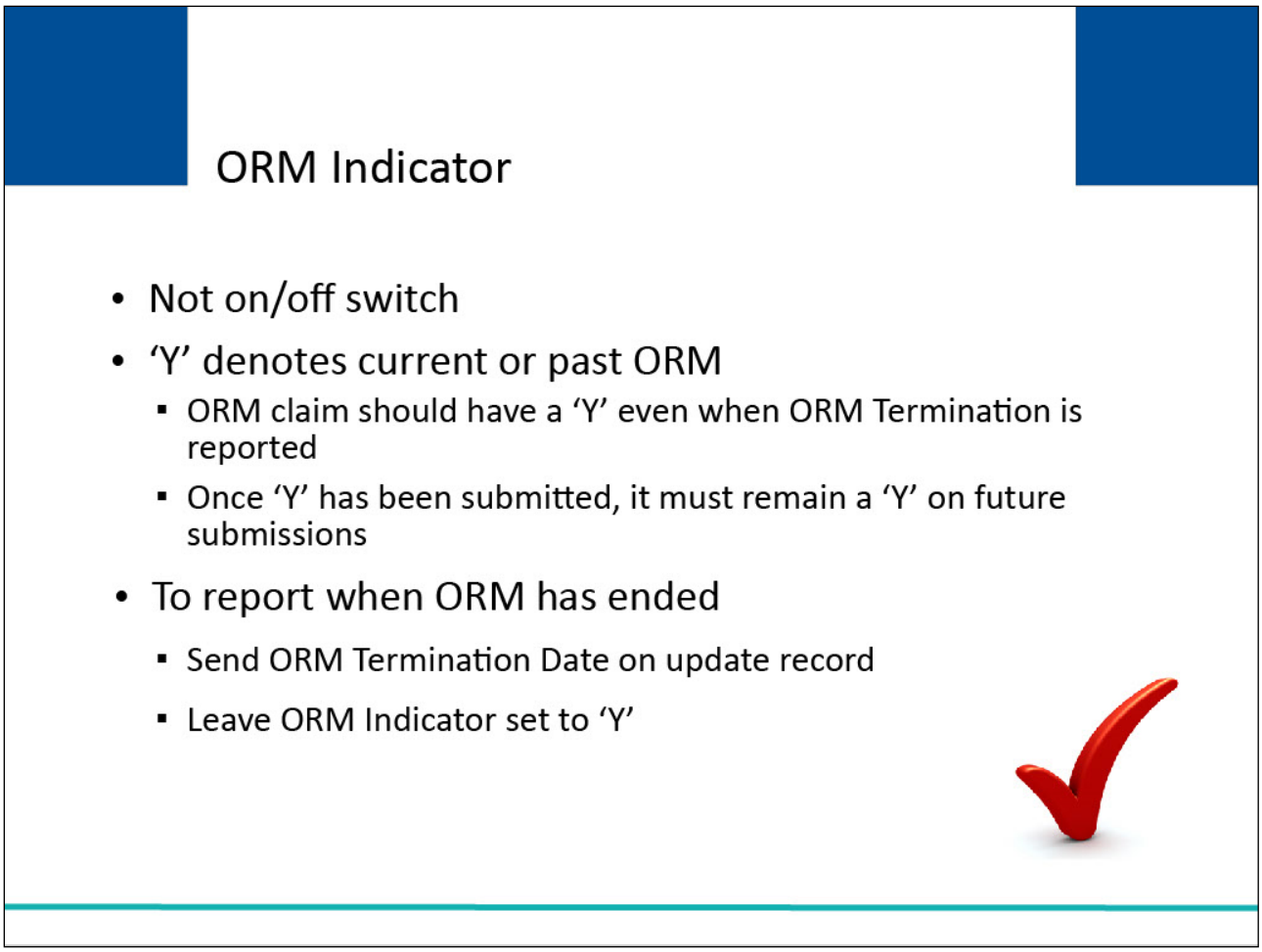
The ORM Indicator may also trigger Medicare recovery efforts. When ORM is indicated, the Commercial Repayment Center (CRC) will search Medicare records for claims paid by Medicare for medical services and supplies related to the beneficiary's reported illness or injury.

The claims search will include claims from the date of incident to the current date or the date ORM ended (ORM termination date).

If Medicare has made primary or conditional payment on claims related to the incident that should have been paid by other insurance, the CRC will pursue recovery from the insurer for the Medicare benefits paid.

For more information on Medicare recovery where the insurer is the identified debtor, see the NGHP Recovery page available at the following link: NGHP Recovery page.

Slide 7 of 34 - ORM Indicator



Slide notes

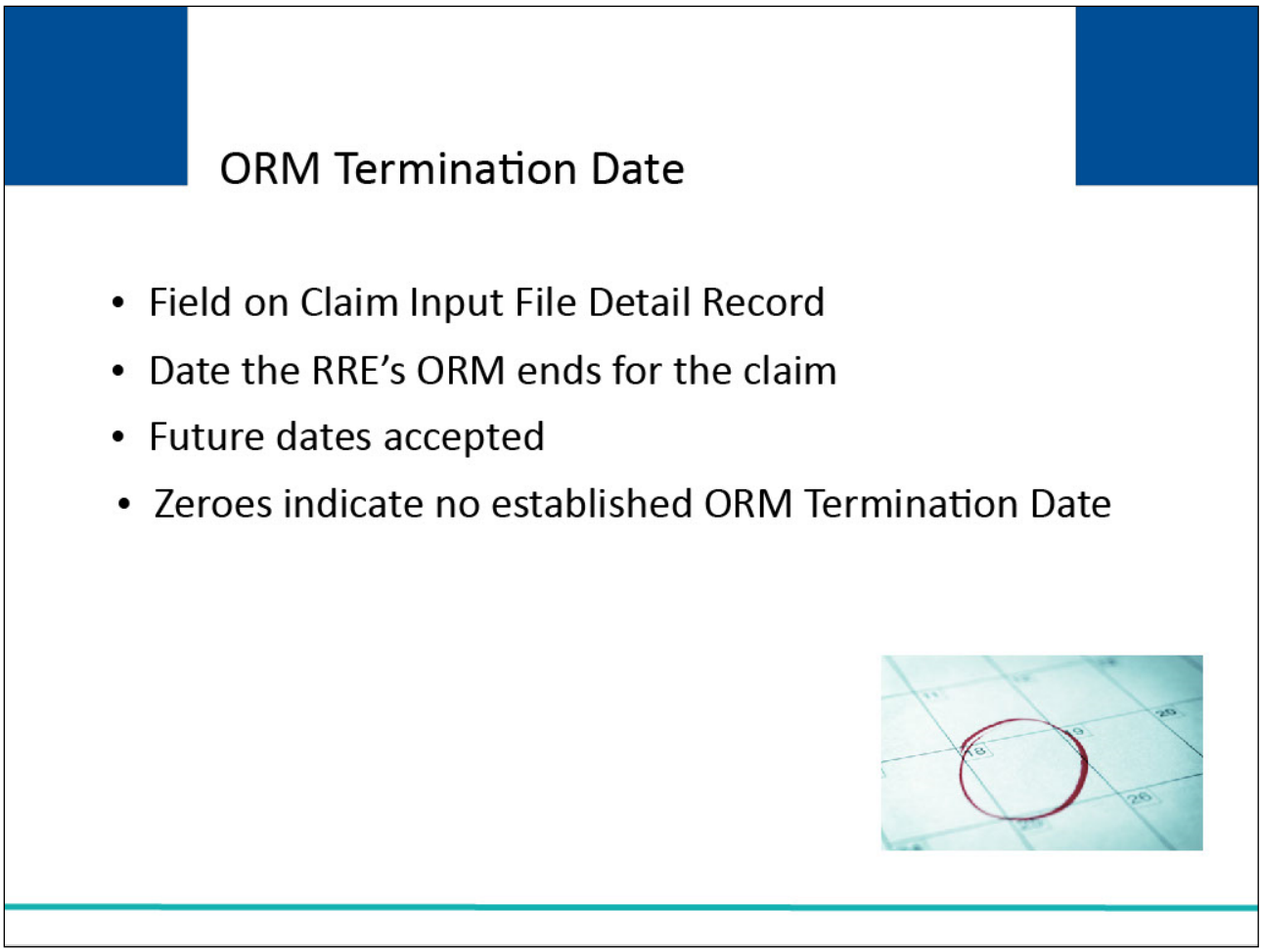
The ORM Indicator is not an on/off switch. A value of 'Y' denotes a claim that currently has or at some time had ORM. Therefore, if there is or ever was ORM, the indicator will always be set to 'Y'.

When reporting a claim with ORM, the ORM Indicator will always be submitted with a value of 'Y', even when an ORM Termination Date is submitted in the same or subsequent record.

Once a value of 'Y' has been submitted on a claim, it must remain 'Y' on future submissions, unless the RRE erroneously reported ORM and never had ORM.

To report when ORM has ended, the RRE sends an ORM Termination Date on an update record but leaves the ORM Indicator set to 'Y'. This will indicate that the RRE had ORM through the ORM Termination Date submitted.

Slide 8 of 34 - ORM Termination Date



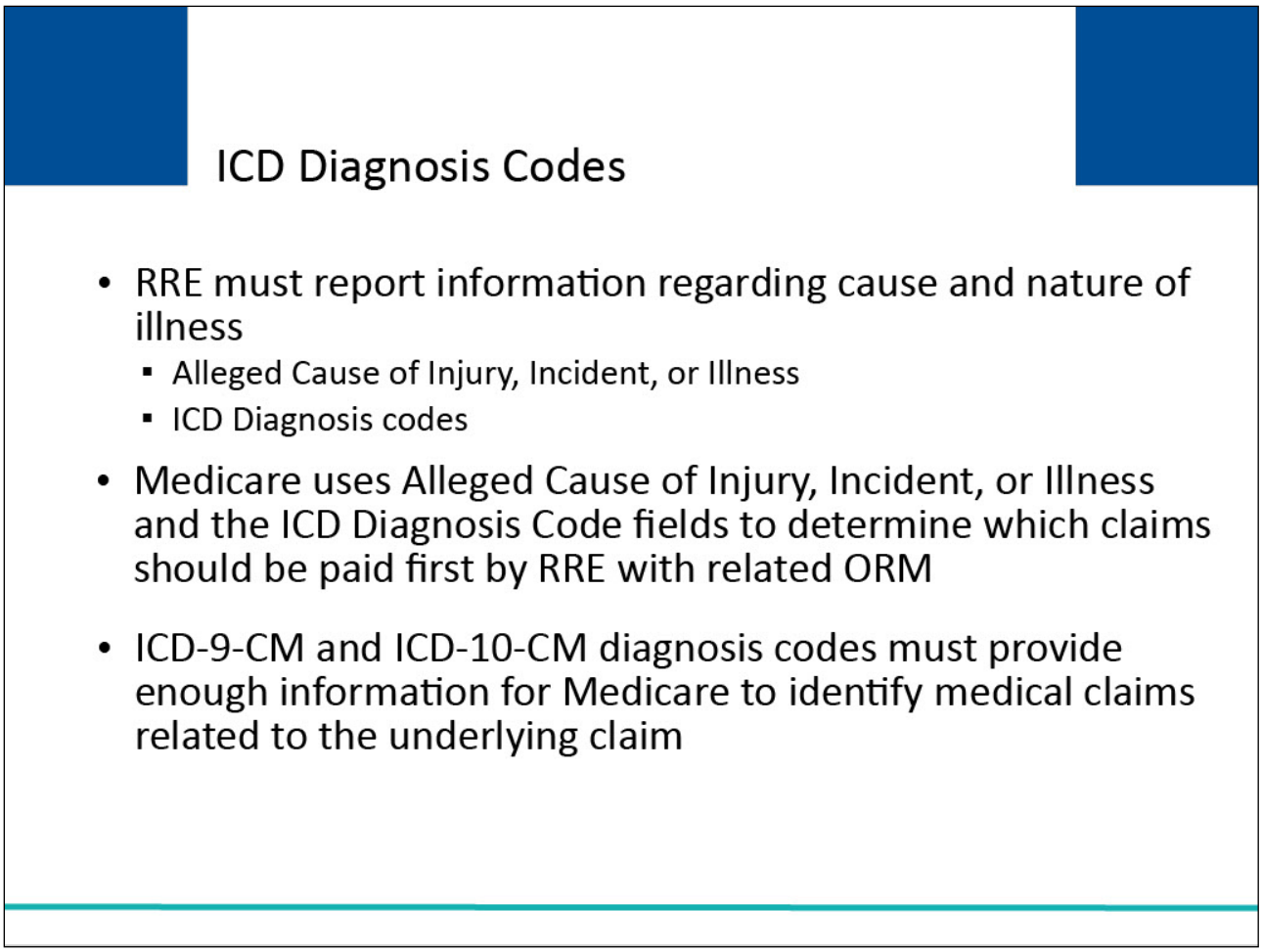
Slide notes

The ORM Termination Date is a field on the Claim Input File Detail Record. This is the date the RRE's ORM ends for the claim. Once the termination date is reported, the 'Y' reflects the existence of ORM prior to the termination date.

Future dates will be accepted in the ORM Termination Date field. A value of all zeroes in the ORM Termination Date field indicates that there is no established end date, as of yet, for the ORM. To address situations where Responsible Report Entities (RREs) can identify future ORM termination dates based on terms of the insurance contact, RREs can now enter a future Ongoing Responsibility for Medicals (ORM) Termination Date (Field 79) up to 75 years from the current date. A value of all zeroes in the ORM Termination Date field indicates that there is no established end date, as of yet, for the ORM.

Note: The guidance on determining the ORM termination date based on a physician statement has been clarified in the NGHP User Guide (Section 6.3.2).

Slide 9 of 34 - ICD Diagnosis Codes



Slide notes

When reporting ORM claims, it is critical to report information regarding the cause and nature of the illness, injury, or incident associated with the claim.

Medicare uses the information submitted in the Alleged Cause of Injury, Incident, or Illness (Field 15), and the ICD Diagnosis Codes (starting in Field 18) to determine what specific medical services claims, if submitted to Medicare, should be paid first by the RRE that has related ORM for the incident and considered only for secondary payment by Medicare.

The ICD-9-CM and ICD-10-CM (International Classification of Diseases, Ninth and Tenth Revision, Clinical Modification) diagnosis codes provided in these fields must provide enough information for Medicare to identify medical claims related to the underlying claim reported by the RRE.

