Job Aid: Reporting Coordination-of-Benefits (COB) Information on Institutional Direct Data Entry (DDE) Claim Submissions When a Third-Party Insurance Has Adjudicated the Claim

This job aid describes the steps providers should follow to report coordination of benefits (COB) information on their institutional direct data entry (DDE) claim submission to MassHealth when another insurer such as Medicare, Medicare Advantage, Commercial, or Casualty Payer has adjudicated the claim. When submitting an institutional DDE claim, follow instructions outlined in the MassHealth Institutional Claims Submission job aid, then use this job aid to report COB information.

> **Note:** Fields with an asterisk are required fields and must be completed to proceed to the next panel.

For specific billing information, providers should reference the relevant billing guides available at:

- MassHealth Provider Publications
- MassHealth Administrative and Billing Regulations, Third Party Liability at 130 CMR 450.316 through 450.318
- Administrative and Billing Instructions, Part 7. Other Insurance
- MassHealth Standard HIPAA Companion Guide for Health Care Claim: Institutional (837I)

Institutional Claims with COB information must follow COB balancing rules as described in the HIPAA 837I Implementation guide. See examples of COB balancing at the end of this job aid.

Coordination of Benefits

1. Click on the **Coordination of Benefits** tab.

On the **List of Coordination of Benefits (COB)** panel:

2. Click **New Item**. The **Coordination of Benefits (COB) Detail** panel displays.

Enter Single Claim
Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

List of Coordination of Benefits (COB)
There is a maximum of 10 COB records.

Carrier Code	Name	Remittance Date	COB Payer Paid Amt.

New Item

Coordination of Benefits (COB) Detail

On the **COB Detail** panel:

3. In the **Carrier Code*** field, enter the MassHealth seven-digit third-party insurance carrier code located in the Eligibility Verification System (EVS). On each date of service and at time of billing, check EVS before submitting your claim to verify the member's other health insurance coverage and obtain the MassHealth third party insurance carrier code.
4. In the **Carrier Name*** field, enter the other insurance carrier name.
5. The **Remittance Date** is a critical field and cannot be entered on both the **Coordination of Benefits** tab and **Procedure** tab.

   In the **Remittance Date** field on the **Coordination of Benefits** tab, enter the other payer's remittance date for inpatient and nursing facility room and board claims or when reporting a Casualty Payer claim.

   For outpatient claims, only enter the **Remittance Date** on the **Coordination of Benefits** tab when one of the following applies:

   - You are reporting a HIPAA claim adjustment amount to balance a Casualty Payer claim, OR
   - You are reporting a HIPAA claim adjustment amount that has been applied to the entire claim and cannot be distributed at the detail service lines.

   If either of the above does not apply to the outpatient claim, enter the **Remittance Date** on the **Procedure** tab**.**
6. In the **Payer Claim*** number field, enter the other insurance claim number.
7. In the **Payer Responsibility*** field, select the appropriate code from the dropdown list.
8. In the **COB Payer Paid Amount** field, enter the amount paid by the other insurance.
9. Only authorized provider types may enter a value in the **Total Noncovered Amount** field. Authorized provider types can refer to the Supplemental Instructions for Submitting Claims with Other Insurance appendix in their provider manual. The appendix outlines the specific conditions for which this field may be used and provides billing instructions.
10. Do not enter a value in the **Remaining Patient Liability** field**.** This is not a required field and is not necessary for claims adjudication.
11. In the **Claims Filing Indicator*** field, select the appropriate code from the dropdown list.
    - Select MA for Medicare Part A
    - Select MB for Medicare Part B
    - Select CI for Commercial Insurance (includes Medicare Advantage & supplemental plans)
12. In the **Release of Information*** field, select the appropriate code from the dropdown list.
13. In the **Assignment of Benefits*** field, select the appropriate code from the dropdown list.

14. In the **Relationship to Subscriber*** field, select the appropriate code from the dropdown list.

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

List of Coordination of Benefits (COB)

There is a maximum of 10 COB records.

Carrier Code	Name	Remittance Date	COB Payer Paid Amt.

