



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

This job aid describes the steps that providers should follow to report coordination of benefits (COB) information on their professional 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 a professional DDE claim, follow instructions outlined in the [MassHealth Professional 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: Professional \(837P\)](#)

Professional claims with COB information must follow COB balancing rules as described in the HIPAA 837 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.

The screenshot shows a web application interface with a navigation bar at the top containing tabs: 'Billing and Service', 'Extended Services', 'Coordination of Benefits', 'Procedure', 'Attachments', and 'Confirmation'. The 'Coordination of Benefits' tab is active. Below the navigation bar is a section titled 'List of Coordination of Benefits (COB)' with a sub-header 'There is a maximum of 10 COB records.' Below this is a table with columns: 'Carrier Code', 'Name', 'Remittance Date', and 'COB Payer Paid Amt.'. A 'New Item' button with a red arrow pointing to it is located at the bottom right of the table area. Below the table is another section titled '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. Do not enter a date in the **Remittance Date** field on the **Coordination of Benefits** tab unless you are reporting a Casualty Payer claim or the other payer has applied a HIPAA adjustment amount to the entire claim that cannot be distributed at the detail service lines. For all other claims, 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 and 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.

The screenshot shows the 'Coordination of Benefits (COB) Detail' form. At the top, there are tabs for 'Billing and Service', 'Extended Services', 'Coordination of Benefits', 'Procedure', 'Attachments', and 'Confirmation'. Below the tabs, there is a header 'List of Coordination of Benefits (COB)' with a note 'There is a maximum of 10 COB records.' and a table with columns for 'Carrier Code', 'Name', 'Remittance Date', and 'COB Payer Paid Amt.'. A 'New Item' button is located to the right of the table. Below the table is the 'Coordination of Benefits (COB) Detail' form. The form contains the following fields and controls:

- 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:
- Subscriber Last Name:
- Subscriber First Name:

A red arrow points to a 'Populate Subscriber' button located below the 'Relationship to Subscriber' field.

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 **Nonpayable Professional Component Amount** are not required for claim adjudication.

Subscriber ID *

Subscriber Group #

Group Name

Patient Signature Source Code

Insurance Type

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

16. Skip to step 23 to save the information that has been entered on **COB Detail** panel unless:

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

If one of the above is true, continue to the **List of COB Reasons/COB Reasons Detail Panel** section.

List of COB Reasons/COB Reasons Detail Panel

Note: Do not enter information in the **COB Reasons Detail** Panel unless:

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

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

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

Group Code	Reason	Amount
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On the **COB Reasons Detail** panel:

18. In the **Group Code*** field, select the appropriate HIPAA Claim Adjustment Group code from the dropdown list to identify the general category of payment adjustment.
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 identifying the detailed reason that the adjustment was made. Do not enter proprietary insurance reason codes.
22. Click **Add** to save **COB Reasons Detail**.

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

Group Code * Amount *
Reason * Units of Service *

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

Remark Code5
Claim ESRD Payment Amount Nonpayable Professional Component Amount

Note: To report multiple payers, click **New Item** on the **List of COB** panel, and then repeat steps 1–2. Otherwise, continue to the **Procedure** tab.

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

Professional Service Detail Panel

Providers should follow the instructions described in the [MassHealth Professional Claims Submission job aid](#) to complete the **Professional Services Detail** panel. Then, follow these steps to report COB.

Note: You must enter detailed COB information on the **COB Line Item Details** panel and the **COB Reasons Detail** panel.

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

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

Carrier Code	Remittance Date	Paid Amt.	Paid Units of Service	Bundled Line
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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 payer has bundled payment for a set of services. See example at the end of this 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. Do not enter a value in the **Remaining Patient Liability** field. This is not a required field and is not necessary for claims adjudication.
31. In the **Procedure Code*** field, enter the procedure code.
32. In the **Modifier** fields, enter the modifiers associated with the procedure code if applicable.
33. In the **Prior Authorization number** field, enter the other payer’s authorization number if applicable. This is not a required field and is not necessary for claims adjudication.

34. In the **Referral number** field, enter the other payer's referral number if applicable. This is not a required field and is not necessary for claims adjudication.