When there is an active Medicare Secondary Payer Recovery Portal (MSPRP) account for the insurer/recovery agent TIN, Section 111 submitters may set Go Paperless options (i.e., choose to receive letters electronically or by mail) for the insurer and recovery agent address using the following new TIN Reference File fields (Appendix B):

- TIN/Office Code Paperless Indicator (Field 23)

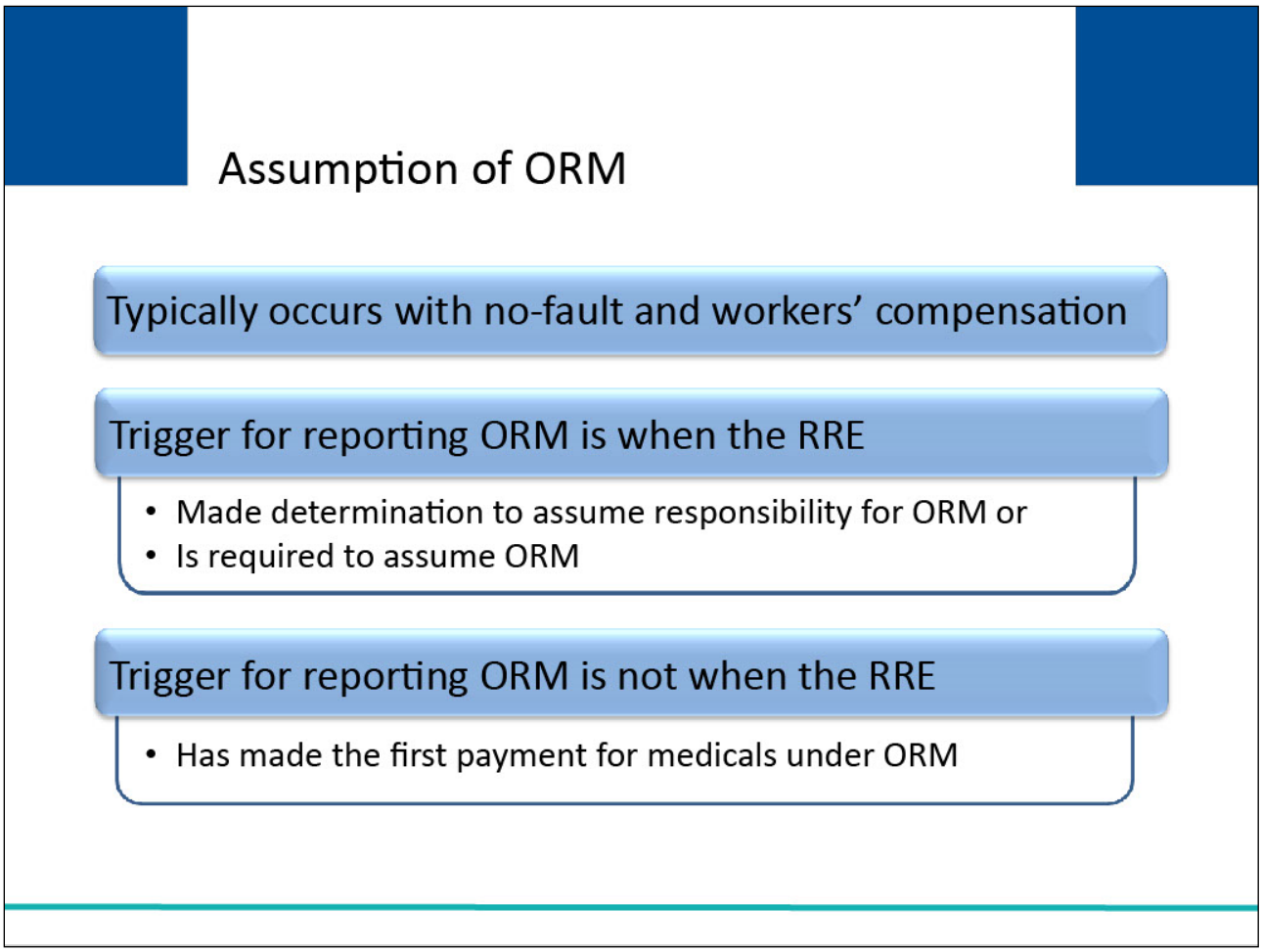
- Recovery Agent Paperless Indicator (Field 24)
- Recovery Agent TIN (Field 25)

There are also five new fields (Fields 48-52) returned for these entries on the TIN Reference Response File (Appendix D). Details on the use of these fields can be found in the ICD Diagnosis Code Requirements CBTs.

RREs will receive error code SP31 when submitting records with effective dates greater than 90 days prior to Medicare entitlement.

Note: Excel spreadsheets of the ICD-9/ICD-10 excluded and valid codes for FY 2023 are now available for download on CMS.gov at https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists

Slide 10 of 34 - Assumption of ORM

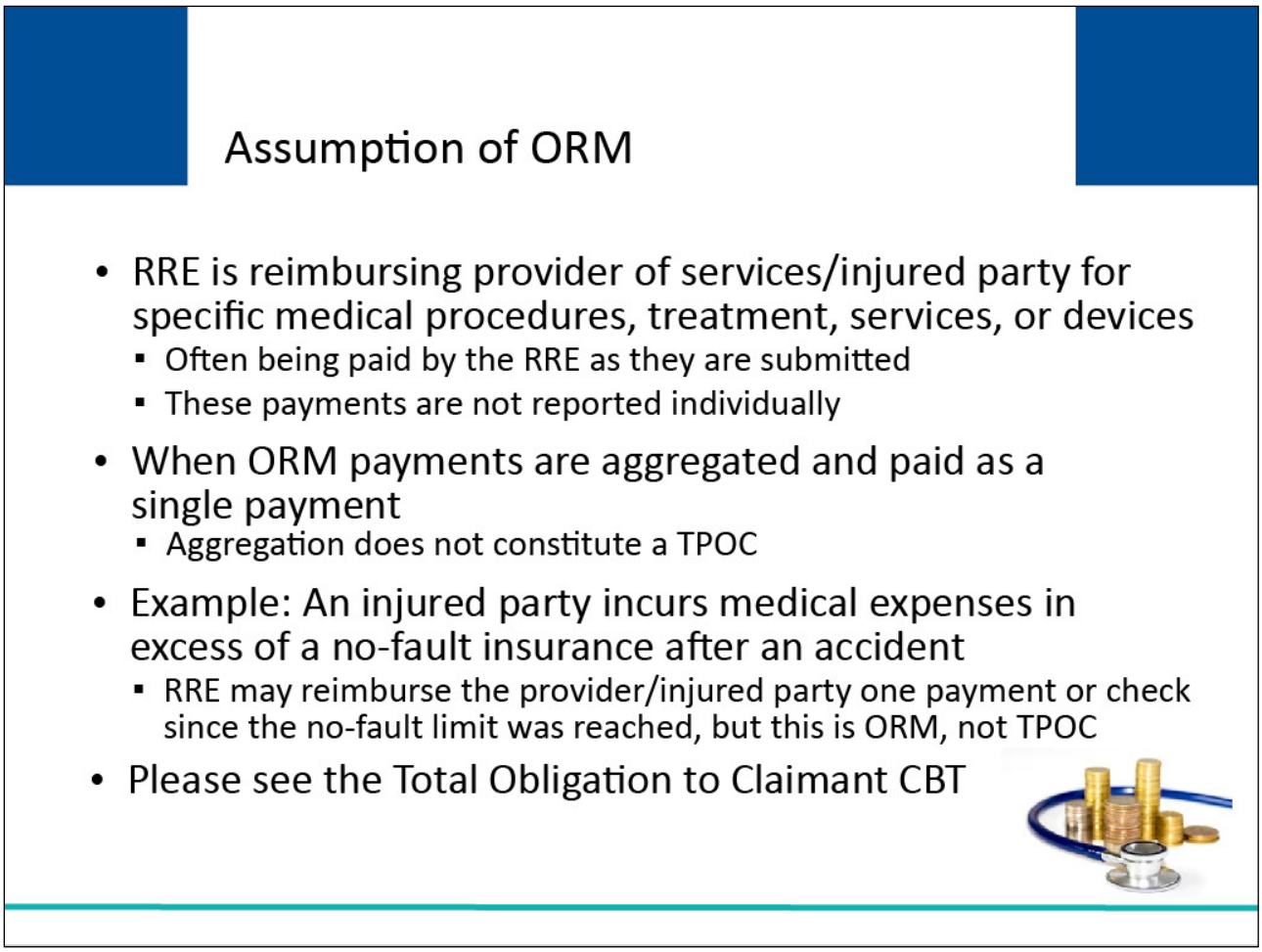


Slide notes

Assumption of ORM often applies to no-fault and workers' compensation claims but may occur in some circumstances related to liability insurance (including self-insurance).

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

Slide 11 of 34 - Assumption of ORM



Slide notes

If an RRE has assumed ORM, the RRE is reimbursing the provider of services (doctor, hospital, etc.) or injured party for specific medical procedures, treatment, services, or devices, such as a doctor's visit, surgery, or ambulance transport, etc.

These medicals are often being paid by the RRE as they are submitted by a provider or injured party. Payments like these are NOT reported individually under Section 111 as Total Payment Obligation to Claimant (TPOCs).

Even when ORM payments are aggregated and paid to a provider or injured party in a single payment, this aggregation does not constitute a TPOC just because it was paid in a "lump sum".

For example, an injured party might incur medical expenses in excess of a no-fault insurance (e.g., automobile personal injury protection (PIP) or Med Pay) shortly after an automobile accident.

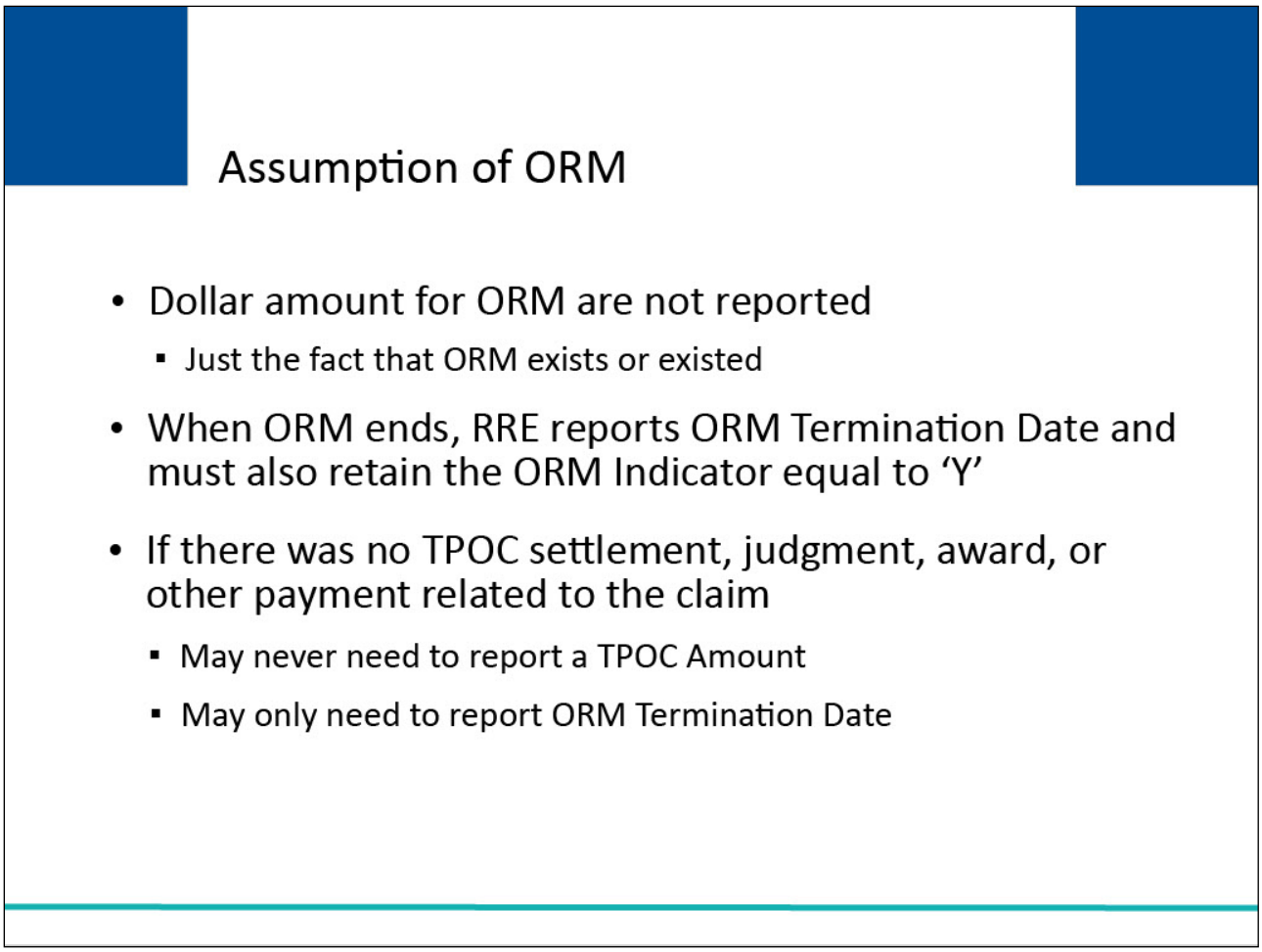
The RRE may reimburse the provider of these medical services or injured party via one payment or check since the no-fault limit was already reached, but the payment still reflects ORM, not a TPOC settlement, judgment, or award.

The RRE would not have paid these medical expenses without specific medical expenses being incurred by the injured party.

When considering the requirements for the Ongoing Responsibility for Medicals (ORM), remember, per current policy, that the dollar limit for No-Fault Insurance Limits (Field 61) represents a combined total of Med-Pay and Personal Injury Protection (PIP) (Section 6.7.1).

Please see the Total Payment Obligation to Claimant CBT for more information on this topic.

Slide 12 of 34 - Assumption of ORM



Slide notes

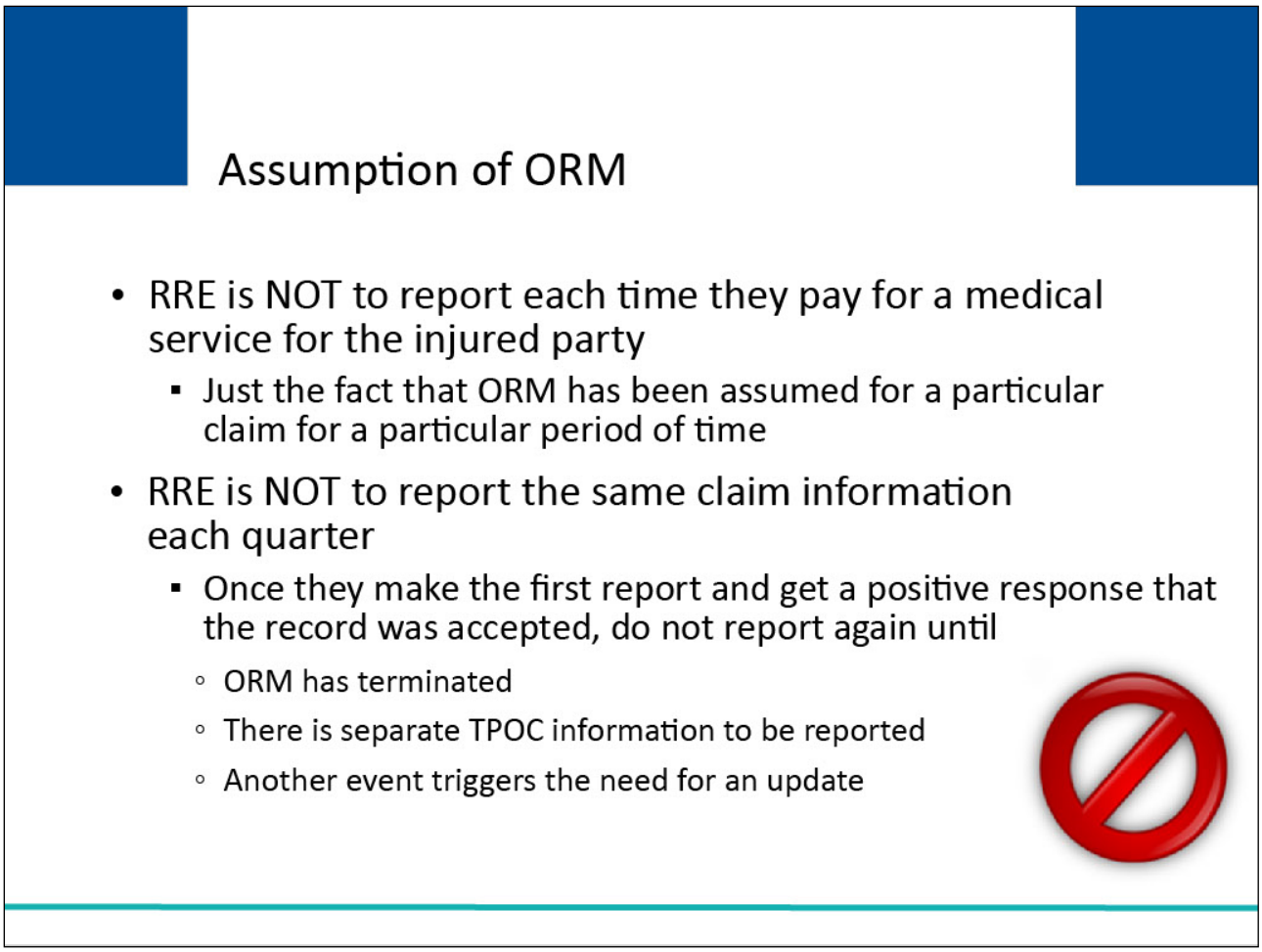
The dollar amounts for ORM are not reported, just the fact that ORM exists or existed.

