Event	RRE Action

ORM Ends for One Injury, Continues for Another
• Claim previously submitted and accepted with ORM Indicator (Field 78) = 'Y', non-zero ORM Termination Date (Field 79), multiple ICD Diagnosis Codes reflecting ORM assumed for multiple injuries
• RRE's ORM subsequently ends for one or more injuries but ORM continues on the claim for one or more other injuries
	Send Update Record
	• '2' in the Action Type
	• Same values previously reported for
	  • Injured Party SSN/Medicare ID (Fields 4/5)
	  • CMS Date of Incident (Field 12)
	  • Plan Insurance Type (Field 51)
	  • 'Y' in ORM Indicator (Field 78)
	• Zeroes in the ORM Termination Date (Field 79)
	• ICD Diagnosis Codes reflecting injuries for which the RRE continues to have ORM (No ICD Diagnosis Codes related to injuries for which ORM ended)
	• Be sure to submit a valid value, not spaces, in ICD Diagnosis Code 1 (Field 18)
	• Same or updated information for all other fields
	• **Note:** Submit ORM Termination Date on subsequent update only when ORM ends for **all** alleged injuries for which the RRE assumed ORM

6.6.5 Claim Input File Reporting Do's and Don'ts

Here are some helpful reminders for RREs to be successful in submitting Section 111 claim information.

Disposition Code '51'

- RREs will receive this disposition code on their response file if the information submitted to identify a beneficiary is not matched to the information CMS has on file for Medicare beneficiaries. The BCRC must find an exact match on the Medicare ID (HICN or MBI) or SSN (i.e., the last 5 digits or full 9 digits of the SSN, whichever is submitted). Then at least three out of four of the following fields must be matched exactly (all four when a partial SSN is used): first initial of the First Name, first 6 characters of the Last Name, Date of Birth (DOB), and Gender. Please note: The matching process depends on the quality of the data submitted.
- If a disposition code of '51' is received, the RRE must validate all the information submitted in the injured party information fields.
- The RRE must check to ensure that data entered in these fields was both correct *and correctly submitted*.
- Example: On a Claim Input File Detail Record, the RRE submits correct beneficiary information. However, the RRE submits the Last Name in the First Name field and submits the First Name in the Last Name field. When this record is processed by the BCRC, a match will not be found on Medicare's records. Although the BCRC will find an exact match on the

Medicare ID, only two of the remaining four data elements (Date of Birth and Gender) exactly match Medicare's records. The response record will be returned with a disposition code '51'. The RRE must then check the data submitted in the injured party fields to ensure that it was both correct and correctly submitted. The RRE must make the appropriate corrections and resubmit the claim report on their next scheduled file submission.

- RREs are advised to obtain a valid Gender from the injured party or the query process prior to submitting claim reports to help ensure they receive a match.
- When using the query process, please be aware that when an RRE submits a query transaction with a '0' (unknown) in the Gender field, the system will change this value to '1' to attempt to get a match. If this record is not matched to a Medicare beneficiary, the Query Response File Record is returned with a disposition code of '51' and the converted '1' in the Gender field. The RRE should NOT use the Gender value returned in this case. The RRE must validate the correct Gender and all other injured party information prior to submitting the Claim Input File Detail Record.
- If the RRE has ensured that the data was submitted correctly and the claim does not have ORM, the record does not have to be resubmitted, unless subsequent TPOC payments are made.
- If the RRE has ensured that the data was submitted correctly, and the claim has ORM, the RRE must monitor the status of the injured party in order to determine if/when the injured party becomes covered by Medicare. Monitoring of the injured party must continue as long as the ORM remains open. When the individual becomes covered by Medicare, the RRE must submit a Claim Detail Record.
- If the ORM terminates and is not subject to reopening or otherwise subject to further request for payment, monitoring of such individuals may cease. One final query or claim report should be submitted after an ORM Termination Date has been reached, to ensure the RRE obtains the most up-to-date information on the individual before they stop checking.

Delete Transactions

Delete transactions should only be submitted to:

- Remove an entire record that was created in error (delete record), or
- To **correct** a key field (i.e., CMS Date of Incident (Field 12), Plan Insurance Type (Liability, No-Fault, Workers' Compensation in Field 51), Policy Number (Field 54), ORM Indicator (Field 78)). In this case, delete the transaction and then add the correction. Do not perform a delete/add to correct or change any other fields. Simply submit an update transaction to correct non-key fields.

