

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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- [ICD-10-CM/PCS Billing and Payment Frequently Asked Questions](#), Fact Sheet (ICN 908974)

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Related CR Transmittal #: R114MSP and R3358CP

Implementation Date: October 5, 2015

Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures Regarding Ongoing Responsibility for Medicals (ORM)

Provider Types Affected

This MLN Matters® Article is intended for providers, physicians, and other suppliers submitting claims to Medicare Administrative Contractors (MACs) for items or services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8984, through which the Centers for Medicare & Medicaid Services (CMS) outlines its Medicare claims processing requirements specific to Ongoing Responsibility for Medicals (ORM) for liability insurance (including self-insurance), no-fault insurance, and workers' compensation in Medicare Secondary Payer (MSP) situations.

Liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans are required to report settlements, judgments, awards, or other payments to CMS, including ORM. The purpose of CR 8984 is to educate and instruct

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providers and the MACs about the policy and procedures related to ORM reporting. Make sure that your billing staffs are aware of these changes.

NOTE: MSP claims impacted by employer Group Health Plan coverage will be not affected by this change.

Background

Pursuant to section 1862(b)(8) of the Social Security Act, “applicable plans” (liability insurance (including self-insurance), no-fault insurance, and workers’ compensation laws or plans) are required to report settlements, judgments, awards or other payments involving individuals who are or were Medicare beneficiaries to CMS. The applicable plan is the “Responsible Reporting Entity” (RRE) for this process. The required reporting includes instances where the RRE has ORM associated with specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted or a workers’ compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers’ compensation claim.

The RRE may assume responsibility for ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual’s liability insurance (including self-insurance), no-fault insurance, or workers’ compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM Termination Date, and this information is uploaded to Medicare's Common Working File (CWF) by the Benefit Coordination & Recovery Center (BCRC).

NOTE: An ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.

Pursuant to section 1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment “has been made, or can reasonably be expected to be made...” under liability insurance (including self-insurance), no-fault insurance, or a workers’ compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

CR 8984 includes modifications to Medicare systems to automate the fact that ORM responsibility is assumed, exists, or did exist for a particular period of time. All MACs shall

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reference the modified CWF MSPD screen to determine if ORM exists in association with MSPD (No-Fault – 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue. When claims are processed, Medicare will compare the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record. All MACs shall deny claims where the ORM indicator is present for the period covered by the claim **and** the diagnosis code(s) match(es) (or match(ed)) within the family of diagnosis codes). As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim be reprocessed. (Any claim will also process for a potential Workers' Compensation Medicare Set-Aside (WCMSA) denial where there is no denial based upon the ORM indicator.)

As stated above, MACs shall deny payment for claim lines with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not override this requirement; therefore, a conditional payment cannot be made to providers when ORM exists for the item or service in question. However, as stated, the reported ORM is not a guarantee that medicals will be paid indefinitely or through a particular date. Consequently, if a claim is denied on the basis of ORM and the MAC receives information that the policy limit has been appropriately exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where part of a group of claims submitted to the RRE was sufficient to exhaust the policy.

When Medicare denies claims due to the ORM indicator, the remittance advice for the denied claim will reflect one of the following Claims Adjustment Reason Codes (CARC) and Remittance Advice Remarks Codes (RARC):

- CARC 19 - “This is a work-related injury/illness and thus the liability of the Workers’ Compensation Carrier.” Also, RARC N728 – “A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis”—will appear. (NOTE: To be used with Group Code PR.)
- CARC 20 – “This injury/illness is covered by the liability carrier.” Also, RARC N725 – “A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis” —will appear. (NOTE: To be used with Group Code PR.)
- CARC 21 - “This injury/illness is the liability of the no-fault carrier.” Also, RARC N727 – “A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis” —will appear. (NOTE: To be used with Group Code PR.)

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However, Medicare payment will be made for services if the following codes and conditions are met (assumption: primary payer did not pay for an acceptable reason; for example, benefits appropriately exhausted, or benefits no longer covered due to state imposed limits, etc.):

- Any of the following CARCs are found on the ORM claim: 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 201, 204, 242, 256, B1 (if a Medicare covered visit), B14; and
- The service is covered and otherwise reimbursable by Medicare.

Additional Information

Important: Providers, physicians, and other suppliers should know that CMS is implementing use of the ORM indicator on a gradual basis, beginning in January 2016. Appeal rights apply to all claims denied due to ORM as part of MSP claims processing.

The official instruction, CR 8984, was issued to your MAC regarding this change via two transmittals. The first transmittal is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R114MSP.pdf> and the second transmittal is at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3358CP.pdf> on the CMS website.

You may find further information about the mandatory reporting required by liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans by going to <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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