When ORM ends (a no-fault limit is reached, the injured worker is healed, back to work and the RRE no longer has ORM, etc.), then the RRE reports an ORM Termination Date and must also retain/submit the ORM Indicator equal to 'Y'.

If there was no TPOC for a settlement, judgment, award, or other payment related to the claim (i.e., an actual settlement for medicals and/or lost wages, etc.), you may never need to report a TPOC Amount on a claim with ORM.

You may just need to send the ORM Termination Date.

Slide 13 of 34 - Assumption of ORM



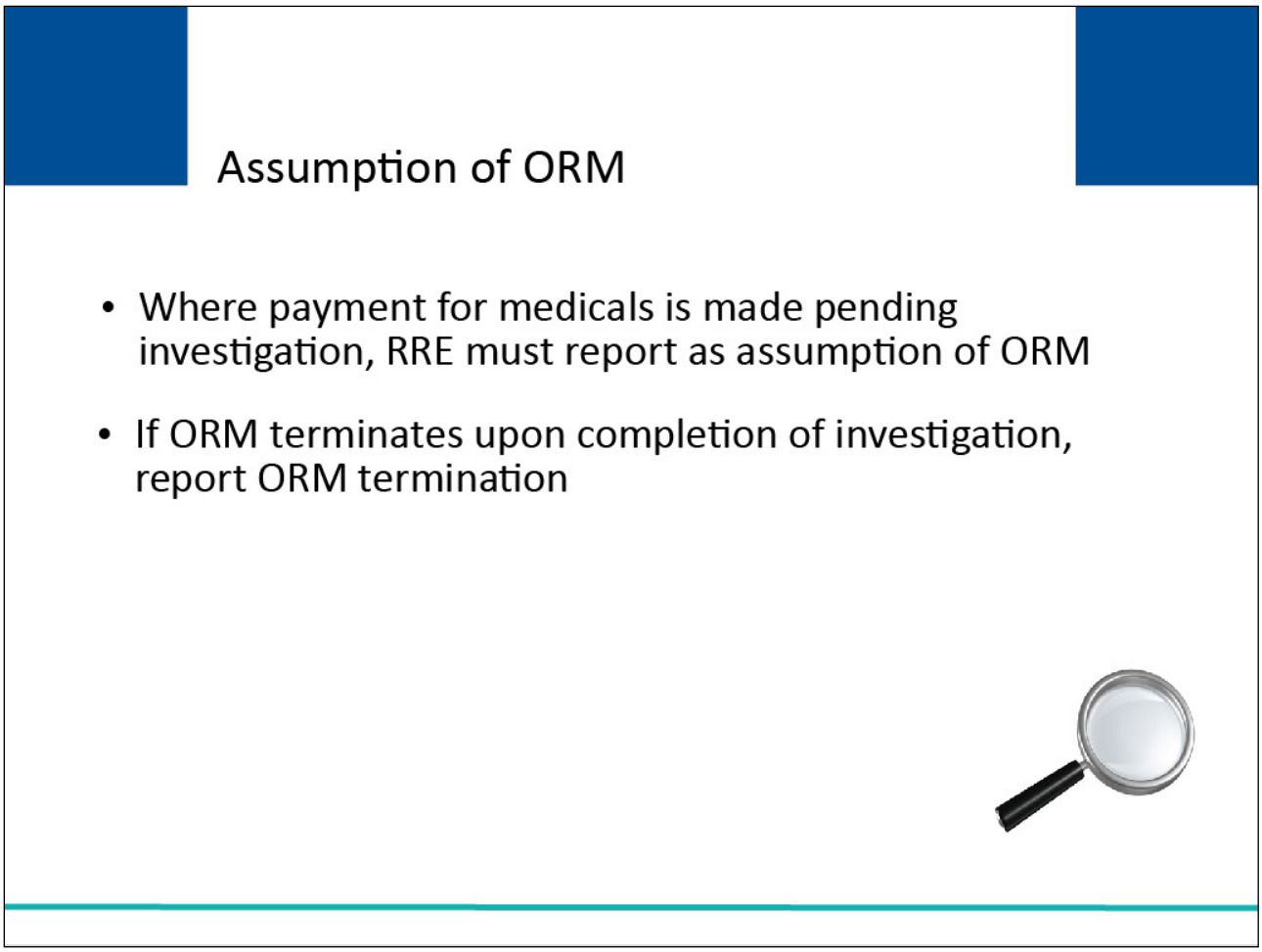
Slide notes

For claims with ORM, the RRE is NOT to report each time they pay for a medical service for the injured party.

The actual amounts paid for specific medical services under the assumption of ORM are not reported, just the fact that ORM has been assumed for a particular claim for a particular period of time.

In addition, RREs are NOT to report the same claim information each quarter. Once they make the first report and get a positive response that the record was accepted, they do not report again until the ORM has terminated, there is separate TPOC information to be reported, or another event occurs that triggers the need for an update.

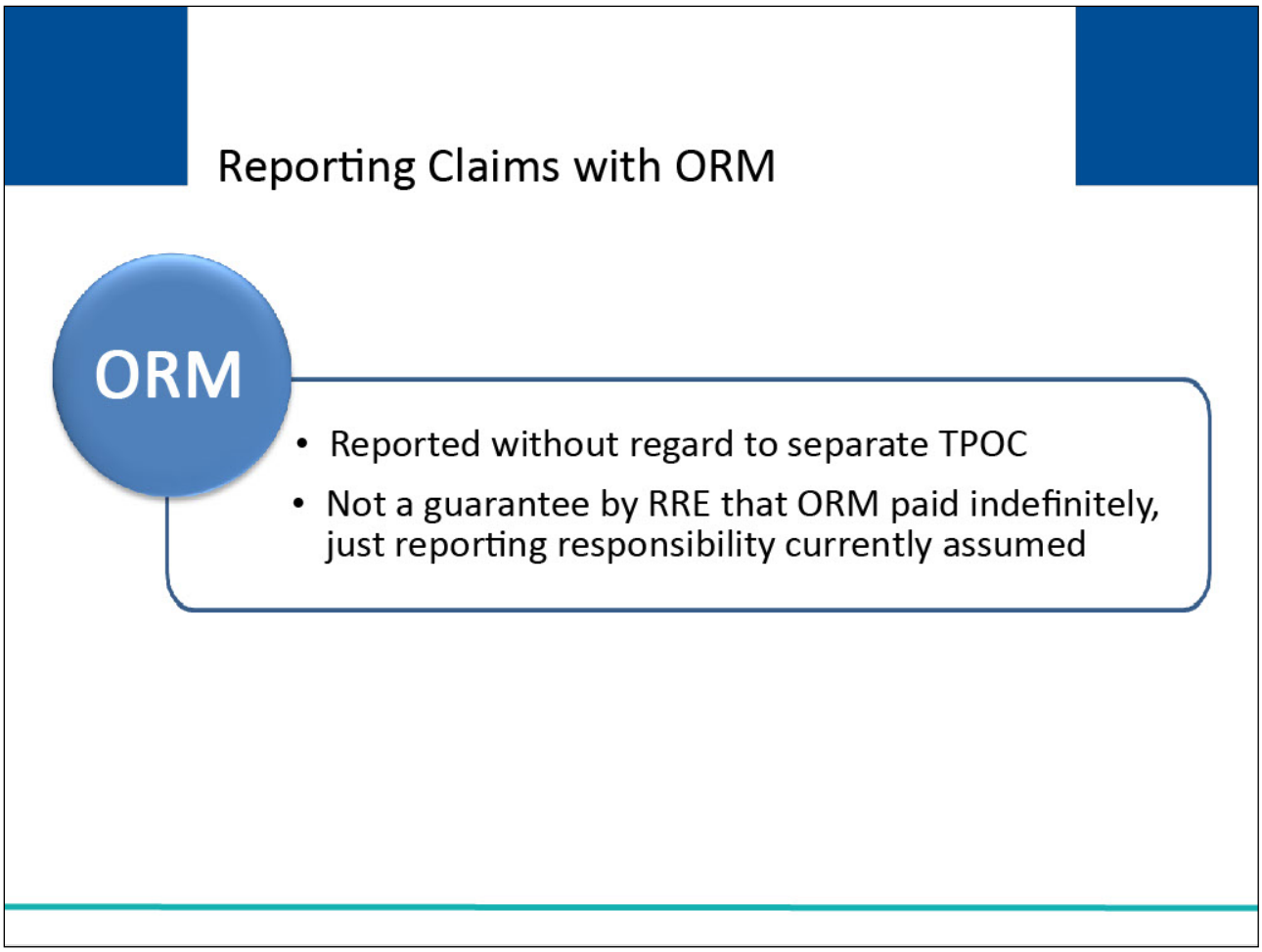
Slide 14 of 34 - Assumption of ORM



Slide notes

Where payment for medicals is made pending investigation, the RRE must report this as an assumption of ORM. If ORM terminates upon completion of the investigation, the termination of ORM must be reported.

Slide 15 of 34 - Reporting Claims with ORM

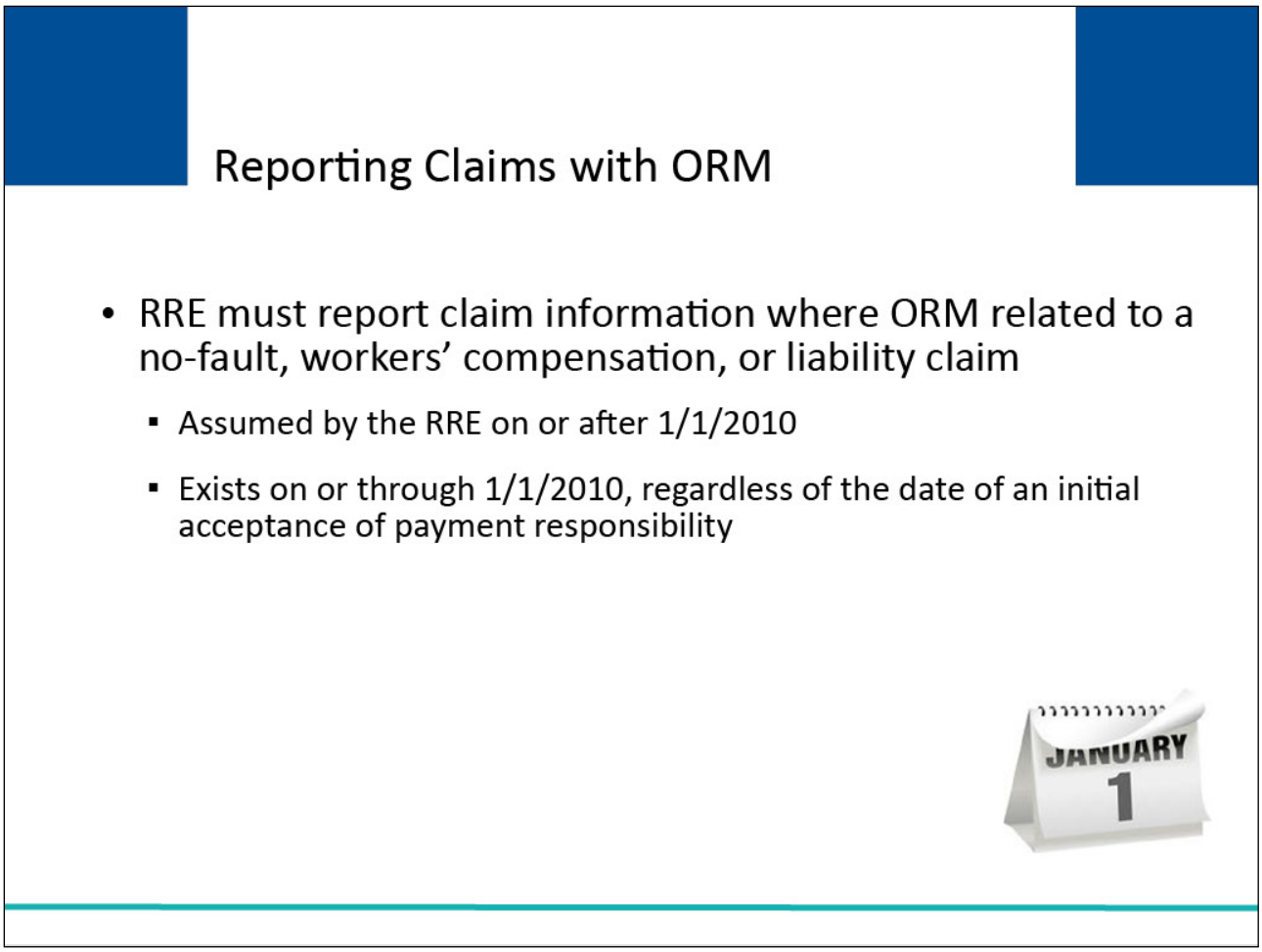


Slide notes

ORM (including a termination date, where applicable) is to be reported without regard to whether there has also been a separate TPOC settlement, judgment, award, or other payment outside of the payment responsibility for ongoing medicals.

Reporting for ORM is not a guarantee by the RRE that ongoing medicals will be paid indefinitely or through a particular date; it is simply a report reflecting the responsibility currently assumed.

