

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
- <u>MassHealth Administrative and Billing Regulations</u>, 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.



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:

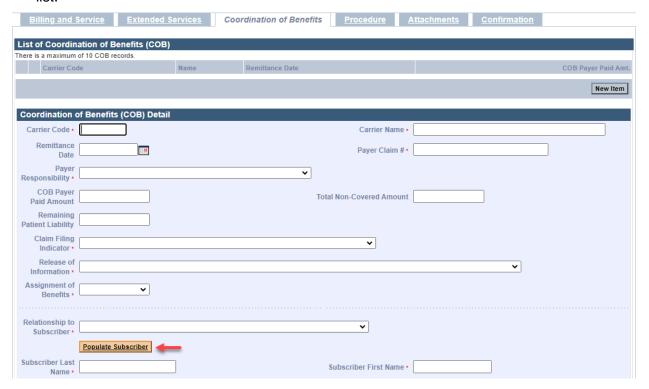
- You are reporting a HIPAA claim adjustment amount to balance a Casualty Payer claim, OR
- You are reporting a HIPAA claim adjustment amount that has been applied to the entire claim and cannot be distributed at the detail service lines.

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.

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



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		Claim HCPCS Payable Amount	
Rate		Ciami Tici C3 Layable Amount	
Remark Code1			
Remark Code2			
Remark Code3			
Remark Code4			
Remark Code5			
Claim ESRD		Nonpayable Professional	
Payment Amount		Component Amount	
Amount			
Inpatient Adjudication Information			
Covered Days or			
Visits			
Lifetime Psychiatric Days		Claim DRG Amount	
Remark Code1			
Claim			
Disproportionate		Claim MSP Pass-through Amount	
Share Amount		Amount	
Claim PPS Capital Amount		PPS-Capital FSP DRG Amount	
PPS-Capital HSP			
DRG Amount		PPS-Capital DSH DRG Amount	
Old Capital		PPS-Capital IME Amount	
Amount			
PP S-Operating Hospital Specific		Cost Report Day Count	
DRG Amount			
PPS-Operating Federal Specific		Claim PPS Capital Outlier	
DRG Amount		Amount	
Claim Indirect		Nonpayable Professional	
Teaching Amount		Component Amount	
Remark Code2			
Remark Code3			
Remark Code3			
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.

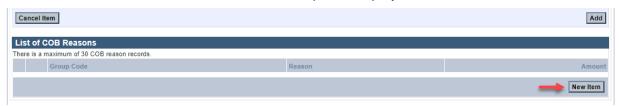
For outpatient claims, data is entered in this panel only when:

- 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.



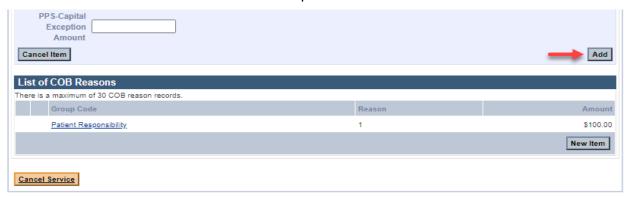
On the COB Reasons Detail panel:

- 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.

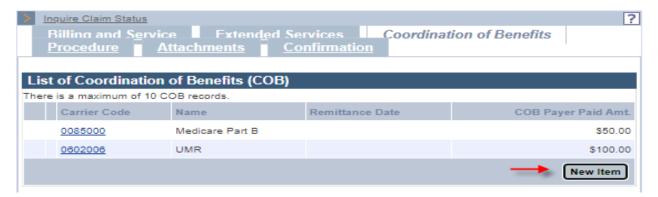


Note: To report additional COB Reasons, repeat steps 16–22.

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



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.



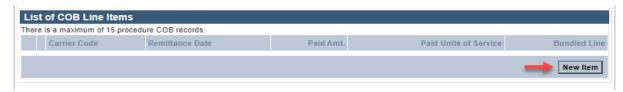
Institutional Service Detail Panel

Providers should follow the instructions described in the <u>MassHealth Institutional Claims</u> <u>Submission job aid</u> 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.