New Item

Coordination of Benefits (COB) Detail

Carrier Code *
Carrier Name *
Remittance Date
Payer Claim # *
Payer Responsibility *
COB Payer Paid Amount
Total Non-Covered Amount
Remaining Patient Liability
Claim Filing Indicator *
Release of Information *
Assignment of Benefits *
Relationship to Subscriber *
Populate Subscriber
Subscriber Last Name *
Subscriber First Name *

If you selected **18—SELF** from the **Relationship to Subscriber** dropdown list, then click **Populate Subscriber**. The following data fields that have been entered on the **Billing and Service** tab will be populated:

- Subscriber Last Name
- Subscriber First Name
- Subscriber Address
- Subscriber City
- Subscriber State
- Subscriber Zip Code

If you select any other value from the **Relationship to Subscriber** dropdown list, you must enter the following required fields.

- Subscriber Last Name
- Subscriber First Name

15. In the **Subscriber ID*** field, enter the other insurance subscriber ID number.

    Note: The remaining data fields on this panel starting from **Subscriber Group #** through **PPS-Capital Exception Amount** are not required for claim adjudication.

Subscriber ID *
Subscriber Group #
Group Name

Outpatient Adjudication Information

Reimbursement Rate | Claim HCPCS Payable Amount
Remark Code1
Remark Code2
Remark Code3
Remark Code4
Remark Code5
Claim ESRD Payment Amount | Nonpayable Professional Component Amount

Inpatient Adjudication Information

Covered Days or Visits
Lifetime Psychiatric Days | Claim DRG Amount
Remark Code1
Claim Disproportionate Share Amount | Claim MSP Pass-through Amount
Claim PPS Capital Amount | PPS-Capital FSP DRG Amount
PPS-Capital HSP DRG Amount | PPS-Capital DSH DRG Amount
Old Capital Amount | PPS-Capital IME Amount
PPS-Operating Hospital Specific DRG Amount | Cost Report Day Count
PPS-Operating Federal Specific DRG Amount | Claim PPS Capital Outlier Amount
Claim Indirect Teaching Amount | Nonpayable Professional Component Amount
Remark Code2
Remark Code3
Remark Code4
Remark Code5
PPS-Capital Exception Amount

Cancel Item | Add

16. For all inpatient and nursing facility room and board claims, continue to the next step in the **List of COB Reasons/COB Reasons Detail Panel** section.

    For outpatient claims, skip to step 23 to save the information that has been entered on **COB Detail** panel unless:

    - You are reporting a HIPAA claim adjustment amount to balance a Casualty Payer claim OR
    - You are reporting a HIPAA claim adjustment amount that the other payer has applied to the entire claim and cannot be distributed at the detail service lines.

    If either of the above is true for the outpatient claim, continue to the **List of COB Reasons/COB Reasons Detail Panel** section.

List of COB Reasons/COB Reasons Detail Panel

For inpatient and nursing facility room and board claims, complete this panel. Do not repeat this information on the **Procedure** tab.

For outpatient claims, data is entered in this panel only when:

- you are reporting a HIPAA claim adjustment amount to balance a Casualty Payer claim, OR
- you are reporting a HIPAA claim adjustment amount that the other payer has applied to the entire claim and cannot be distributed at the detail service lines.

This HIPAA claim adjustment amount cannot be entered on both the **Coordination of Benefits** and the **Procedure** tabs.

On the **List of COB Reasons** panel:

17. Click **New Item**. The **COB Reasons Detail** panel displays.

Cancel Item | Add

List of COB Reasons

There is a maximum of 30 COB reason records.

		Group Code	Reason	Amount

New Item

On the **COB Reasons Detail** panel:

18. In the **Group Code*** field, select the appropriate HIPAA Claim Adjustment Group code (CAGC) identifying the general category of payment adjustment from the dropdown list.
19. In the **Amount*** field, enter the HIPAA adjustment amount associated with the group/reason code.
20. In the **Unit of Service*** field, enter the units of service being adjusted.
21. In the **Reason*** field, enter the HIPAA Claim Adjustment Reason code (CARC) identifying the detailed reason that the adjustment was made. Do not enter proprietary insurance reason codes. Proprietary codes must be translated to a HIPAA CARC.
22. Click **Add** to save COB Reasons Detail.

List of COB Reasons

There is a maximum of 30 COB reason records.

		Group Code	Reason	Amount

New Item

COB Reasons Detail

Group Code * | Amount *

Reason * | Units of Service *

Cancel Item | Add

Cancel Service

Note: To report additional COB Reasons, repeat steps 16–22.