Slide 16 of 34 - Reporting Claims with ORM



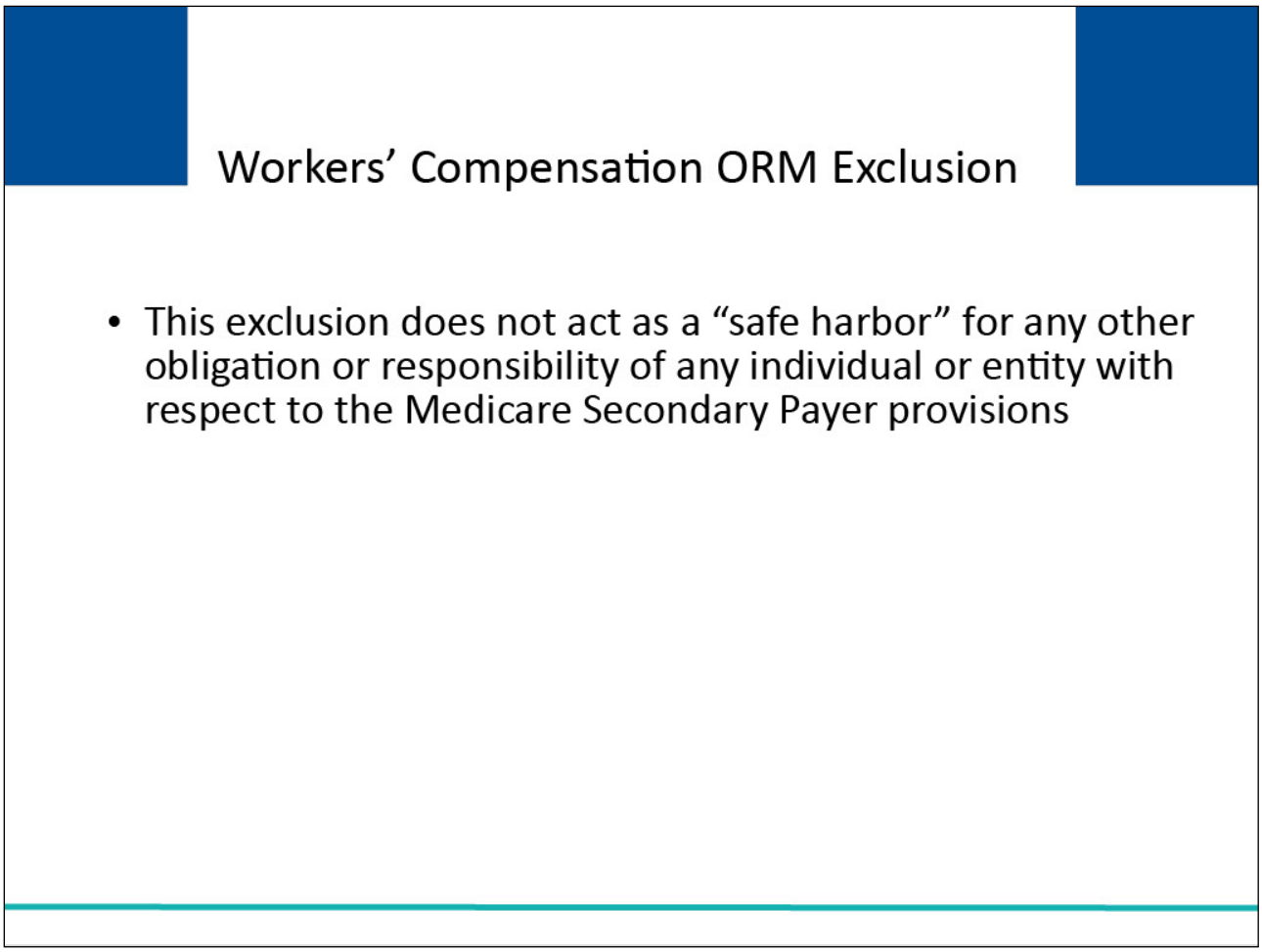
Slide notes

RREs must report claim information where ORM related to a no-fault, workers' compensation, or liability claim was assumed by the RRE on or after January 1, 2010.

In addition, claim information is to be transmitted for no-fault, workers' compensation, and liability claims for which ORM exists on or through January 1, 2010, regardless of the date of an initial acceptance of payment responsibility.

Note: For liability claims, it is now optional to report 'NOINJ' codes in certain circumstances (NGHP User Guide, Section 6.2.5.2)

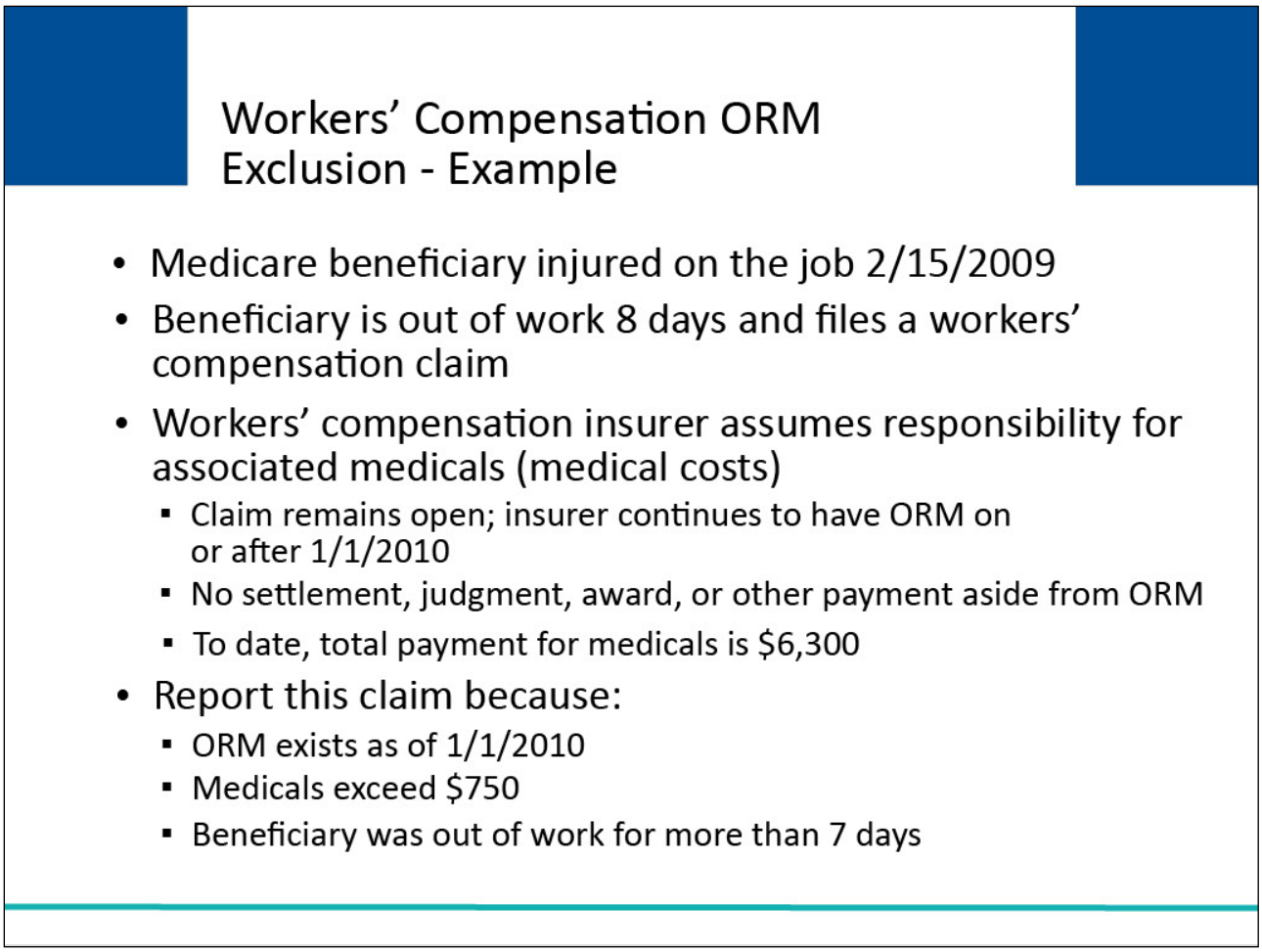
Slide 17 of 34 - Workers' Compensation ORM Exclusion



Slide notes

It is important to note that this exclusion does not act as a "safe harbor" for any other obligation or responsibility of any individual or entity with respect to the Medicare Secondary Payer provisions.

Slide 18 of 34 - Workers' Compensation ORM Exclusion - Example



Slide notes

A Medicare beneficiary is injured on the job on 2/15/2009, is out of work for 8 days and files a workers' compensation claim. The workers' compensation insurer assumes responsibility for his associated medicals (medical costs).

The claim remains open and the workers' compensation insurer continues to have responsibility for medicals on or after 1/1/2010.

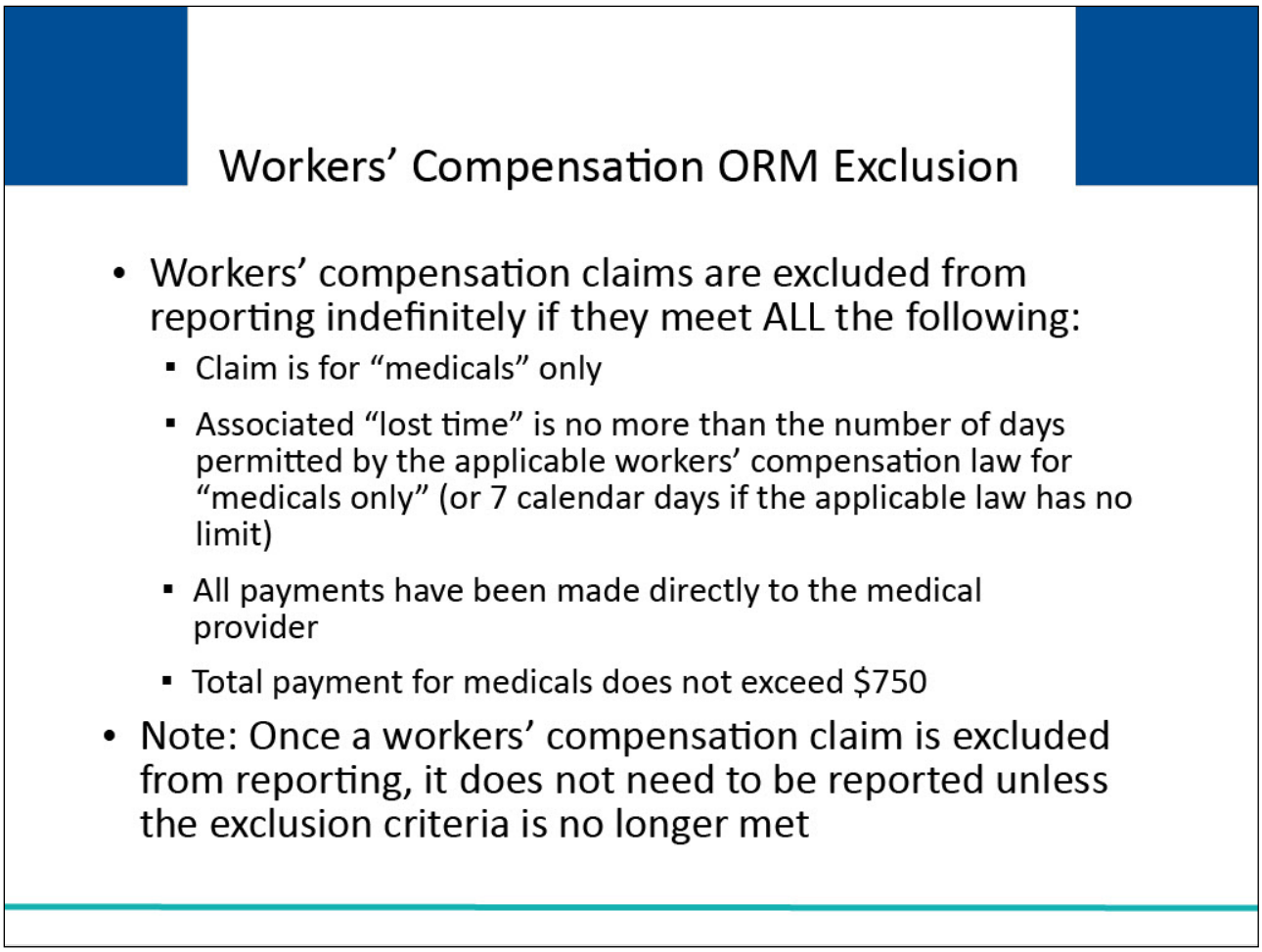
There is no settlement, judgment, award, or other payment aside from the assumption of responsibility for medicals. To date, the total payment for medicals is $6,300.

In this example, this claim does not meet all of the criteria for the workers' compensation exclusion, and therefore should be reported.

To review, ORM exists as of 1/1/2010. The workers' compensation ORM reporting threshold was exceeded because medicals were greater than $750, and the beneficiary was out of work for more than the associated time allowable for a 'medicals only' claim. As a result, this claim should be reported. Note: The threshold for physical trauma-based liability insurance settlements will remain at $750. CMS will maintain the $750 threshold for no-fault insurance and workers' compensation

settlements, where the no-fault insurer or workers' compensation entity does not otherwise have ongoing responsibility for medicals (ORM).

Slide 19 of 34 - Workers' Compensation ORM Exclusion



Slide notes

Workers' Compensation ORM that existed, or exists on or after January 1, 2010, must be reported. However, workers' compensation ORM claims are excluded from reporting indefinitely if they meet ALL of the following criteria:

The claim is for "medicals" only,

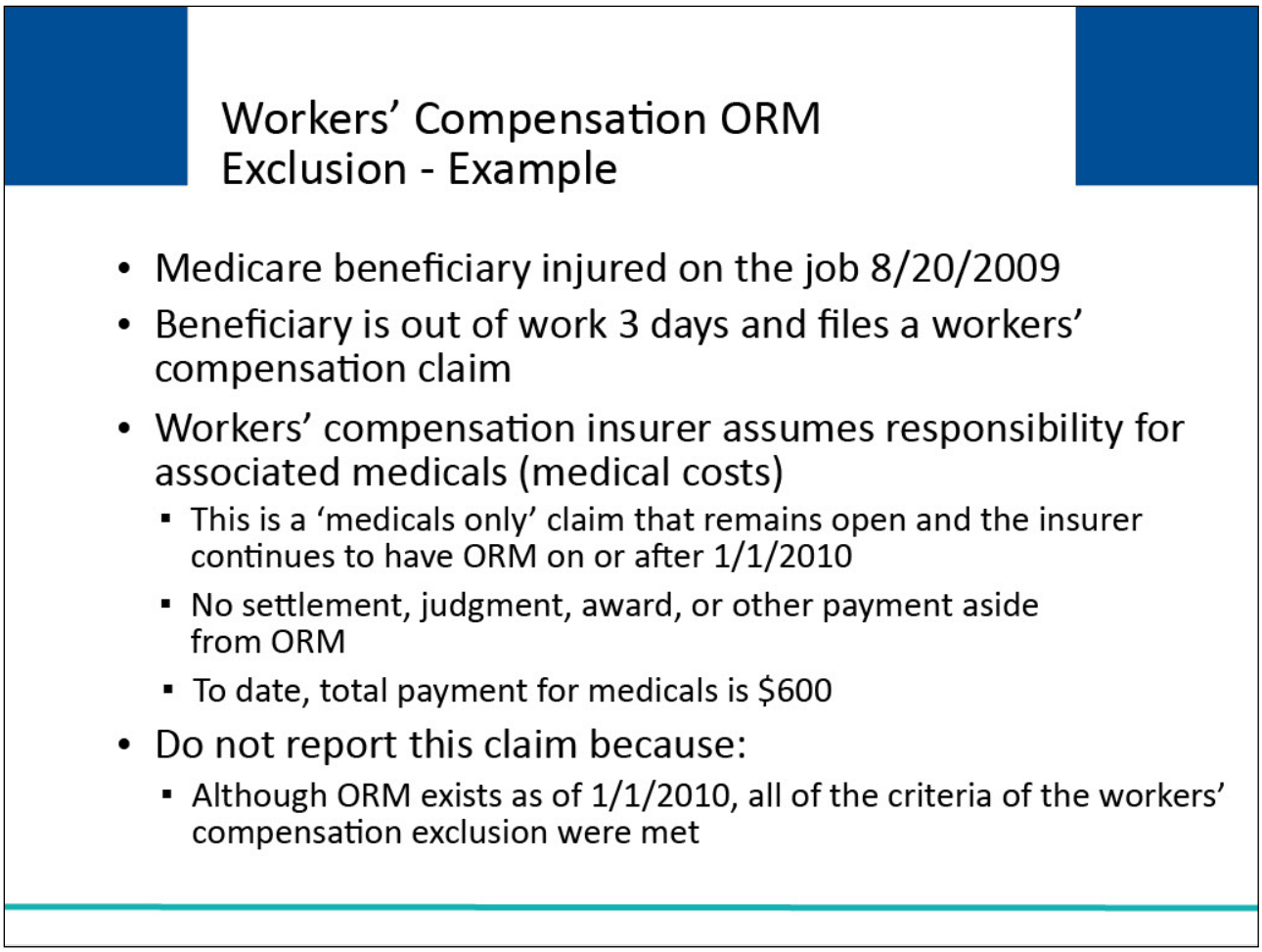
the associated "lost time" is no more than the number of days permitted by the applicable workers' compensation law for "medicals only" (or 7 calendar days if applicable law has no such limit),

all payment(s) has/have been made directly to the medical provider, AND

total payment for medicals does not exceed $750.

