6.3 Ongoing Responsibility for Medicals (ORM) Reporting

The following section reviews the major requirements for reporting the assumption or establishment of ORM for no-fault insurance, liability insurance (including self-insurance), and workers' compensation. Information regarding an RRE's reporting for the assumption of ORM has been presented in other sections of the NGHP User Guide. This section provides the basic policy information. See Table 6-2 for a summarized view of the ORM reporting requirements for no-fault, liability insurance (including self-insurance), and workers' compensation. The Technical Information Chapter IV must also be referenced for additional ORM reporting requirement specifications.

The reference to "ongoing" is not related to "ongoing reporting" or repeated reporting of claims under Section 111, but rather to the RRE's responsibility to pay, on an ongoing basis, for the injured party's (Medicare beneficiary's) medicals associated with the claim. This often applies to no-fault and workers' compensation claims, but may occur in some circumstances with liability insurance (including self-insurance).

The trigger for reporting ORM is the assumption of ORM by the RRE, which is when the RRE has made a determination to assume responsibility for ORM and when the beneficiary receives medical treatment related to the injury or illness. Medical payments do not actually have to be paid, nor does a claim need to be submitted, for ORM reporting to be required. The effective date for ORM is the DOI, regardless of when the beneficiary receives the first medical treatment or when ORM is reported.

If an RRE has assumed ORM, the RRE is reimbursing a provider, or the injured party, for specific medical procedures, treatment, services, or devices (doctor's visit, surgery, 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 TPOCs (see Section 6.4 for more information on 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 no-fault insurance (such as 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 since the no-fault limit was already reached, but the payment still reflects ORM, **not** a TPOC settlement, judgment or award.

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, or the RRE otherwise no longer has ORM, etc.) the RRE reports an ORM Termination Date. If there was no TPOC settlement, judgment, award, or other payment related to the claim (an actual settlement for medicals and/or lost wages, etc.), **you do not need to report a TPOC Amount on the claim with ORM**. You can just submit the ORM Termination Date.

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

It is critical to report ORM claims with 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 and considered only for secondary payment by Medicare. The ICD-9/ICD-10 codes provided in these fields must provide enough information for Medicare to identify medical claims related to the underlying Injury, Incident or Illness claim reported by the RRE. **Note**: The Alleged Cause of Injury, Incident or Illness (Field 15) is not required.