23. Click **Add** on the **COB Detail Information** panel to save the COB information.

PPS-Capital Exception Amount

Cancel Item | Add

List of COB Reasons

There is a maximum of 30 COB reason records.

		Group Code	Reason	Amount
		Patient Responsibility	1	$100.00

New Item

Cancel Service

Note: To report multiple payers, click **New Item** on the **List of COB** panel, and then repeat steps 1–22. Otherwise, continue to the **Procedure** tab.

Inquire Claim Status

Billing and Service | Extended Services | *Coordination of Benefits* | Procedure | Attachments | Confirmation

List of Coordination of Benefits (COB)

There is a maximum of 10 COB records.

		Carrier Code	Name	Remittance Date	COB Payer Paid Amt.
		0085000	Medicare Part B		$50.00
		0602006	UMR		$100.00

New Item

Institutional Service Detail Panel

Providers should follow the instructions described in the MassHealth Institutional Claims Submission job aid to complete the **Institutional Service Detail** panel. Then, follow these steps to report COB.

For outpatient claims, the detailed COB information must be entered on the **COB Line Details** panel and the **COB Reasons Detail** panel.

On the **List of COB Line Items** panel:

24. Click **New Item**. The **COB Line Details** panel displays.

List of COB Line Items

There is a maximum of 15 procedure COB records.

		Carrier Code	Remittance Date	Paid Amt.	Paid Units of Service	Bundled Line

New Item

On the **COB Line Details** panel:

25. In the **Carrier Code*** field, the carrier code will pre-populate with the carrier code that was entered on the **Coordination of Benefits** tab. If there are multiple carrier codes, select the appropriate code from the dropdown list.

26. In the **Bundled into Line #** field, enter the line number of the service line into which this service has been bundled. This field should only be used when the other insurance has bundled payment for a set of services. See example at end of job aid.
27. In the **Remittance Date** field, enter the other payer's remittance date. The Remittance Date is a critical field for COB adjudication and must be entered on the Procedure tab.
28. In the **Paid Amount** field, enter the amount paid by the other insurance.
29. In the **Paid Units of Service*** field, enter the number of paid units.
30. In the **Revenue Code*** field, enter the appropriate revenue code.
31. Do not enter a value in the **Remaining Patient Liability** field**.** This is not a required field and is not necessary for claims adjudication.
32. In the **Procedure Code** field, enter the procedure code associated with the revenue code if applicable.
33. In the **Modifier** fields, enter the modifiers associated with the procedure code if applicable.
34. In the **Proc Qualifier** field, enter the procedure qualifier associated with the procedure code if applicable.

COB Line Details

Carrier Code *
Bundled into Line #
Remittance Date
Paid Amount
Paid Units of Service *
Revenue Code *
Remaining Patient Liability
Procedure Code
Modifier 1
Modifier 2
Modifier 3
Modifier 4
Proc Qualifier
Cancel Item
Add

On the **List of COB Reasons** panel:

35. Click **New Item**. **The COB Reasons Detail** panel displays.

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

		Group Code	Reason	Amount

New Item

On the **COB Reasons Detail** panel:

36. In the **Group Code*** field, select the appropriate HIPAA Adjustment Group code (CAGC) to identify the general category of payment adjustment from the dropdown list.
37. In the **Amount*** field, enter the HIPAA adjustment amount associated with the group/reason code.
38. In the **Reason*** field, enter the HIPAA Adjustment Reason code (CARC) identifying the detailed reason that the adjustment was made. Do not enter proprietary insurance reason codes. Proprietary codes must be translated to a HIPAA CARC.
39. In the **Units of Service*** field, enter the units of service being adjusted.

40. Click **Add** to save **COB Reasons Detail**.

Note: To report additional COB Reasons, repeat steps 37–41.

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

		Group Code	Reason	Amount

New Item

COB Reasons Detail

Group Code * Amount *

Reason * Units of Service *

Cancel Item Add

41. Click **Add** again to save the **COB Line Details.**

Note: To report multiple payers, repeat steps 25–42.