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

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

On the **COB Reasons Detail** panel:

36. In the **Group Code*** field, select the appropriate HIPAA Claim Adjustment Group code (CAGC) from the dropdown list to identify the general category of payment adjustment.

37. In the **Amount*** field, enter the adjustment amount associated with the group/reason code.

38. 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.

39. In the **Units of Service*** field, enter the units of service being adjusted.

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

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

Note: To report additional COB Reasons, repeat steps 37–41. To report multiple payers, repeat steps 25–42.

COB Line Details

Carrier Code * Bundled into Line #
Remittance Date Paid Amount
Paid Units of Service * Remaining Patient Liability
Procedure Code * Modifier 1 Modifier 2
Modifier 3 Modifier 4
Prior Authorization # Referral #

42. Click **Add** again to save the **Professional Services Detail** panel information.

Note: Refer to the [MassHealth Professional Claims Submission job aid](#) to complete a claim submission.

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
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The following pages contain COB Balancing and Bundled Payment Examples.

COB Balancing Examples for Professional Claims (for reference purposes only)

Example 1: COB Payer Paid Amount Balancing and Service Line Billed Amount Balancing

COB Payer Paid Amount Balancing: For each payer on the claim, the **COB Payer Paid Amount** (\$26.00) 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 (\$22.00) and detail 2 (\$4.00)).

Coordination of Benefits Tab

The screenshot shows the 'Coordination of Benefits' tab selected in a software interface. Below the navigation tabs, there is a section titled 'List of Coordination of Benefits (COB)' with a note: 'There is a maximum of 10 COB records.' A table contains one record:

Carrier Code	Name	Remittance Date	COB Payer Paid Amt.
0085000	MEDICARE B		\$26.00

A 'New Item' button is located at the bottom right of the table.

Procedure Tab

The screenshot shows the 'Procedure' tab selected in the software interface. The 'Procedure' sub-tab is highlighted with a red box.

Detail 1

The screenshot shows the 'COB Line Details' panel for Detail 1. The 'Paid Amount' field is highlighted with a red box and contains the value \$22.00. Other fields include Carrier Code (0085000), Remittance Date (01/01/2024), Paid Units of Service (1), Procedure Code (A0000), and Bundled into Line # (0).

Detail 2

The screenshot shows the 'COB Line Details' panel for Detail 2. The 'Paid Amount' field is highlighted with a red box and contains the value \$4.00. Other fields include Carrier Code (0085000), Remittance Date (01/01/2024), Paid Units of Service (1), Procedure Code (A0001), and Bundled into Line # (0).

Service Line Billed Amount Balancing: For each payer 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 (\$100.00) equals the sum of the other Payer Paid Amount (\$22.00) and the service line HIPAA Adjustment Amounts (\$68.00 + \$10.00=\$78.00).

Procedure Tab

Inquire Claim Status ?

Billing and Service | Extended Services | Coordination of Benefits

Procedure | Attachments | Confirmation

List of Professional Services

There is a maximum of 50 professional service detail records.

Detail	Procedure	Service Date Range	Units	Charges
01	A0000	12/15/2023 - 12/15/2023	1	\$100.00

Detail 1

COB Line Details

Carrier Code * 0085000 Bundled into Line # 0

Remittance Date 01/01/2024 Paid Amount \$22.00

Paid Units of Service * 1 Remaining Patient Liability

Procedure Code * A0000 Modifier 1 Modifier 2

Modifier 3 Modifier 4

Prior Authorization # Referral #

List of COB Reasons

There is a maximum of 30 procedure COB reason records.

Group Code	Reason	Amount
Contractual Obligations	45	\$68.00
Patient Responsibility	2	\$10.00

Service Line Billed Amount Balancing: For each payer 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 (\$64.00) equals the sum of the other Payer Paid Amount (\$4.00) and the service line HIPAA Adjustment Amounts (\$58.00 + \$2.00=\$60.00)

Procedure Tab

Enter Single Claim

[Billing and Service Confirmation](#)
[Extended Services](#)
[Coordination of Benefits](#)
[Procedure](#)
[Attachments](#)

List of Professional Services

There is a maximum of 50 professional service detail records.

