



Your Premiere Compliance Solution

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Use of ICD-9 Diagnosis Codes in Medicare Section 111 Mandatory Reporting

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Webinar Questions and Answers

Question: If we need to put in alleged or released diagnoses for a TPOC report, this will result in demand for conditional payments on diagnoses we have not accepted. do you have strategy recommendation for how to deal with this issue on settlement documents

Answer: *First, understand that CMS is not bound by your determination as to liability. Second, understand that does not mean the carrier is automatically responsible for repayment of Medicare conditional payments outside of settlement. What should be done is to obtain the conditional payment information and put it on the settlement table as one other issue that must be resolved as part of settlement. Depending on the agreement to resolve this conditional payments this is then formalized in the settlement documents.*

Question: I often use ODG (Official Disability Guidelines), are those ICD-9 codes valid?

Answer: *Only the approved ICD-9 codes are to be used for Section 111 reporting.*

Question: In your example of an auto accident with no injury but payment for inconvenience over \$5,000. Would you simply enter NOINJ in the Diagnosis Code?

Answer: *As CMS has indicated in previous conference calls, reporting is mandatory any time medicals are claimed and/or released. So even if they don't claim medicals, if they release medicals it is technically reportable. If in your settlement documents you have any language implying the release against any future medical treatment related to this claim, you will technically have to report it.*

CMS is considering whether or not they can give some type of exception on reporting in situations where there are no medical claims. There's no, injury at all and reporting is only implicated because of the release.

But we don't have any final language on that as of yet. You cannot enter the NOINJ code if the policy is NO Fault. NOINJ is to be used in limited liability policies only for loss of consortium, EO etc. In this case you must enter a proper Cause of Injury E code and select at least one ICD 9 code that reflects the alleged problem.

Question: What would CMS consider the difference in using E8130 instead of E8120?

Answer: *E8120 is Other motor vehicle traffic accident involving collision with motor vehicle injuring driver of motor vehicle other than motorcycle. E8130 is Motor vehicle traffic accident involving collision with other vehicle injuring driver of motor vehicle other than motorcycle. The difference is that the vehicle in E8130 is non-motor, such as a bicycle.*

Question: Does ORM still exist AFTER a settlement is negotiated on a liability claim?

Answer: *Assuming ORM existed prior to settlement then if the settlement releases or has the effect of releasing future medicals for the claim then no ORM would not continue. Legal statutes vary state by state for when ORM can be terminated.*



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Question: When can/should a liability claim be closed?

Answer: *The definition of closed is vague. If you make any medical payments towards a claim and that claimant is Medicare eligible then you must report that claim as ORM as soon as you accept that responsibility (even if you have not paid out any monies to that point). By CMS statutes the claim is closed for Section 111 reporting purposes once you have a settlement, judgment or award that releases future medical payment responsibilities.*

Question: Should all claims be reported to CMS, regardless of the liability decision?

Answer: *It does not require a determination or admission of liability. So the fact that you reach a settlement and continue to deny liability does not release you from an obligation to report. You have reporting responsibilities as long as there is a settlement, judgment, award or other payment involving a Medicare eligible claimant.*

Question: What if person has an auto. accident but does not seek medical treatment. They are paid a settlement for "inconvenience" - does that have to be reported?

Answer: *If the claimant signs a release for any future medical treatment related to that claim then if the settlement value is over \$5,000 then the claim is currently considered reportable. Again, CMS is looking to add language that clearly defines situations where medical treatment is not sought and no injuries are alleged that would negate reporting of this type of claim.*

Question: Do you have to report an injury code and ICD-9 for claims you have no ORM?

Answer: *There are only two types of claims that CMS is looking to be reported, ORM and TPOC settlements. Both require Cause of Injury E codes and at least one ICD 9 code for reporting purposes.*

Question: If there is just an ambulance evaluation at the scene of an accident, and no further injury is claimed, does this need reported to CMS as an ORM?

Answer: *If the policy is a No Fault one then yes it should be reported if the claimant is Medicare eligible. If it is a Liability policy then if the claimant signs a release for any future Medical treatment and the value of any medical services rendered is less than \$5,000 then this claim would not be reported.*

Question: The \$5K threshold is currently being used or we have to wait until 2012?

Answer: *The \$5,000 threshold for reporting TPOC is now in effect.*

*Thank you again for attending MedAllocators' January webinar. To learn about upcoming webinars or if you have additional questions, please contact your local Account Executive or utilize the **ASK an EXPERT** section on our website at www.MedAllocators.com.*