Once a workers' compensation ORM claim is excluded from reporting, it does not need to be reported unless the circumstances change such that it no longer meets the exclusion criteria.

Slide 20 of 34 - Workers' Compensation ORM Exclusion - Example



Slide notes

For this example, a Medicare beneficiary is injured on the job on 8/20/2009, is out of work for three days and files a workers' compensation claim.

The workers' compensation insurer assumes responsibility for the associated medicals (medical costs). This is a 'medicals only' claim.

The claim remains open and the workers' compensation insurer continues to have the responsibility for medicals on or after 1/1/2010. There is no settlement, judgment, award, or other payment aside from the assumption of responsibility for medicals.

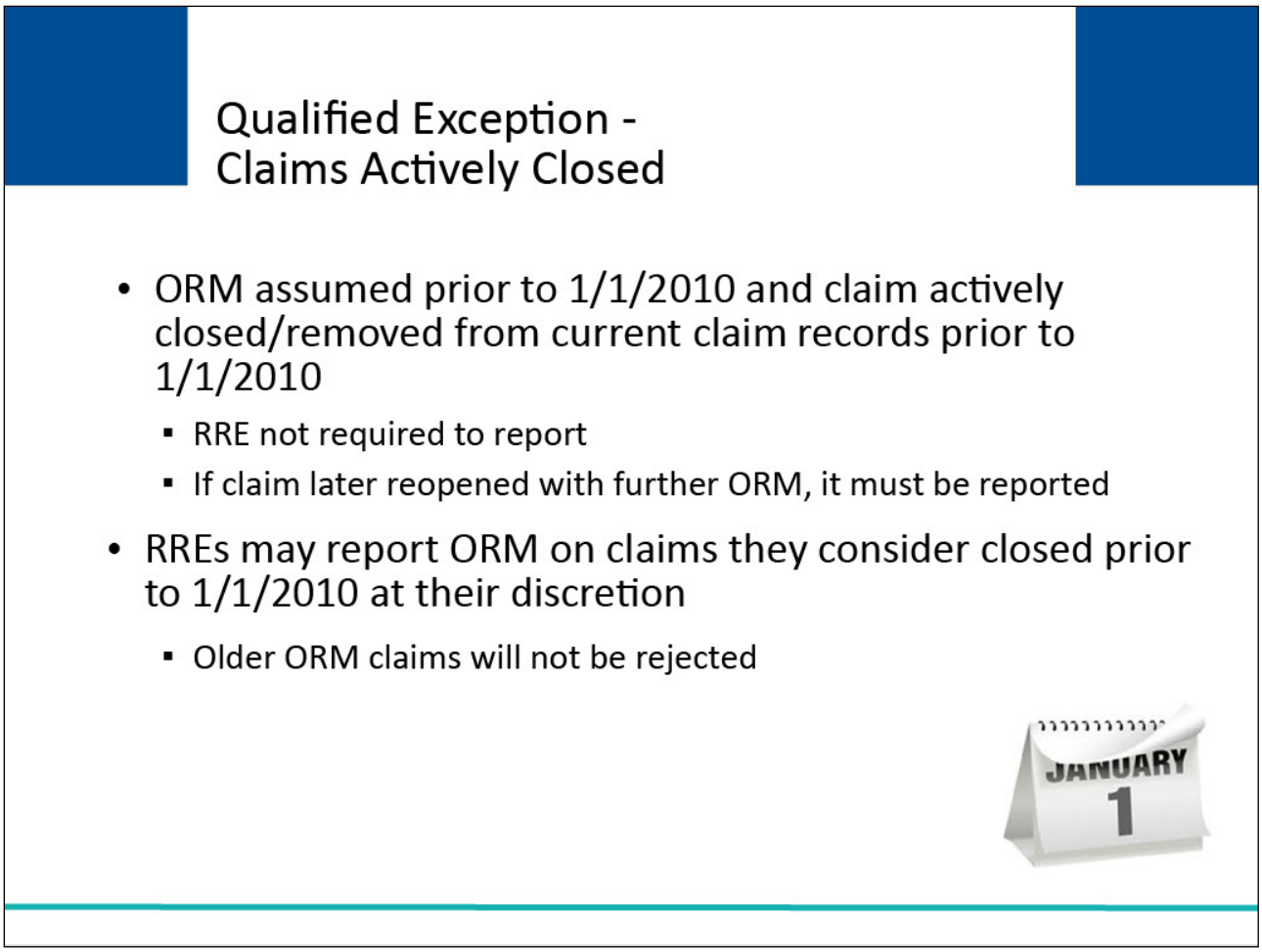
The total payment to date, $600, was made directly to the provider.

In this example, the claim meets all of the criteria for the workers' compensation exclusion and should not be reported.

Although ORM exists as of 1/1/2010, all of the criteria of the workers' compensation exclusion were met (i.e., this is a 'medicals only' claim, the associated 'lost time' was not more than the number of days permitted by the applicable workers' compensation law for 'medicals only', the payment was

made directly to the provider and the total payment did not exceed $750); therefore, this claim is excluded from reporting.

Slide 21 of 34 - Qualified Exception - Claims Actively Closed



Slide notes

If ORM was assumed prior to 1/1/2010, and the claim was actively closed or removed from current claims records prior to 1/1/2010, the RRE is not required to identify and report that ORM under the requirement for reporting ORM assumed prior to 1/1/2010.

If such a claim is later subject to reopening with further ORM, it must be reported with full information, including the original Date of Incident (as defined by CMS).

This means that when looking back through claims history to create your initial Claim Input File and fulfilling the requirement to report claims with ORM that was assumed prior to 1/1/2010, you only need to check the status of these claims as of 1/1/2010.

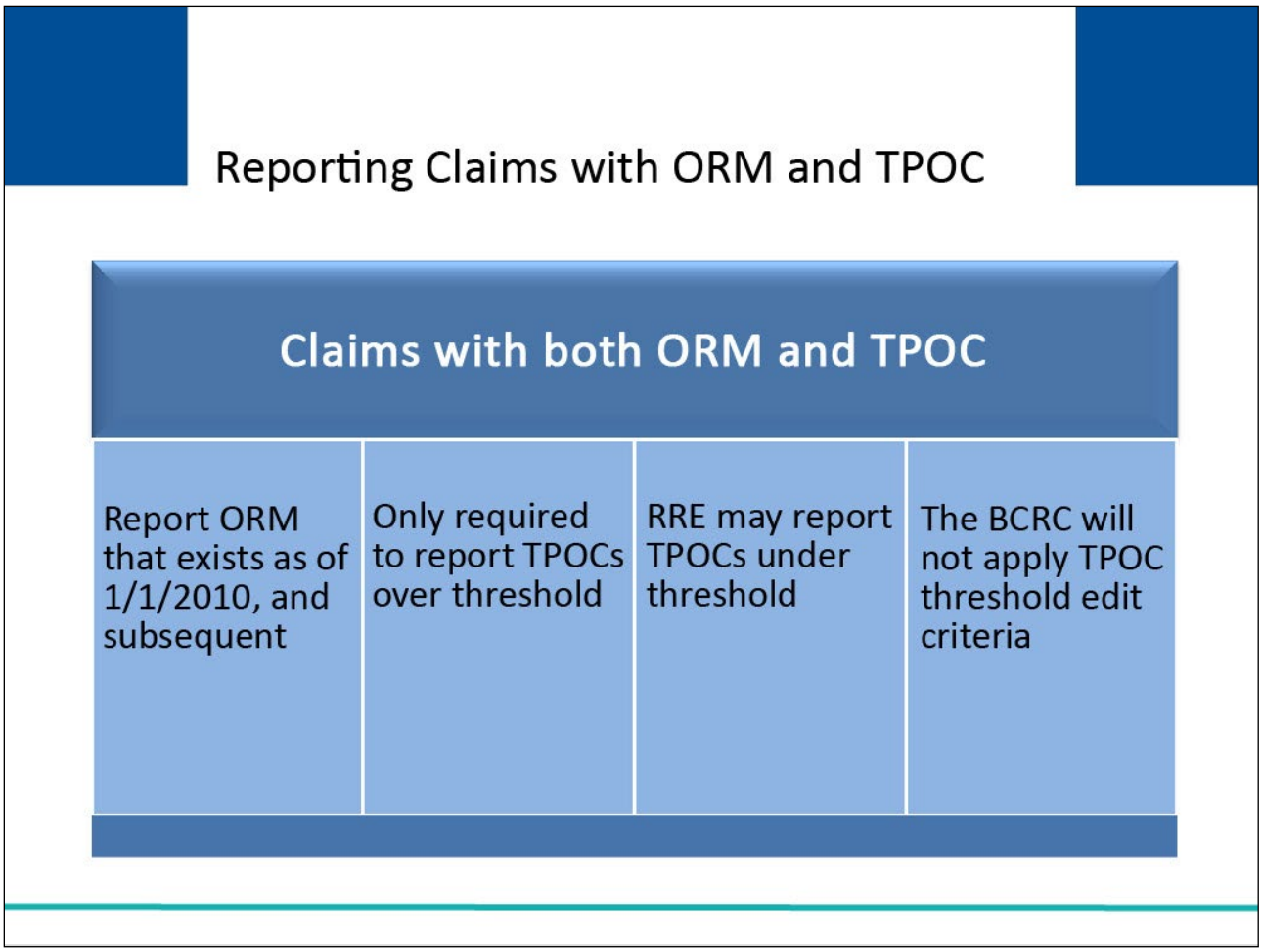
If the ORM claim was removed from the RRE's current/active claim file prior to 1/1/2010, it does not need to be reported unless it is reopened.

RREs may report ORM on claims they consider closed prior to January 1, 2010, at their discretion. "Older" ORM claims will not be rejected. To support previous system changes, Policy Number (Field 54) has been added as a key field. If this field changes, RREs must submit a delete Claim Input File record

that matches the previously accepted add record, followed by a new add record with the changed information (i.e., delete/add process).

Note: Guidance on what triggers the need to report ORM has been clarified in the NGHP User Guide (Sections 6.3 and 6.5.1.1).

Slide 22 of 34 - Reporting Claims with ORM and TPOC

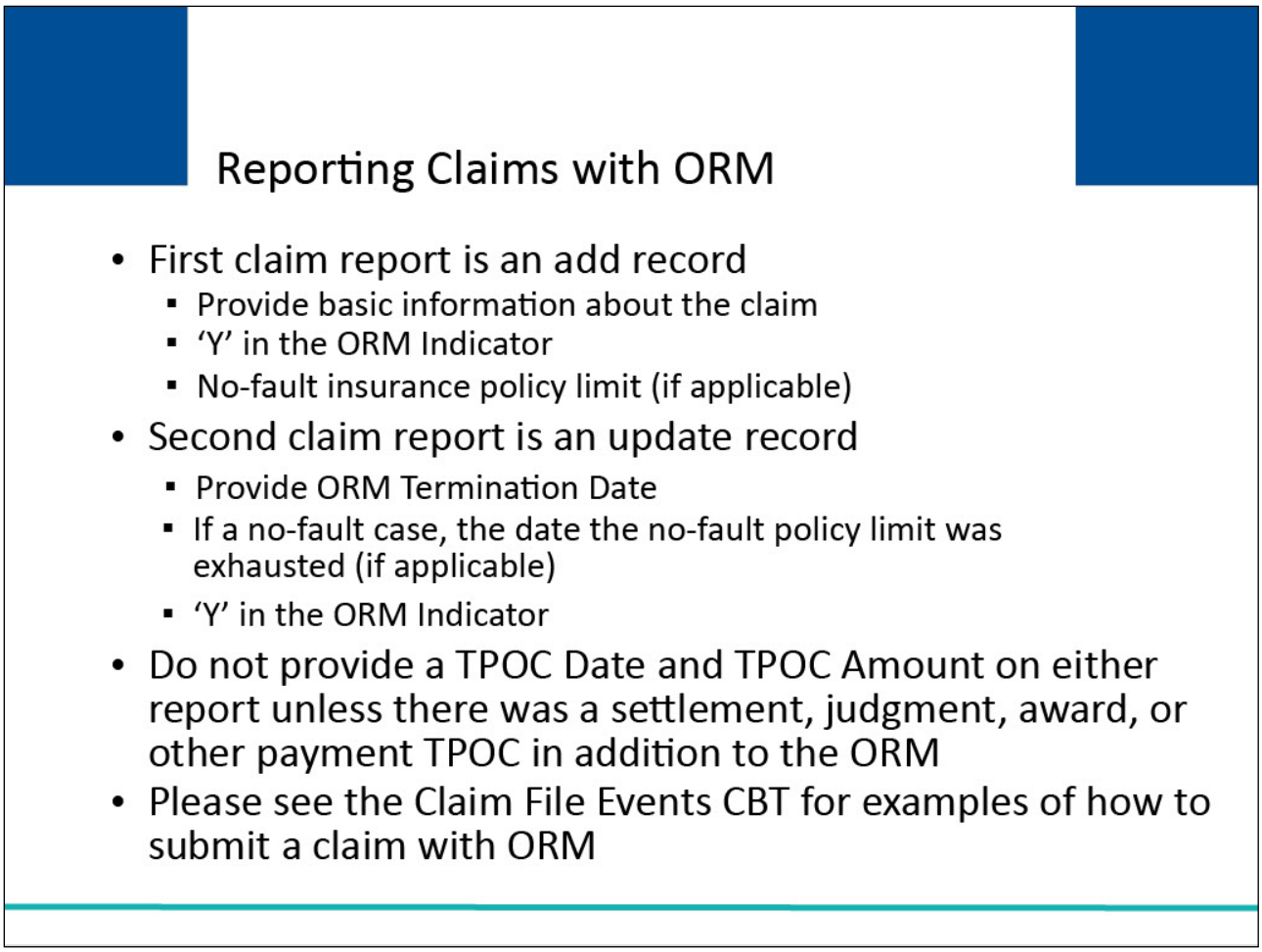


Slide notes

Once a workers' compensation ORM claim is excluded from reporting, it does not need to be reported unless the circumstances change such that it no longer meets the exclusion criteria.

For these claims, the RRE may report TPOCs under the threshold at their discretion. In other words, the BCRC will not apply the TPOC threshold edit criteria to claims reported with ORM.

Slide 23 of 34 - Reporting Claims with ORM



Slide notes

In most cases ORM reporting will require two Section 111 reports - one to add the report of ORM, and another to report the termination of ORM. The first claim report is an add record when the insurer assumed the ORM.