Detail	Procedure	Service Date Range	Units	Charges
02	A0001	12/16/2023 - 12/16/2023	1	\$64.00
01	A0000	12/15/2023 - 12/15/2023	1	\$100.00

[New Item](#)

Detail 2

COB Line Details

Carrier Code: 0085000
 Remittance Date: 01/01/2024
 Paid Units of Service: 1
 Procedure Code: A0001
 Prior Authorization #:
 Bundled into Line #:
 Paid Amount: \$4.00
 Remaining Patient Liability:
 Modifier 1: Modifier 2:
 Modifier 3: Modifier 4:
 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	45	\$58.00
Patient Responsibility	2	\$2.00

[New Item](#)

Example 2: COB Payer Paid Amount Balancing

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

For each payer reported on the claim, the **COB Payer Paid Amount** (\$55.00) 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 (\$60.00) and detail 2 (\$10.00)—minus the claim level HIPAA Adjustment Amount (\$15.00) entered on the **Coordination of Benefits** tab.

Coordination of Benefits Tab

The screenshot shows the 'Coordination of Benefits' tab selected in the 'Enter Single Claim' window. The 'List of Coordination of Benefits (COB)' section contains one record for Medicare B with a 'COB Payer Paid Amt.' of \$55.00. The 'List of COB Reasons' section contains one record for 'Patient Responsibility' with an 'Amount' of \$15.00. Red boxes highlight the 'Coordination of Benefits' tab, the 'COB Payer Paid Amt.' field, and the 'Amount' field.

Carrier Code	Name	Remittance Date	COB Payer Paid Amt.
0085000	MEDICARE B		\$55.00

Group Code	Reason	Amount
Patient Responsibility	1	\$15.00

Procedure Tab

The screenshot shows the 'Procedure' tab selected in the 'Enter Single Claim' window. The 'Coordination of Benefits' tab is also visible. Red boxes highlight the 'Procedure' tab and the 'Coordination of Benefits' tab.

Detail 1

The screenshot shows the 'COB Line Details' panel for Detail 1. The 'Paid Amount' field is highlighted with a red box and contains the value \$60.00. Other fields include Carrier Code (0085000), Remittance Date (01/01/2024), Paid Units of Service (1), Procedure Code (A0000), and Remaining Patient Liability.

Detail 2

The screenshot shows the 'COB Line Details' panel for Detail 2. The 'Paid Amount' field is highlighted with a red box and contains the value \$10.00. Other fields include Carrier Code (0085000), Remittance Date (01/01/2024), Paid Units of Service (1), Procedure Code (A0001), and Remaining Patient Liability.

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 (\$150.00) equals the sum of the other Payer Paid Amount (\$60.00) and the service line HIPAA Adjustment Amounts (\$80.00 + \$10.00=\$90.00)

Procedure Tab

Detail	Procedure	Service Date Range	Units	Charges
01	A0000	12/17/2023 - 12/17/2023	1	\$150.00

Detail 1

COB Line Details

Carrier Code: 0085000
 Remittance Date: 01/01/2024
 Paid Units of Service: 1
 Procedure Code: A0000
 Prior Authorization #:
 Bundled into Line #:
 Paid Amount: \$60.00
 Remaining Patient Liability:
 Modifier 1:
 Modifier 2:
 Modifier 3:
 Modifier 4:
 Referral #:
 Buttons: Cancel Item, Update, Remove

List of COB Reasons

Group Code	Reason	Amount
Contractual Obligations	45	\$80.00
Patient Responsibility	2	\$10.00

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 (\$50.00) equals the sum of the other Payer Paid Amount (\$10.00) and the service line HIPAA Adjustment Amounts (\$35.00 + \$5.00=\$40.00)

Procedure Tab

Enter Single Claim ?

List of Professional Services

There is a maximum of 50 professional service detail records

Detail	Procedure	Service Date Range	Units	Charges
→ 02	A0001	12/18/2023 - 12/18/2023	1	\$50.00
01	A0000	12/17/2023 - 12/17/2023	1	\$150.00

Detail 2

COB Line Details

Carrier Code: 0085000
 Remittance Date: 01/01/2024
 Paid Units of Service: 1
 Procedure Code: A0001
 Prior Authorization #:

Bundled into Line #:
 Paid Amount: \$10.00
 Remaining Patient Liability:

Modifier 1:
 Modifier 2:
 Modifier 3:
 Modifier 4:
 Referral #:

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

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 the 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