CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1369	**Date: NOVEMBER 02, 2007**
	Change Request 5780

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

I. SUMMARY OF CHANGES: System changes are being made to the manner in which the shared system sets the CLM08 value in the Coordination of Benefits (COB) flat file. Language is being modified in the Internet Only Manual Form CMS-1500 submission requirements related to box 13 which clarifies the COB ramifications of completing or not completing box 13 of the Form CMS-1500.

New / Revised Material
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	26/10.3/Items 11a - 13 - Patient and Insured Information

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1369	Date: November 2, 2007	Change Request: 5780

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

Effective Date: **April 1, 2008**

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: Coordination of Benefits (COB) trading partners are requesting that CMS change the current process of automatically setting a "Y" value in the CLM08 segment of the 837 Professional 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.

Shared systems and contractors are requested to initiate system changes to appropriately set the correct indicator in CLM08 based on the presence of or lack of a signature in box 13 of the Form CMS-1500. In addition, the Form CMS-1500 claim completion instructions are being revised in order to inform providers regarding how the presence or lack of a signature in box 13 will affect downstream patient assignment of benefits.

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

B. Policy: The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program and 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, Pub.L. 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5780.1	Contractors shall make the necessary internal changes to recognize the presence of a signature or the statement "signature on file and/or SOF" in box 13 of the Form CMS-1500.	X	X		X							
5780.1.1	The presence of a signature or "signature on file and/or SOF" in box 13 shall be internally flagged as "Y".	X	X		X							
5780.1.2	The lack of a signature or "signature on file and/or SOF" in box 13 shall be internally flagged as "N".	X	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5780.2	The shared system maintainers shall develop system modifications to capture the box 13 indicators from the contractors and use the value to set the appropriate CLM08 value on the outbound claim.								X	X		
5780.2.1	The internal box 13 indicator of "Y" shall set the value of "Y" in CLM08 on the outbound COB flat file.								X	X		
5780.2.2	The internal box 13 indicator of "N" shall set the value of "N" in CLM08 on the outbound COB flat file.								X	X		
5780.3	Contractors shall note the changes in chapter 26 of Pub. 100-04	X	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5780.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	**X**	**X**		**X**							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov

Post-Implementation Contact(s): Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:

The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10.3 - Items 11a - 13 - Patient and Insured Information

(Rev. 1369; Issued: 11-02-07; Effective: 04-01-08; Implementation: 04-07-08)

Item 11a - Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Item 11b - Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."

Item 11c - Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d - Leave blank. Not required by Medicare.

Item 12 - The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, “General Billing Requirements.” If the patient is physically or mentally unable to sign, a representative specified in Chapter 1, "General Billing Requirements” may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by “by” the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless *the* patient or the patient's representative revokes this arrangement.

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

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

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. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient’s signature or a*

“signature on file” is not required in order for Medicare payment to be made directly to the physician or supplier.

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 CMS has 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 affect supplemental payments to providers and/or their patients.

*In addition, t*he 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.