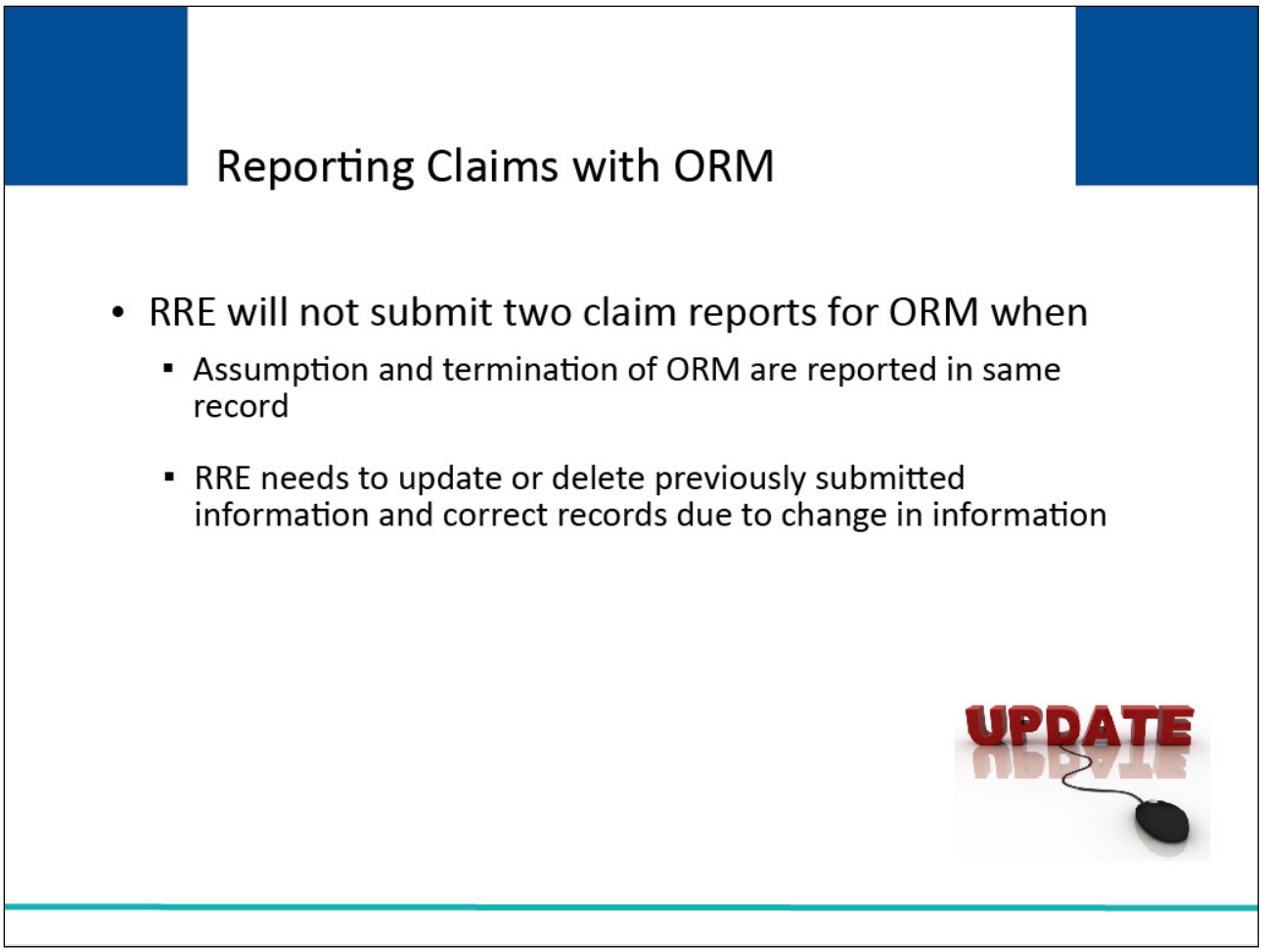
On this report, the RRE provides basic information about the claim including a 'Y' in the ORM Indicator and the no-fault insurance policy limit (if applicable). The second report is an update record when the ORM terminates.

On this report, the RRE provides the ORM Termination Date (date when ORM ended) and, if a no-fault case, the date the no-fault policy limit was exhausted (if applicable). The second report will also have a 'Y' in the ORM Indicator field.

The RRE does not provide a TPOC Date and TPOC Amount on either report of ORM unless there was a settlement, judgment, award, or other payment TPOC Amount in addition to the ORM.

Note: Please see the Claim File Events CBT to see examples of how to submit a claim with ORM.

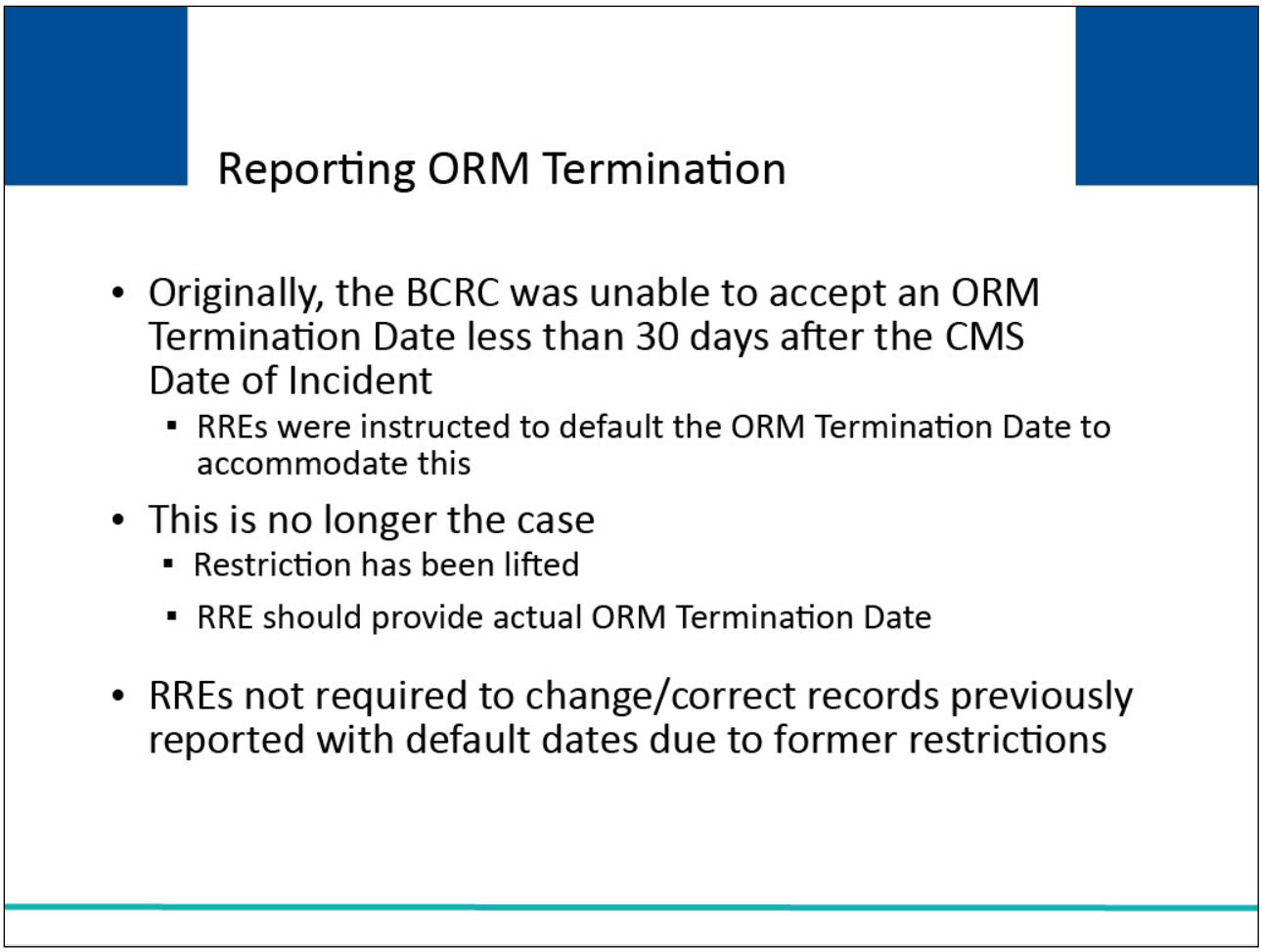
Slide 24 of 34 - Reporting Claims with ORM



Slide notes

The only exceptions to two claim reports for ORM will be when assumption and termination of ORM are reported in the same record or when the RRE needs to update or delete previously submitted information and correct records due to a change in important information sent on the prior record.

Slide 25 of 34 - Reporting ORM Termination



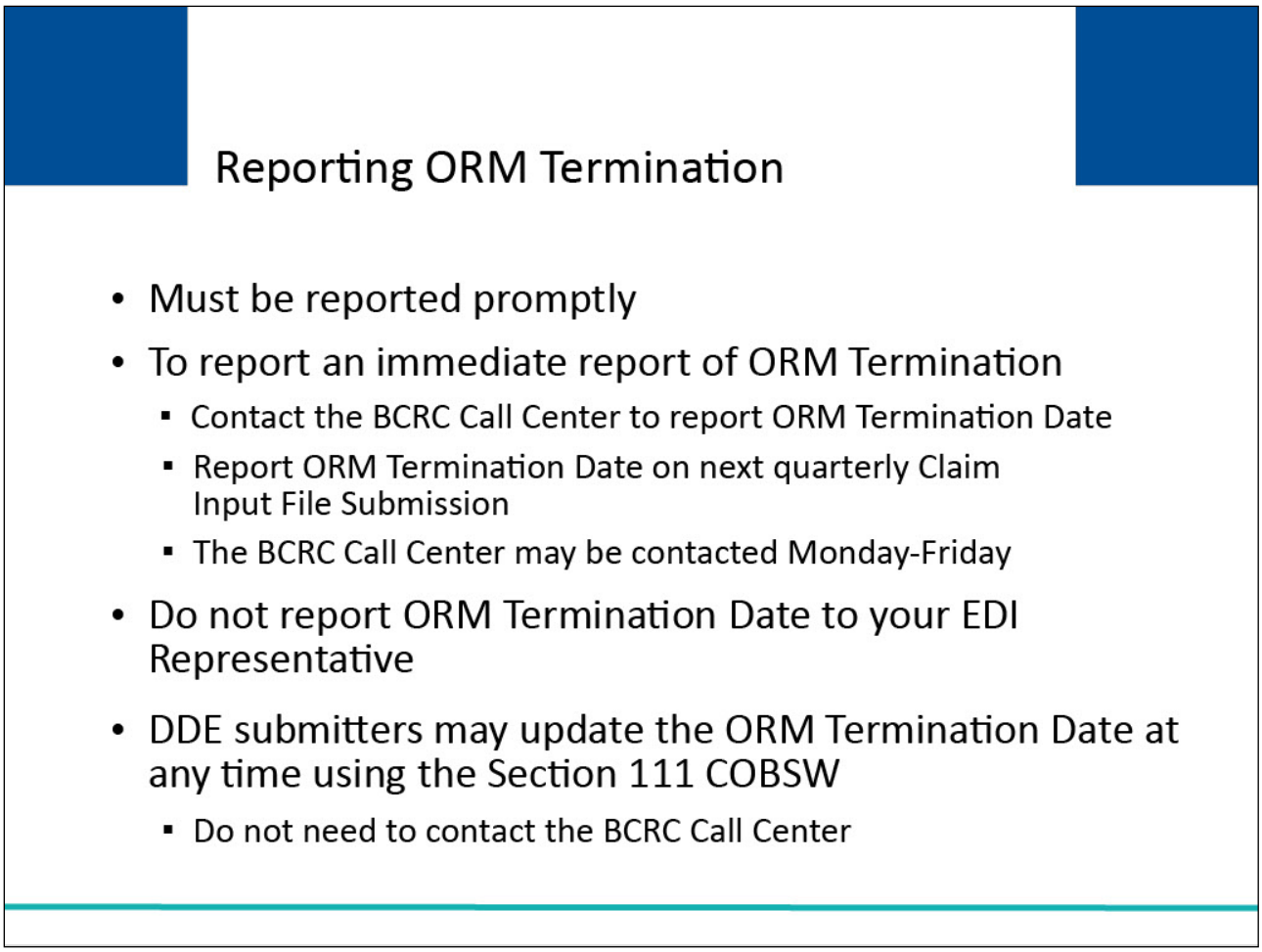
Slide notes

Originally, the BCRC was unable to accept an ORM Termination Date (Field 79) less than 30 days after the CMS Date of Incident (Field 12). RREs were instructed to default the ORM Termination Date to accommodate this.

This is no longer the case, and this restriction has been lifted. RREs should provide the actual ORM Termination Date as defined in the field description in NGHP User Guide Appendices Chapter (Appendix A).

RREs are not required to go back and change/correct records reported previously with default dates due to the former restrictions.

Slide 26 of 34 - Reporting ORM Termination



Slide notes

Since CMS uses reports of ORM in the Medicare claims process, it is imperative that ORM Termination be reported promptly. See NGHP User Guide Technical Information Chapter (Section 6.7 and 6.8) for the related timely ORM reporting requirements.

If an RRE wishes to make an immediate report of ORM Termination prior to its next quarterly file submission, a representative from the RRE may contact the BCRC Call Center and report an ORM Termination Date for a single claim report previously submitted and accepted via a Section 111 Claim Input File.

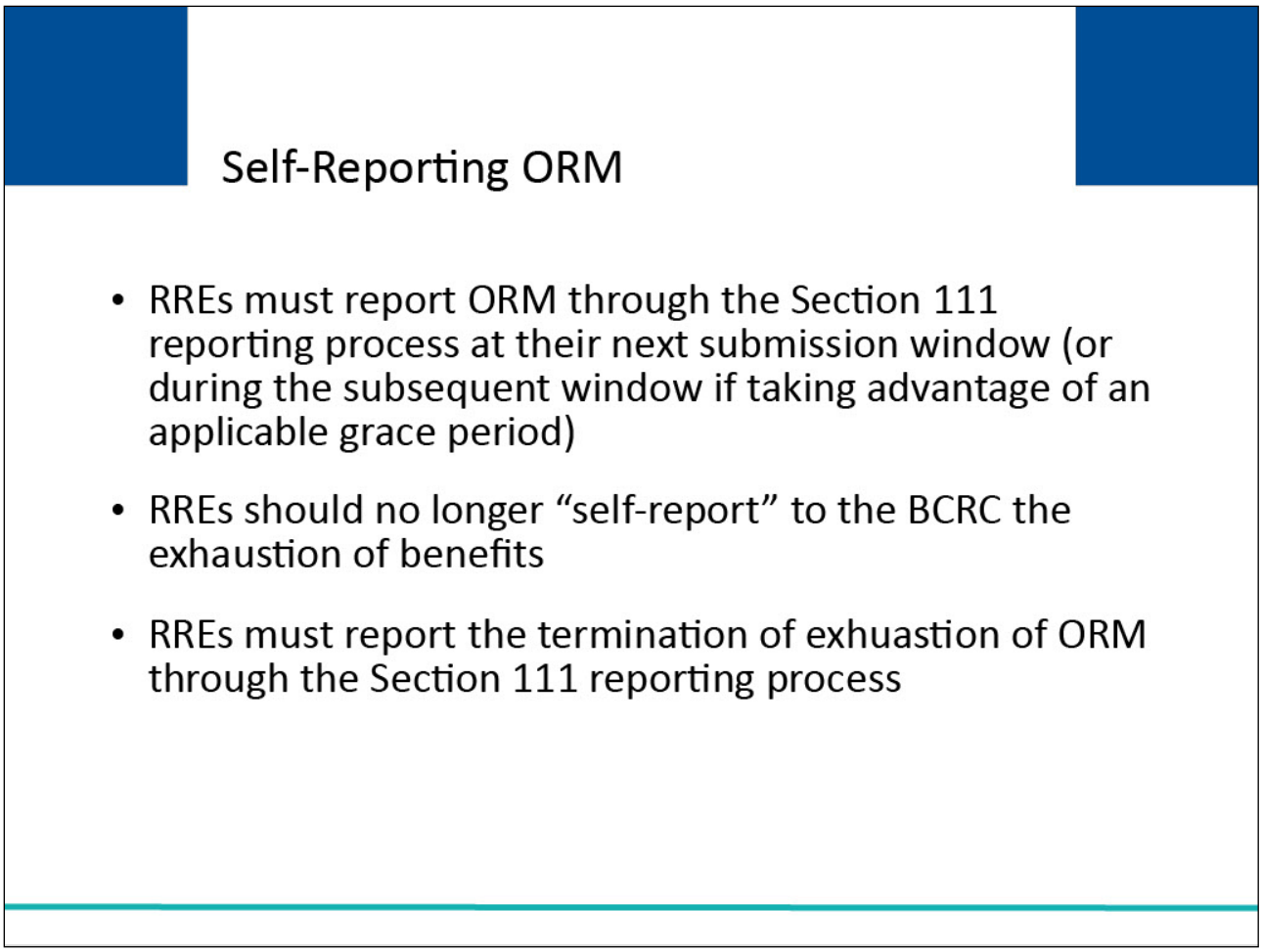
However, the RRE must still submit the report of ORM Termination on its next quarterly Claim Input File submission.