COB Line Details

Carrier Code * Bundled into Line #

Remittance Date Paid Amount

Paid Units of Service * Revenue Code *

Remaining Patient Liability

Procedure Code Modifier 1 Modifier 2 Modifier 3 Modifier 4

Proc Qualifier

Cancel Item Add

42. Click **Add** again to save the **Institutional Service Detail** panel information.

Note: Refer to the MassHealth Institutional Claims Submission job aid to complete a claim submission.

Cancel Item Add

List of COB Line Items

There is a maximum of 15 procedure COB records.

		Carrier Code	Remittance Date	Paid Amount	Paid Units of Service	Bundled Line

The following pages contain COB Balancing and Bundled Payment Examples.

COB Balancing Examples for Institutional Claims *(for reference purposes only)*

Example 1: Claim Billed Amount Balancing for an Inpatient and Nursing Facility Room and Board Claims

Claim Billed Amount Balancing: For each payer reported on the claim, the **Total Charges** entered on the **Billing and Service** tab ($1,980.04) must balance to the sum of **COB Payer Paid Amount** ($690.02) and the claim level HIPAA Adjustment **Amounts** ($983.53 + $300.00 + $6.49 = $1,290.02) entered on the **Coordination of Benefits** tab.

Billing and Service Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

Claims Charges

Total Charges * $1,980.04 Patient Responsibility

Coordination of Benefits Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

List of Coordination of Benefits (COB)

There is a maximum of 10 COB records.

Carrier Code	Name	Remittance Date	COB Payer Paid Amt.
0084000	MEDICARE A	02/01/2024	$690.02

New Item

List of COB Reasons

There is a maximum of 30 COB reason records.

Group Code	Reason	Amount
Contractual Obligations	45	$983.53
Patient Responsibility	1	$300.00
Patient Responsibility	2	$6.49

New Item

Example 2: Payer Paid Amount Balancing and Service Line Billed Amount Balancing for an Outpatient Claim

COB Payer Paid Amount Balancing: For each payer reported on the claim, the **COB Payer Paid Amount** ($591.22) entered on the **Coordination of Benefits** tab must balance to the sum of all the service line other payer **Paid Amounts** entered on the **Procedure** tab in the **COB Line Details** panel detail 1 ($591.22) and detail 2 ($0.00).

Coordination of Benefits Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

List of Coordination of Benefits (COB)

There is a maximum of 10 COB records.

Carrier Code	Name	Remittance Date		COB Payer Paid Amt.
0084000	MEDICARE A			$591.22

New Item

Procedure Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

Detail 1

COB Line Details

Carrier Code *	0084000	Bundled into Line #	
Remittance Date	2/01/2024	Paid Amount	$591.22
Paid Units of Service *	10	Revenue Code *	0120
Remaining Patient Liability			
Procedure Code		Modifier 1 / Modifier 2 / Modifier 3 / Modifier 4	
Proc Qualifier	HC - HCPCS Codes		

Cancel Item | Add

Detail 2

COB Line Details

Carrier Code *	0084000	Bundled into Line #	
Remittance Date	02/01/2024	Paid Amount	$0.00
Paid Units of Service *	1	Revenue Code *	0760
Remaining Patient Liability			
Procedure Code		Modifier 1 / Modifier 2 / Modifier 3 / Modifier 4	
Proc Qualifier	HC - HCPCS Codes		

Cancel Item | Add

Service Line Billed Amount Balancing: For each payer reported on the claim, the Provider Billed Amount **(Charges)** for the service line entered on the **Procedure** tab must balance to the sum of the service line other payer **Paid Amount** and service line HIPAA Adjustment **Amounts** entered on the **Procedure** tab.

Detail 1: Provider Billed Amount **(Charges)** for the service line ($980.04) equals the sum of the other payer **Paid Amount** ($591.22) and the service line HIPAA Adjustment **Amounts** ($217.20 + $28.64 + $142.98 = $388.82)

Procedure Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure
Attachments | Confirmation

Detail 1

List of Institutional Services

There is a maximum of 999 institutional service detail records.