On the COB Line Details panel:

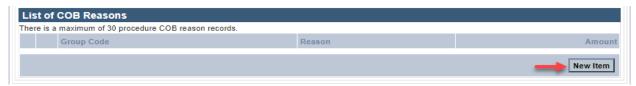
25. In the **Carrier Code*** field, the carrier code will pre-populate with the carrier code that was entered on the **Coordination of Benefits** tab. If there are multiple carrier codes, select the appropriate code from the dropdown list.

- 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.



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 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.



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

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



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

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



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

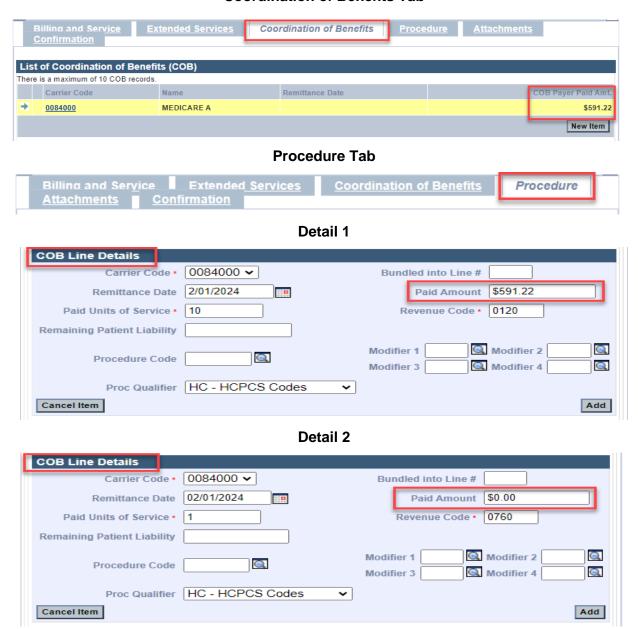
Claim Billed Amount Balancing: For each payer reported on the claim, the Total Charges entered on the Billing and Service tab (\$1,980.04) must balance to the sum of COB Payer Paid Amount (\$690.02) and the claim level HIPAA Adjustment Amounts (\$983.53 + \$300.00 + \$6.49 = \$1,290.02) entered on the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

Billing and Service Tab Extended Services Billing and Service Coordination of Benefits Confirmation **Claims Charges** Total Charges * \$1,980.04 Patient Responsibility **Coordination of Benefits Tab** Coordination of Benefits <u>Attachments</u> 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 Contractual Obligations \$983.53 Patient Responsibility \$300.00 2 \$6.49 Patient Responsibility

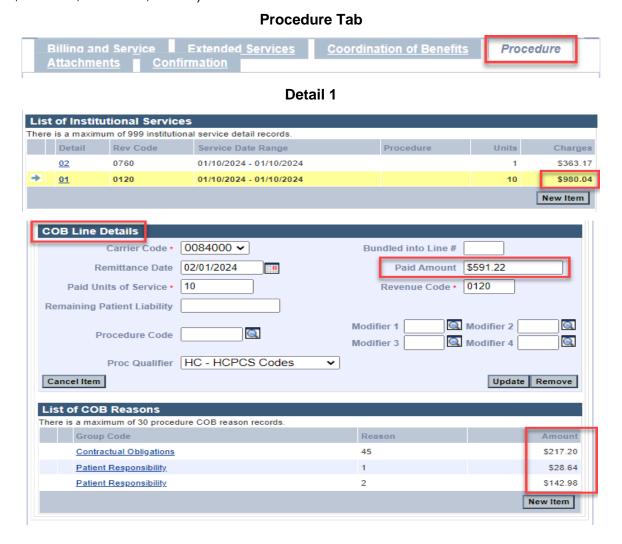
Example 2: Payer Paid Amount Balancing and Service Line Billed Amount Balancing for an Outpatient Claim

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).