The BCRC Call Center may be contacted Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired.

Do not make this report of ORM Termination to your Electronic Data Interchange (EDI) Representative.

RREs using the DDE option may update a claim originally entered via DDE with an ORM Termination Date at any time using the Section 111 Coordination of Benefits Secure Website (COBSW) and therefore do not need to contact the BCRC Call Center.

Slide 27 of 34 - Self-Reporting ORM



Slide notes

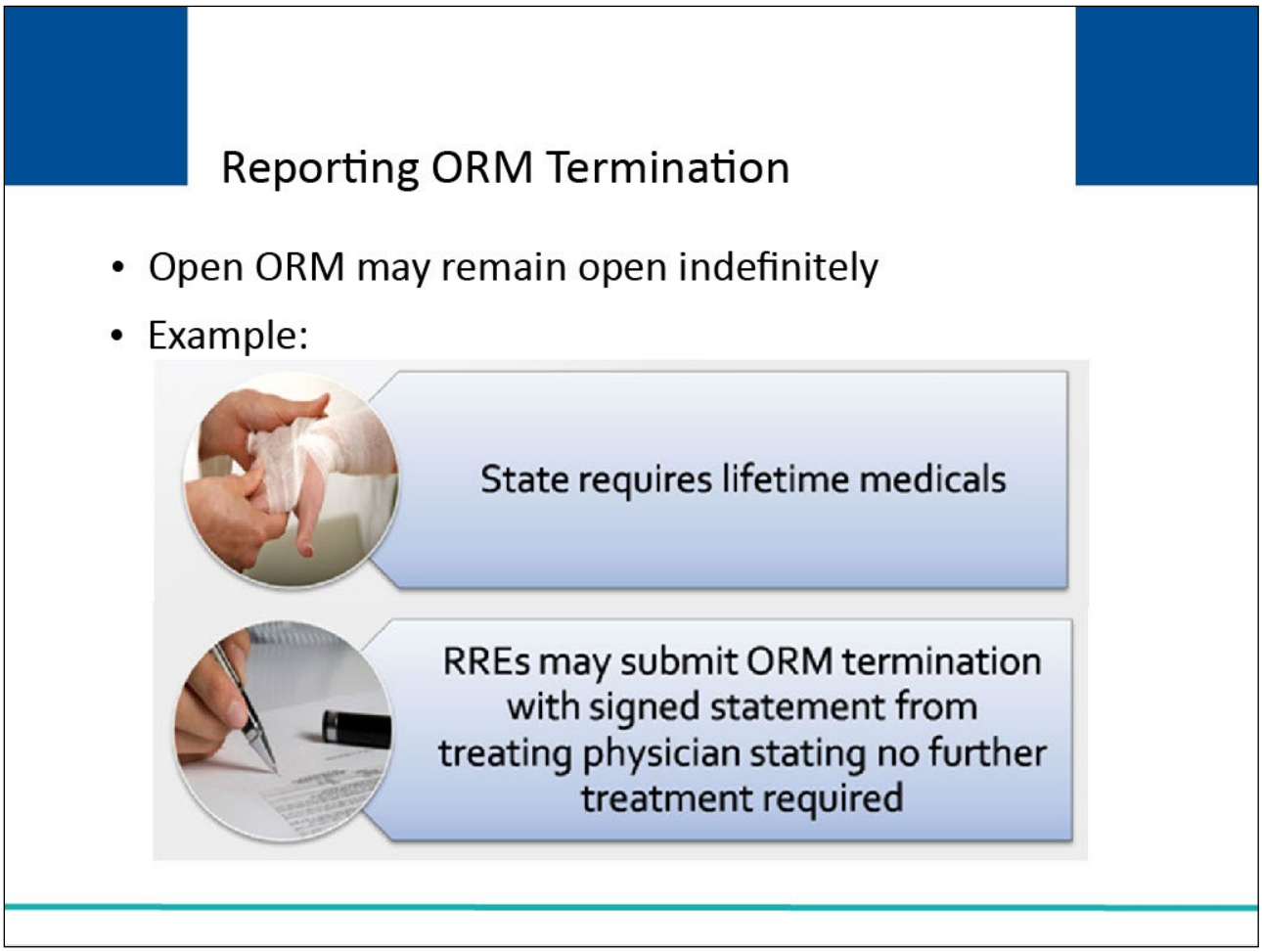
With the implementation of Section 111 Mandatory Insurer Reporting, a "self-report" for certain ORM is no longer needed.

RREs must report ORM through the Section 111 reporting process at their next submission window (or during the subsequent window if taking advantage of an applicable grace period).

RREs should no longer "self-report" to the BCRC the exhaustion of benefits. RREs must report the termination or exhaustion of ORM through the Section 111 reporting process.

Note: Guidance on what triggers the need to report ORM has been clarified in the NGHP User Guide (Sections 6.3 and 6.5.1.1).

Slide 28 of 34 - Reporting ORM Termination



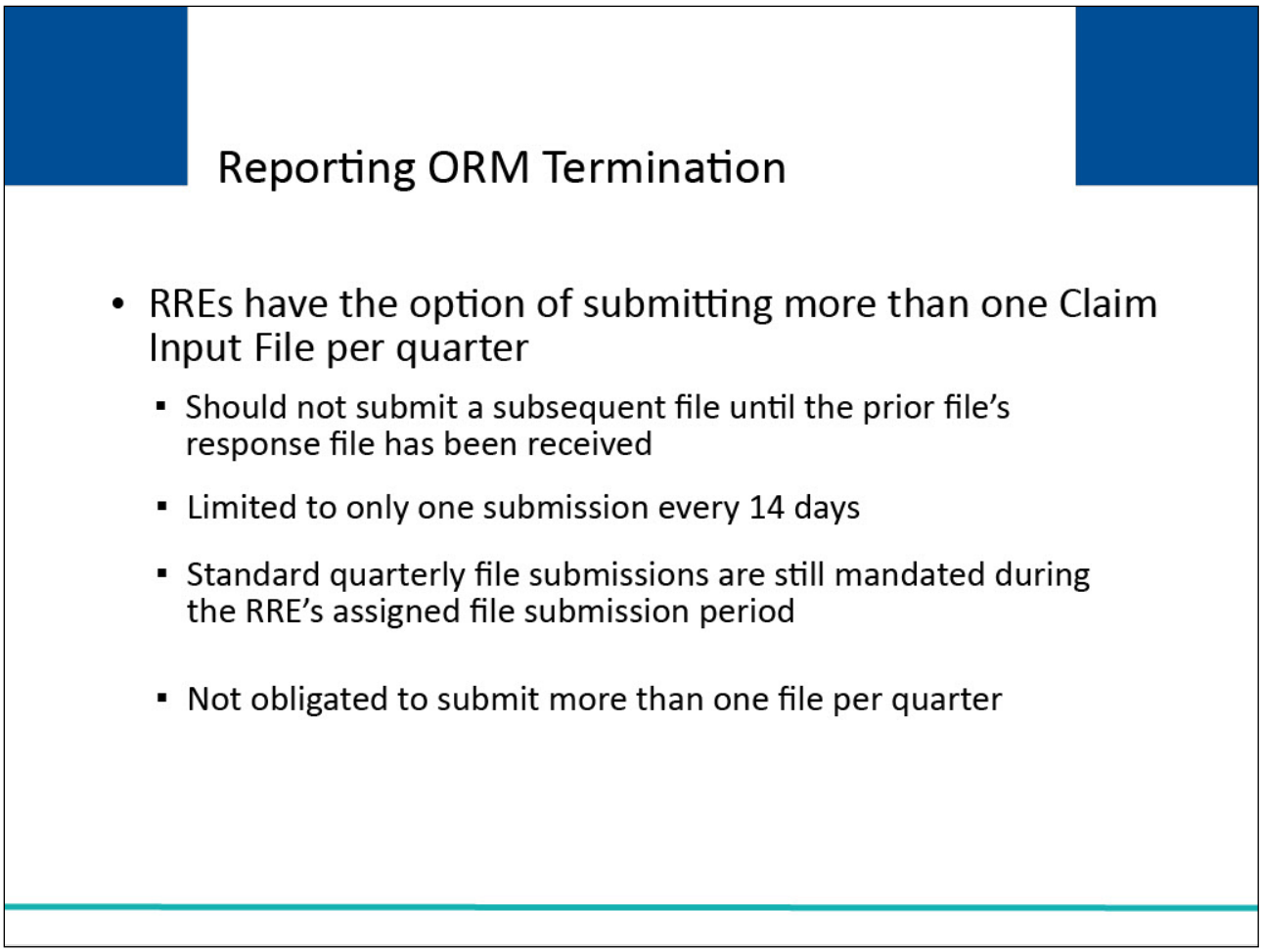
Slide notes

Because ORM may involve all levels of injury, open ORM records may remain open indefinitely, even where, as a practical matter, there is no possibility of associated future treatment.

An example might be a relatively minor, fully healed, flesh wound in a state where workers' compensation requires lifetime medicals.

To address this situation, RREs may submit a Termination Date for ORM if they have a signed statement from the injured individual's treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or a claim for further payment.

Slide 29 of 34 - Reporting ORM Termination



Slide notes

Under appropriate circumstances, NGHP RREs may submit multiple files within a single quarter. This is to allow RREs to more expediently post updates for records with ORM when ORM has terminated.

There are two limitations that apply to this change. The first limitation is that a subsequent file submission will not be processed until the response file for the prior file submission has been generated.

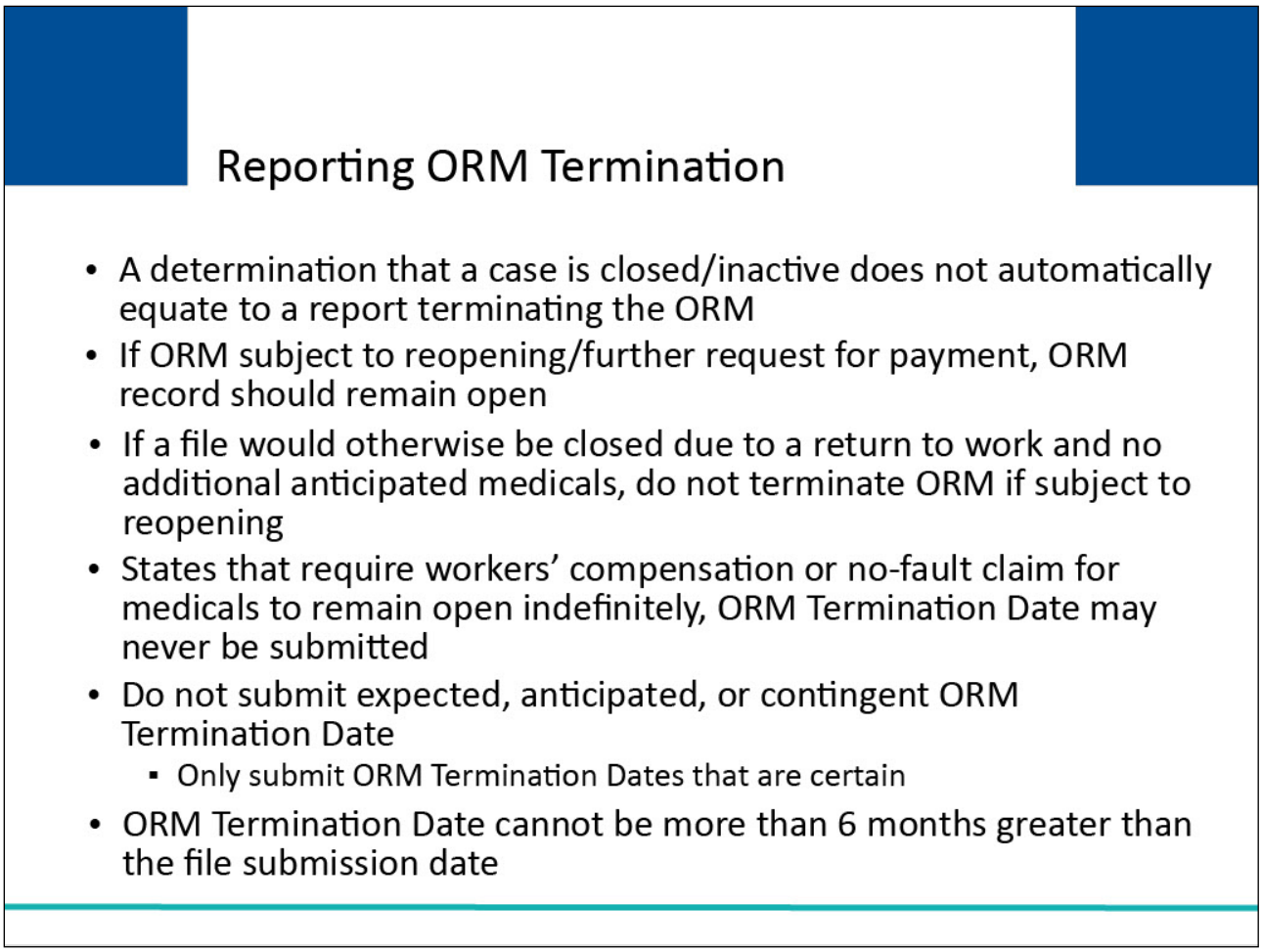
RREs should not submit a subsequent file until the prior file's response file has been received.

If a new Claim Input File is submitted before the prior file has completed processing, the newly submitted file will be placed in a "System Hold" status and will not be released from that status until the prior file has completed processing.

The second limitation is that RREs are limited to only one file submission every 14 days.

Please note that standard quarterly file submissions are still mandated during the RRE's assigned file submission period, and that RREs are under no obligation to submit more than one file per quarter.

Slide 30 - of 34 - Reporting ORM Termination



Slide notes

With respect to ORM, a determination that a case is "closed" or otherwise inactive does not automatically equate to a report terminating the ORM.

If the ORM is subject to reopening or otherwise subject to a further request for payment, the record submitted for ORM should remain open.

(Medicare beneficiaries have a continuing obligation to apply for all no-fault or workers' compensation benefits to which they are entitled.)

