



News Flash - Effective January 1, 2008, National Provider Identifiers (NPIs) will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.) You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims until May 23, 2008, if you choose.

MLN Matters Number: MM5780

Related Change Request (CR) #: 5780

Related CR Release Date: November 2, 2007

Effective Date: April 1, 2008

Related CR Transmittal #: R1369CP

Implementation Date: April 7, 2008

Note: This article was updated on September 25, 2012, to reflect current Web addresses. All other information remains the same.

Crossover of Assignment of Benefits Indicator (CLM08) From Paper Claim Input

Provider Types Affected

Physicians and suppliers submitting paper claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

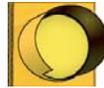
Provider Action Needed



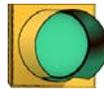
STOP – Impact to You - This article is based on Change Request (CR) 5780 which makes system changes to the manner in which the Medicare sets the CLM08 value in the Coordination of Benefits (COB) flat file for transmission of claims to COB partners.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



CAUTION – What You Need to Know – CR 5780 will result in changes to Medicare systems to appropriately set the correct indicator in CLM08 based on the presence of or lack of a patient signature in box/item 13 of the Form CMS-1500.



GO – What You Need to Do – See the Background and Additional Information Sections of this article for further details regarding these changes and be sure billing personnel complete box/item 13 of the Form CMS-1500 in accordance with the revised instructions.

Background

The basic claims form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program is the Form CMS-1500. It answers the needs of many health insurers, and it is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 (http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr424_02.html).

Coordination of Benefits (COB) trading partners requested that CMS change the current process of automatically setting a “Y” value in the CLM08 segment of the 837 Professional Coordination of Benefits (COB) claim crossover file. Trading partners may use the CLM08 value to determine where the claim reimbursement is to go and have, in some cases, reimbursed the provider instead of the beneficiary.

Note: CLM08 is the assignment of benefits indicator, and a “Y” value indicates insured or authorized person authorizes benefits to be assigned to the provider; an “N” value indicates benefits have not been assigned to the provider.

CR 5780 initiates system changes to appropriately set the correct indicator in CLM08 based on the presence of or lack of a signature in box/item 13 of the Form CMS-1500. In addition, CR5780 revises the Form CMS-1500 claim completion instructions in order to inform providers regarding how the presence or lack of a signature in box 13 will affect downstream patient assignment of benefits. Specifically, the Medicare Claims Processing Manual (Chapter 26, Section 10.3 – Items 11a-13 – Patient and Insured Information) is revised (*changes are bolded and italicized*) as follows:

“Item 13 - The patient’s signature or the statement “signature on file” in this item authorizes payment of medical benefits to the physician or supplier.

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The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream Coordination of Benefits trading partners (supplemental insurers) with whom we have a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may or may not affect supplemental payments to providers and/or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked."

NOTE: This can be "Signature on File" signature and/or a computer generated signature."

The business requirements in CR 5780 do not affect inbound claims or current Medicare claims processing guidelines. They specifically address COB claims only which are sent to trading partners.

Additional Information

The official instruction, CR5780, issued to your carrier, DME MAC, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1369CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare carrier, DME MAC, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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