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VIA EMAIL

Steve Forry
Division Director
Center for Medicare and Medicaid Services
Office of Financial Management, Medicare
Secondary Payor Unit
7500 Security Boulevard
Baltimore, MD 21244

RE: MARC Coalition – ORM Call

Dear Steve:

On behalf of the MARC Coalition, thank you and your team for meeting with us on Thursday, March 9, to discuss ORM issues. We appreciate the engagement on finding solutions to the problems continuing to affect all stakeholders involved in the ORM process, and we are grateful for your commitment to help Medicare beneficiaries who are inappropriately being denied care for treatments unrelated to an accident or injury subject to the MSP process.

In follow up to our call, we wanted to set out three specific requests for how the ORM program could be reformed in a beneficial manner for all stakeholders. Before doing so, however, we want to reiterate a key point that we discussed on the call – approximately 20% of all ORM cases are reported because an insurer has opened a claim even though no treatment has been sought, or will ever be sought, by a beneficiary/policyholder covered by a no fault policy or an employee covered by workers' compensation. It is routine practice for insurers of all types to open claims files and accept ongoing responsibility for medicals *even in cases where medicals are not being claimed and will not in the future be claimed.* Typically, these claims are closed promptly (within weeks of being opened) because no medicals have been claimed and in the best judgment of the adjuster no medicals will be claimed. But Medicare requires these "no treatment" ORM claims be kept open, and there is no way for primary plans to terminate ORM in these cases without a signed physician statement.

Other insurers with potential subrogation claims, including Medicaid programs, rely on the judgment of the adjusters to determine appropriate claim closure. It is these Medicare "no treatment" claims that are of significant concern. We urge CMS to investigate actual claims practices, how the Agency's User Guide must be implemented, and the impact on beneficiaries, as it considers the below requests.

As to our proposals for ORM reform, we urge CMS to undertake the following changes as soon as possible:

1. If the accident/event occurs during the coverage period and the post-accident/event examination of the beneficiary establishes that the beneficiary will not be seeking treatment for any injuries resulting from the covered accident/event, the RRE can terminate ORM when the RRE establishes no treatment will be sought.
2. Eliminate the requirement (User Guide, Chapter III, Section 6.3.2 first bullet) that ORM can only be terminated following receipt of a letter from a treating physician, and instead allow ORM to be terminated when, in the best professional judgment of the insurer, a claim is administratively closed, or there is other reasonable evidence that no future medical treatment will be needed (such as an Independent Medical Evaluation letter, a chart note, a "*pro re nata"* or PRN record, beneficiary attestation that they will seek no further treatment for a loss, or any other indication of no further treatment); and
3. Increasing the $25,000 claim "threshold" to $100,000 (in Section 6.3.2, second bullet, fourth sub-bullet) and decrease the five year time frame to three years.

We appreciate your consideration of our request, and welcome further constructive dialogue with CMS on these important issues.

Please let us know if we can provide any additional information to you.

Sincerely,

David Farber

cc: Jacqueline Cipa, CMS