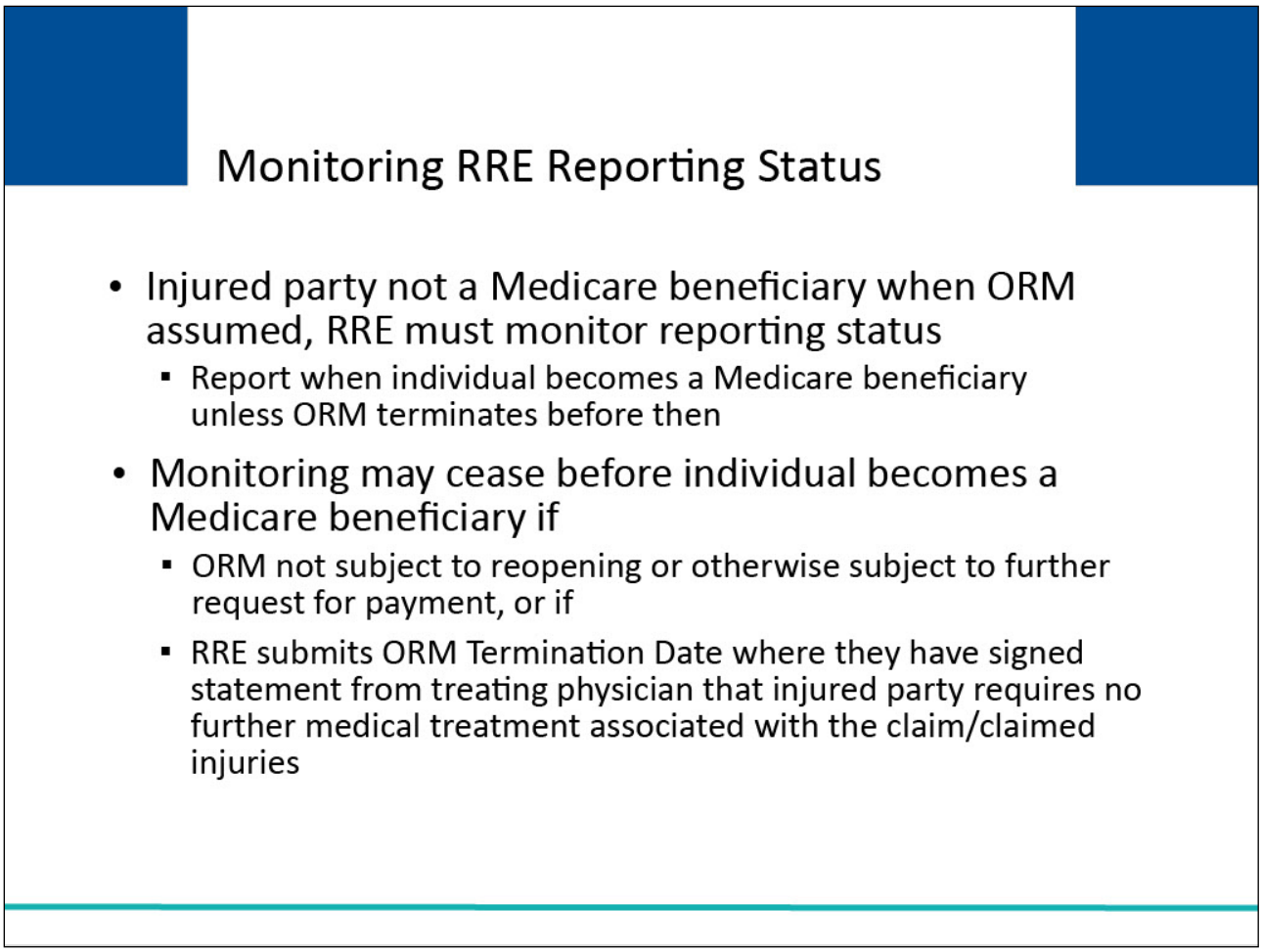
Similarly, if a file would otherwise be closed due to a return to work and no additional anticipated medicals, a report terminating the ORM should not be submitted, as long as the ORM is subject to reopening or otherwise subject to an additional request for payment.

For certain states which require a workers' compensation or no-fault claim be left open for medicals indefinitely, this second type of report may never be submitted.

In addition, RREs are not to submit an expected, anticipated, or contingent ORM Termination Date. ORM Termination Dates should only be submitted when the termination of ORM is certain.

Future-dated ORM Termination Dates can be dated no more than 6 months after the file submission date (ORM Termination Date cannot be more than 6 months greater than the file submission date).

Slide 31 of 34 - Monitoring RRE Reporting Status

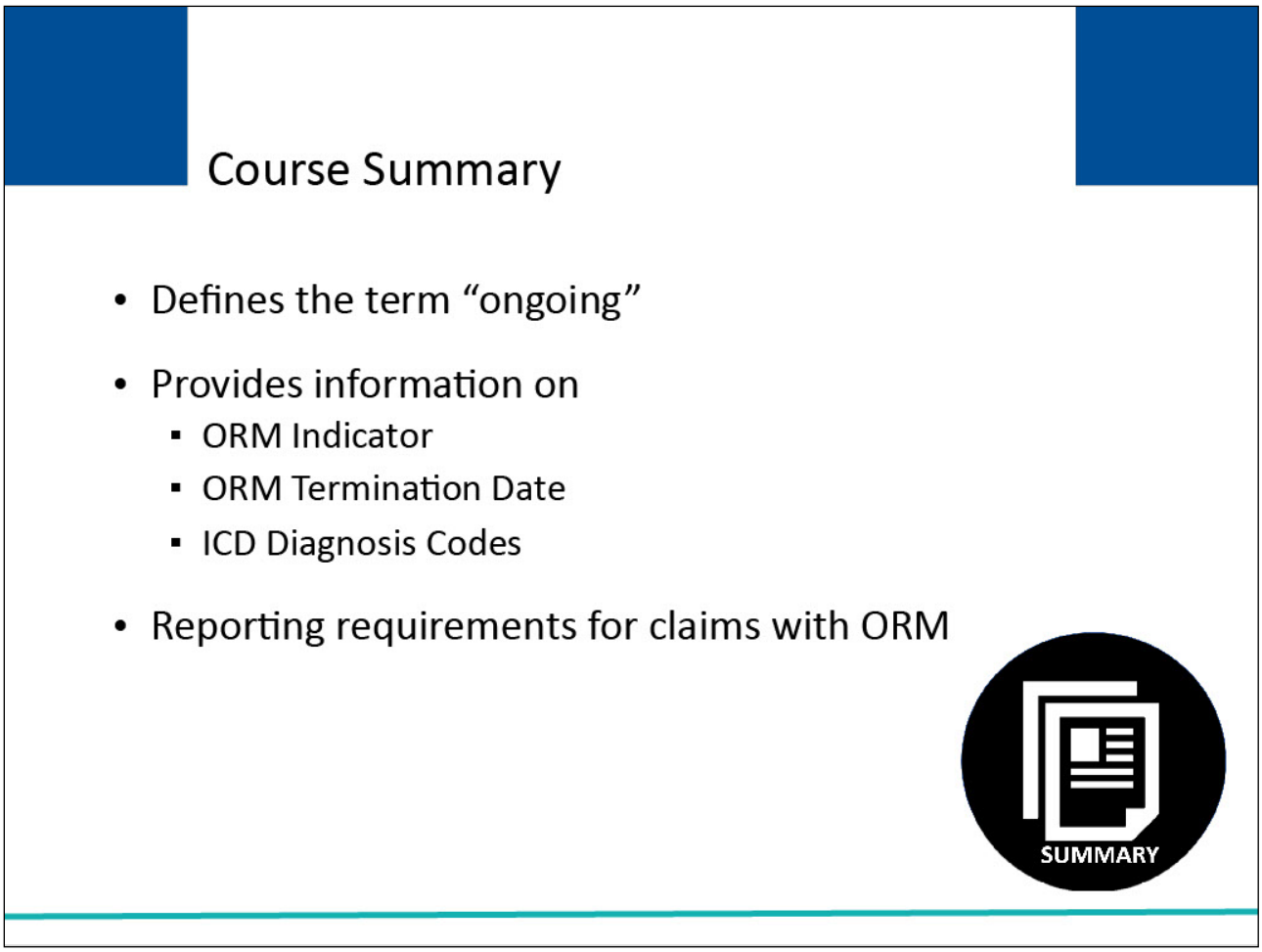


Slide notes

If the injured party was not a Medicare beneficiary at the time responsibility for ongoing medicals was assumed, the RRE must monitor the status of that individual and report when that individual becomes a Medicare beneficiary, unless responsibility for ongoing medicals has terminated before the individual becomes a Medicare beneficiary.

However, monitoring of such individuals may cease before they become a Medicare beneficiary, if the ORM is not subject to reopening or otherwise subject to further request for payment, or if the RRE submits a Termination Date for ORM where they have a signed statement from the injured individual's treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or otherwise subject to a claim for further payment.

Slide 32 of 34 - Course Summary



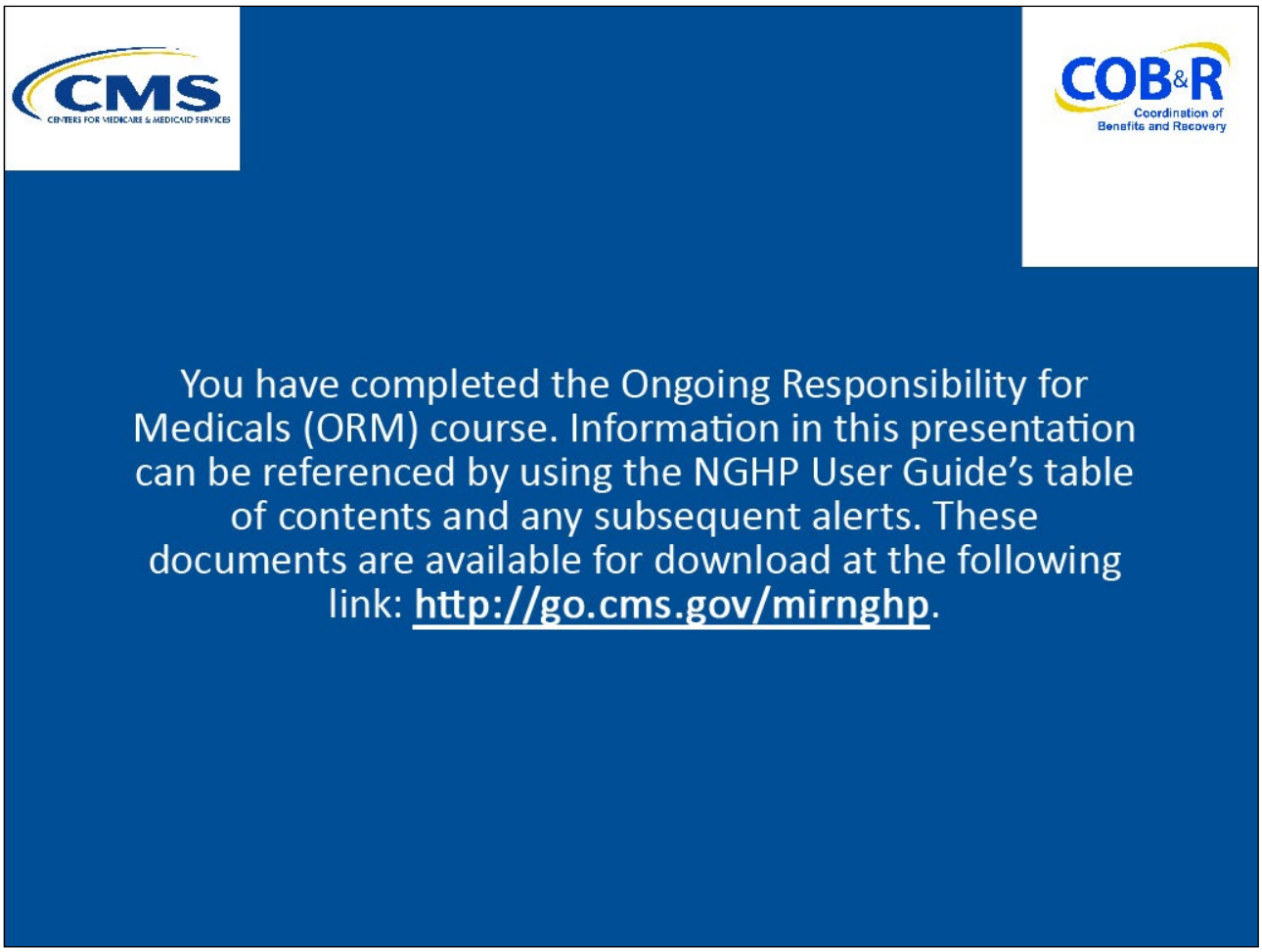
Slide notes

You now know the definition of “ongoing” and understand some of the fields used in reporting ORM:

- ORM Indicator
- ORM Termination Date
- International Classification of Diseases (ICD) Diagnosis codes

It also clarified what is meant by the assumption of ORM and discussed the reporting requirements for claims where ORM has been assumed.

Slide 33 of 34 - Conclusion

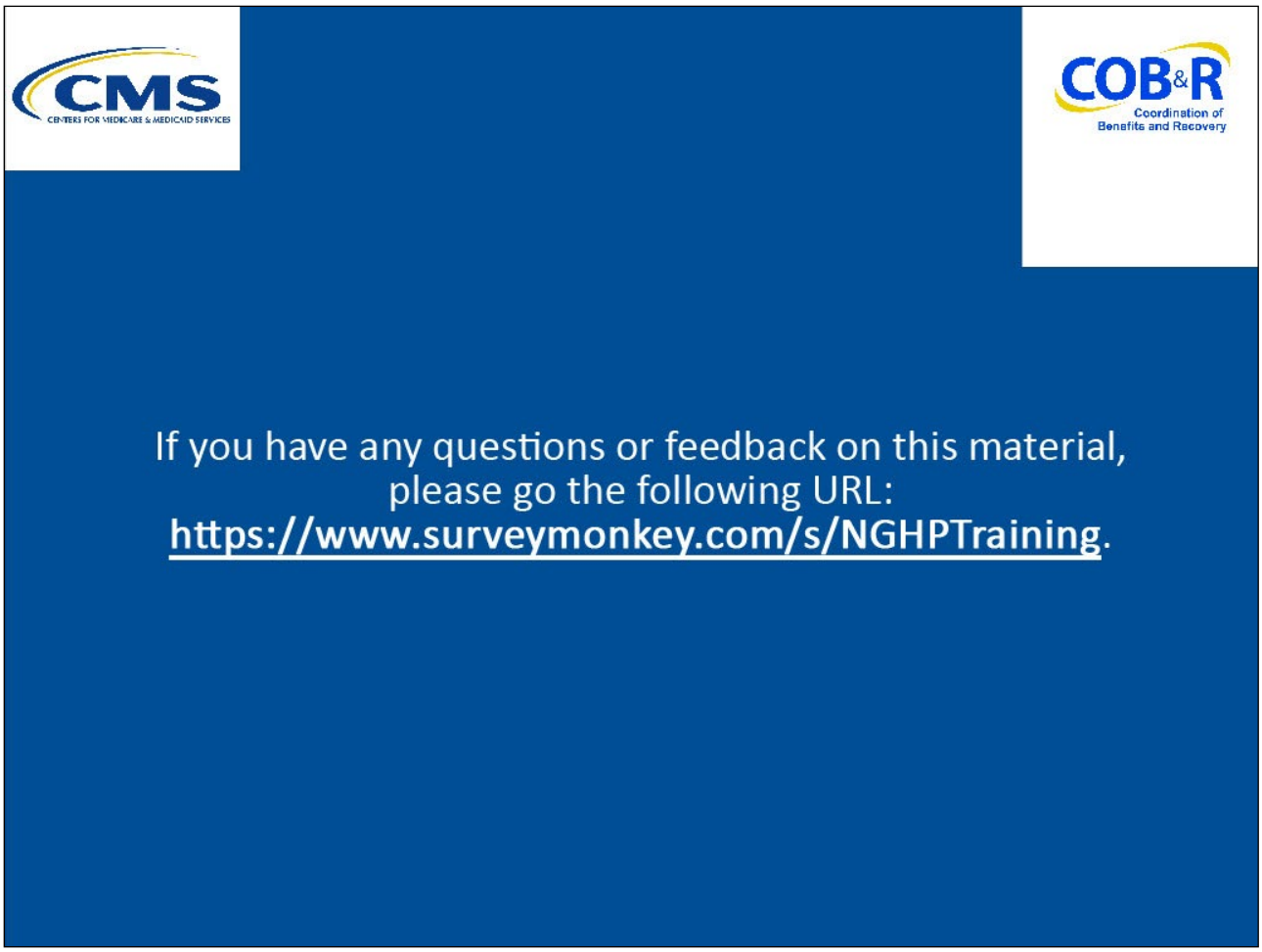


Slide notes

You have completed the Ongoing Responsibility for Medicals (ORM) course. Information in this presentation can be referenced by using the NGHP User Guide's table of contents and any subsequent alerts.

These documents are available for download at the following link: CMS NGHP Website.

Slide 34 of 34 - NGHP Training Survey



Slide notes

If you have any questions or feedback on this material, please go the following URL: Training Survey.