RRE Address Validation

- RREs are encouraged to pre-validate insurer and recovery agent addresses using postal verification software or online tools available on the USPS website pages such as https://tools.usps.com/go/ZipLookupAction_input. RREs should try to use standard abbreviations and attempt to limit data submitted in these fields and adhere to USPS standards. The address validation enhancements in place will "scrub" addresses submitted on the TIN Reference File using USPS standards, and we recommend that RREs also attempt to meet these standards, to improve results. Although NGHP DDE reporters do not submit TIN

Reference Files, they do submit the same TIN information online. It is recommended that DDE reporters also pre-validate RRE addresses.

- Please address errors immediately, as TN errors delay MSP record posting.

Reporting ICD Diagnosis Codes

- Be sure to submit ICD Diagnosis Codes (starting in Field 18) that exactly match the first 5 positions of a code on the list of valid ICD-9s or ICD-10s (See Section 6.2.5 – ICD-9 and ICD-10 Codes). *Partial codes are not accepted*.
- Retain leading and trailing zeroes but do not add leading or trailing zeroes if they are not shown for the code in the list of valid ICD-9s and ICD-10s.
- *Do not include the decimal point*, but be sure to include any digits that may follow the decimal point. For example, ICD-9 diagnosis code 038.42 should be submitted as 03842. Records with any of these invalid entries will be rejected with the errors C105-C1023, depending on the fields in error.

Reporting ORM Information

- As soon as ongoing responsibility for medicals (ORM) is established, report the ORM as an add record (ORM Indicator set to 'Y'). Do not wait until the ORM has terminated before reporting the existence of ORM. If there is no established end date, a value of all zeroes must be entered in the ORM Termination Date.
- To terminate the ORM record, submit an update record with the ORM Termination Date and a 'Y' in the ORM Indicator field. Remember, if the claim ever involved ORM, it should be reported with a 'Y' in the ORM Indicator, even after ORM has terminated. Do not send a delete transaction when the RRE's ORM ends.
- When no-fault limits are reached and ORM is terminated on a no-fault insurance claim report (Plan Insurance Type 'D'), be sure to submit an ORM Termination Date (Field 79) in addition to the Exhaust Date for Dollar Limit for No-Fault Insurance (Field 62). Failure to submit an ORM Termination Date may result in improper denial of medical claims submitted to Medicare after no-fault limits are reached.

ORM Indicator/TPOC Threshold

- Add records submitted with 'N' in the ORM Indicator (Field 78) must contain a TPOC Amount greater than zero. There is no circumstance under which an RRE would submit 'N' in the ORM Indicator and no TPOC information. This will result in rejection of the record with the CJ07 error. Information is to be reported *after* the RRE assumes ORM or *after* there is a TPOC settlement, judgment, award, or other payment.

Reporting the Self-Insured Type

- The value in the Self Insured Type (Field 45) must correspond to the value in the Self Insured Indicator (Field 44). The Self Insured Type must be 'I' (Individual) or 'O' (Other than Individual) if the Self Insured Indicator is 'Y' (Yes). The Self Insured Type must be blank if the Self Insured Indicator is 'N' (No) or blank. Records submitted incorrectly will be rejected with a CS02 error.

Reporting the Plan Insurance Type

- Values in the Plan Insurance Type (Field 51) must correspond with the Self Insured Indicator (Field 44). If the Plan Insurance Type is 'E' (Workers' Compensation) or 'L' (Liability), the Self Insured Indicator must equal 'Y' (Yes) or 'N' (No). If the Plan Insurance Type is 'D' (No-Fault), the Self Insured Indicator must equal 'N' or blank.
- Note: If you are a liability insurer (self-insurer) that is administered as a no-fault plan, the Plan Insurance Type must be entered as 'L' (Liability).
- Please ensure that the Plan Insurance Type is entered correctly when the RRE is assuming ORM. Analysis of early files has identified numerous records where an RRE is mistakenly reporting Liability with an ORM indicator of "Y". Assuming ORM in Liability cases is not a common occurrence. While there are instances where this may be correct, RREs should review their information to be certain they have provided the correct Plan Insurance Type/ORM indicator combination.

Reporting the Policy Number

- The Policy Number (Field 54) is a required data element. In the case of self-insurance where the RRE has no policy number associated with the claim, this field must be filled with all zeroes—it may not be left blank. Records submitted with all blanks in the Policy Number field will be rejected with the error CP04.
- If multiple RREs are submitting claims under the same policy number, enter this number consistently and in the same format.
- While the Policy Number is not required when the insurance type is self insurance, if this number is available, please provide it on all new "add" records.

6.7 Ongoing Responsibility for Medicals (ORM) - When and What to Report

The following section reviews the 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 additional policy information. Please see Table 6-13 for a summarized view of the ORM reporting requirements for no-fault, liability insurance (including self-insurance), and workers' compensation.

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—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 for ORM reporting to be required.

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