	Detail	Rev Code	Service Date Range	Procedure	Units	Charges
	02	0760	01/10/2024 - 01/10/2024		1	$363.17
→	01	0120	01/10/2024 - 01/10/2024		10	$980.04

New Item

COB Line Details

Carrier Code * 0084000

Remittance Date 02/01/2024

Paid Units of Service * 10

Remaining Patient Liability

Procedure Code

Proc Qualifier HC - HCPCS Codes

Bundled into Line #

Paid Amount $591.22

Revenue Code * 0120

Modifier 1 Modifier 2

Modifier 3 Modifier 4

Cancel Item Update Remove

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

		Group Code	Reason		Amount
		Contractual Obligations	45		$217.20
		Patient Responsibility	1		$28.64
		Patient Responsibility	2		$142.98

New Item

Service Line Billed Amount Balancing: For each payer reported on the claim, the Provider Billed Amount **(Charges)** for the service line entered on the **Procedure** tab must balance to the sum of the service line other payer **Paid Amount** and service line HIPAA Adjustment **Amounts** entered on the **Procedure** tab.

Detail 2: Provider Billed Amount **(Charges)** for the service line ($363.17) equals the sum of the other payer **Paid Amount** ($0.00) and the service line HIPAA Adjustment **Amounts** ($363.17)

Procedure Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

Detail 2

List of Institutional Services

There is a maximum of 999 institutional service detail records.

	Detail	Rev Code	Service Date Range	Procedure	Units	Charges
→	02	0760	01/10/2024 - 01/10/2024		1	$363.17
	01	0120	01/10/2024 - 01/10/2024		10	$980.04

New Item

COB Line Details

Carrier Code: 0084000
Bundled into Line #:
Remittance Date: 02/01/2024
Paid Amount: $0.00
Paid Units of Service: 1
Revenue Code: 0760
Remaining Patient Liability:
Procedure Code:
Modifier 1: | Modifier 2:
Modifier 3: | Modifier 4:
Proc Qualifier: HC - HCPCS Codes

Cancel Item | Add

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

Group Code	Reason	Amount
Patient Responsibility	96	$363.17

New Item

Example 3: COB Payer Paid Amount Balancing for an Outpatient Claim

A HIPAA Claim Adjustment Amount has been applied to the entire claim and cannot be distributed at the detail lines and Service Line Billed Amount Balancing.

COB Payer Paid Amount Balancing: For each payer reported on the claim, the **COB Payer Paid Amount** ($155.00) entered on the **Coordination of Benefits** tab must balance to the sum of all the service line other payer **Paid Amounts** entered on the **Procedure** tab in the **COB Line Details** panel (detail 1 ($150.00) and detail 2 ($20.00)) minus the claim level HIPAA Adjustment **Amount** ($15.00) entered on the **Coordination of Benefits** tab.

Coordination of Benefits Tab

Billing and Service Confirmation | Extended Services | Coordination of Benefits | Procedure | Attachments

List of Coordination of Benefits (COB)

There is a maximum of 10 COB records.

Carrier Code	Name	Remittance Date	COB Payer Paid Amt.
0084000	MEDICARE A		$155.00

New Item

List of COB Reasons

There is a maximum of 30 COB reason records.

Group Code	Reason	Amount
Patient Responsibility	1	$15.00

New Item

Procedure Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

Detail 1

COB Line Details

Field	Value	Field	Value
Carrier Code *	0084000	Bundled into Line #	
Remittance Date	02/01/2024	Paid Amount	$150.00
Paid Units of Service *	10	Revenue Code *	0120
Remaining Patient Liability			
Procedure Code		Modifier 1 / Modifier 2 / Modifier 3 / Modifier 4	
Proc Qualifier	HC - HCPCS Codes		

Cancel Item | Update | Remove

Detail 2

COB Line Details

Field	Value	Field	Value
Carrier Code *	0084000	Bundled into Line #	
Remittance Date	02/01/2024	Paid Amount	$20.00
Paid Units of Service *	1	Revenue Code *	0760
Remaining Patient Liability			
Procedure Code		Modifier 1 / Modifier 2 / Modifier 3 / Modifier 4	
Proc Qualifier	HC - HCPCS Codes		

Cancel Item | Update | Remove

Service Line Billed Amount Balancing: For each payer reported on the claim, the Provider Billed Amount **(Charges)** for the service line entered on the **Procedure** tab must balance to the sum of the service line other payer **Paid Amount** and service line HIPAA Adjustment **Amounts** entered on the **Procedure** tab.