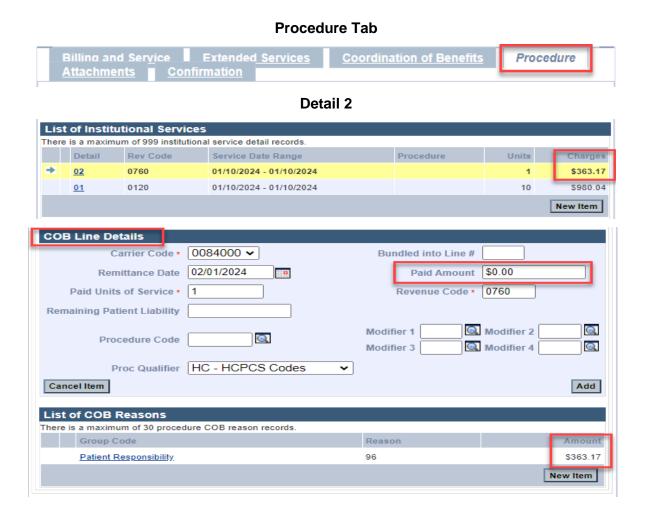
Coordination of Benefits Tab



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)



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)



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 Coordination of Benefits List of Coordination of Benefits (COB) There is a maximum of 10 COB records Carrier Code 0084000 MEDICARE A \$155.00 New Item List of COB Reasons There is a maximum of 30 COB reason records Group Code Patient Responsibility \$15.00 New Item **Procedure Tab** Billing and Ser<u>vi</u>ce Extended Services Coordination of Benefits Procedure **Detail 1** COB Line Details 0084000 🕶 Bundled into Line # Remittance Date 02/01/2024 ... Paid Amount \$150.00 0120 Paid Units of Service * Remaining Patient Liability Modifier 2 Modifier 1 Q Procedure Code Q Modifier 4 Modifier 3 Proc Qualifier HC - HCPCS Codes Cancel Item Update Remove **Detail 2** COB Line Details Carrier Code * 0084000 🕶 Bundled into Line # Remittance Date 02/01/2024 Paid Amount \$20.00 -0760 Revenue Code * Paid Units of Service * 1 Remaining Patient Liability Modifier 2 Q Modifier 1 Q Procedure Code Modifier 4 Q Modifier 3 Proc Qualifier HC - HCPCS Codes ~ Cancel Item Update Remove

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 **Detail 1 List of Institutional Services** There is a maximum of 999 institutional service detail records Detail Rev Code Service Date Range Units 0120 01/10/2024 - 01/10/2024 10 \$240.00 02 0760 01/10/2024 - 01/10/2024 \$60.00 New Item COB Line Details Carrier Code * 0084000 🕶 Bundled into Line # 02/01/2024 Paid Amount \$150.00 Remittance Date • 0120 Paid Units of Service * Remaining Patient Liability Modifier 2 Modifier 1 Procedure Code Q 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 Contractual Obligations 45 \$60.00 Patient Responsibility 2 \$30.00

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 Extended Services **Coordination of Benefits** Procedure **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 0120 01/10/2024 - 01/10/2024 10 \$240.00 01 0760 01/10/2024 - 01/10/2024 \$60.00 02 New Item **COB Line Details** Carrier Code ∗ 0084000 ∨ Bundled into Line # Remittance Date 02/01/2024 \$20.00 Paid Amount 0760 Paid Units of Service * 1 Revenue Code * Remaining Patient Liability Modifier 2 Q Modifier 1 Q Procedure Code Modifier 3 Modifier 4 Q Proc Qualifier HC - HCPCS Codes ~ Cancel Item Update Remove **List of COB Reasons** There is a maximum of 30 procedure COB reason records. Reason **Group Code** 45 \$35.00 Contractual Obligations 2 \$5.00 Patient Responsibility 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 **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** Q Q Modifier 1 Modifier 2 Q Procedure Code * 99285 Q 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** Reas **Amount** \$80.00 Other adjustments Patient Responsibility 2 \$20.00 New Item

Detail 2