Detail 1: Provider Billed Amount **(Charges)** for the service line ($240.00) equals the sum of the other payer **Paid Amount** ($150.00) and the service line HIPAA Adjustment **Amounts** ($60.00 + $30.00= $90.00)

Procedure Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

Detail 1

List of Institutional Services

There is a maximum of 999 institutional service detail records.

Detail	Rev Code	Service Date Range	Procedure	Units	Charges
01	0120	01/10/2024 - 01/10/2024		10	$240.00
02	0760	01/10/2024 - 01/10/2024		1	$60.00

New Item

COB Line Details

Carrier Code * 0084000
Bundled into Line #
Remittance Date 02/01/2024
Paid Amount $150.00
Paid Units of Service * 10
Revenue Code * 0120
Remaining Patient Liability
Procedure Code
Modifier 1 | Modifier 2 | Modifier 3 | Modifier 4
Proc Qualifier HC - HCPCS Codes

Cancel Item | Update | Remove

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

Group Code	Reason	Amount
Contractual Obligations	45	$60.00
Patient Responsibility	2	$30.00

New Item

Service Line Billed Amount Balancing: For each payer reported on the claim, the Provider Billed Amount **(Charges)** for the service line entered on the **Procedure** tab must balance to the sum of the service line other payer **Paid Amount** and service line HIPAA Adjustment **Amounts** entered on the **Procedure** tab.

Detail 2: Provider Billed Amount **(Charges)** for the service line ($60.00) equals the sum of the other payer **Paid Amount** ($20.00) and the service line HIPAA Adjustment **Amounts** ($35.00 + $5.00= $40.00)

Procedure Tab

Billing and Service | Extended Services | Coordination of Benefits | Procedure | Attachments | Confirmation

Detail 2

List of Institutional Services

There is a maximum of 999 institutional service detail records.

	Detail	Rev Code	Service Date Range	Procedure	Units	Charges
	01	0120	01/10/2024 - 01/10/2024		10	$240.00
→	02	0760	01/10/2024 - 01/10/2024		1	$60.00

New Item

COB Line Details

Carrier Code * 0084000
Bundled into Line #
Remittance Date 02/01/2024
Paid Amount $20.00
Paid Units of Service * 1
Revenue Code * 0760
Remaining Patient Liability
Procedure Code
Modifier 1 Modifier 2
Modifier 3 Modifier 4
Proc Qualifier HC - HCPCS Codes

Cancel Item | Update | Remove

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

Group Code	Reason	Amount
Contractual Obligations	45	$35.00
Patient Responsibility	2	$5.00

New Item

COB Balancing Error Messages

When a COB DDE claim is not balanced, one of the following error messages will appear on the **Confirmation** page.

- The sum of all line level payments amounts less any claim level adjustment amounts must balance to the claim level payment amount for the matched payer. Please correct and submit.

- The sum of the line level adjustment amounts and line level payments in each line adjudication information loop must balance to the provider's charge for that line. Please correct and submit.

Bundled Payment Example (*for reference purposes only*)

The Bundled into Line # field should only be used when the other payer has bundled payment for a set of services.

In this example, there is a bundled payment of $100 on Detail 1.

The Bundled into Line # of 1 on Detail 2 indicates that Detail 2 has been bundled into other payer paid amount on Detail 1.

Procedure Tab

Enter Single Claim

Billing and Service Confirmation | Extended Services | Coordination of Benefits | Procedure | Attachments

Detail 1

COB Line Details

Carrier Code * 0200008
Bundled into Line #
Remittance Date 02/01/2024
Paid Amount $100.00
Paid Units of Service * 1
Remaining Patient Liability
Procedure Code * 99285
Modifier 1 | Modifier 2
Modifier 3 | Modifier 4
Prior Authorization #
Referral #

Cancel Item | Update | Remove

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

Group Code	Reason	Amount
Other adjustments	45	$80.00
Patient Responsibility	2	$20.00

New Item

Detail 2

COB Line Details

Carrier Code * 0200008
Bundled into Line # 1
Remittance Date 02/01/2024
Paid Amount $0.00
Paid Units of Service * 1
Remaining Patient Liability
Procedure Code * 93042
Modifier 1 | Modifier 2
Modifier 3 | Modifier 4
Prior Authorization #
Referral #

Cancel Item | Update | Remove

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

Group Code	Reason	Amount
Contractual Obligations	97	$250.00

New Item