

MMIS POSC Job Aid: Supplemental Instructions for Reporting Coordination-of-Benefits (COB) Information on Institutional Direct Data Entry (DDE) Claim Submissions When 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 Medicare or a commercial insurer has adjudicated the claim. These instructions supplement the instructions found in the *Institutional Claim Submission with MassHealth* job aid. Providers should follow the instructions described in the *Institutional Claim Submission with MassHealth* job aid, and then come back to this job aid when reporting COB information on the claim. Providers can find POSC job aids on the web by clicking [here](#).

For specific billing information, providers should reference the relevant billing guides, available at www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/ (click [MassHealth Billing Guides for Paper Claim Submitters](#) to access a specific guide).

COB DATA ENTRY REQUIREMENTS FOR INSTITUTIONAL CLAIMS

For inpatient and nursing facility room and board claims, enter the COB information on the **Coordination of Benefits** tab on the following panels.

- **Coordination of Benefits (COB) Detail**
- **List of COB Reasons**

Do not repeat this information on the **Procedure** tab.

For outpatient claims, enter the COB information on the **Coordination of Benefits** tab on the **Coordination of Benefits (COB) Detail** panel. Do not enter information on the **List of COB Reasons** panel. On the **Procedure** tab, enter detailed COB information on the **COB Line Item Details** and **COB Reason Detail** panels.

COB BALANCING

Claim Billed Amount Balancing—For each payer reported on inpatient and nursing facility room and board claims, the sum of the COB Payer Paid Amount and HIPAA Adjustment Amounts entered on the **Coordination of Benefits** tab should balance to the Total Charges entered on the **Billing and Services** tab. (See Balancing Examples **1** and **2** on pages 6-8)

COB Payer Paid Amount Balancing—For each payer reported on outpatient claims, the total COB Payer Paid Amount entered on the **Coordination of Benefits** tab must balance to the sum of all the service line other Payer Paid Amounts entered on the **List of COB Line Items** panel in the **Procedure** tab. (See Balancing Examples **3** and **4** on pages 9-15)

If there is a HIPAA Adjustment Amount that a payer has applied to the entire claim that cannot be distributed at the service lines, the total COB Payer Paid Amount entered on the **Coordination of Benefits** tab must balance, for each payer reported on the claim, to the sum of all the service line other Payer Paid Amounts entered on the **List of COB Line Items** panel in the **Procedure** tab, minus the claim level HIPAA Adjustment Amounts entered on the **Coordination of Benefits** tab. (See Balancing Example **5** on pages 16–17.)

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Service Line Billed Amount Balancing—For each payer reported on outpatient claims, the sum of the service line other Payer Paid Amount and service line HIPAA Adjustment Amounts entered on the **Procedure** tab should balance to the Provider Billed Amount for the service line entered on the **Procedure** tab. (See Balancing Examples **3**, **4**, or **5** on pages 10–17.)

For outpatient claims, the **same** HIPAA Adjustment Reason Codes and Amounts cannot be entered on both the **Coordination of Benefits** and **Procedure** tabs.

REMITTANCE DATE

The **Remittance Date** is critical for COB claims adjudication. The **Remittance Date** cannot be entered on both the **Coordination of Benefits** and **Procedure** tabs. For inpatient and nursing facility room and board claims, enter the **Remittance Date** on the **Coordination of Benefits** tab and not on the **Procedure** tab. For outpatient claims, enter the **Remittance Date** on the **Procedure** tab and not on the **Coordination of Benefits** tab.

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On the Coordination of Benefits Tab

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

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

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

2. In the **Carrier Code** field, enter the other insurance carrier code. For a Medicare claim submission, enter **0084000**.
3. In the **Carrier Name** field, enter the other insurance carrier name.
4. In the **Remittance Date** field, enter the remittance date for inpatient and nursing facility room and board claims only. Do not enter a remittance date on outpatient claims.
5. In the **Payer Claim number** field, enter the other insurance claim number.
6. In the **Payer Responsibility** field, select the appropriate code from the drop-down list.
7. In the **COB Payer Paid Amount** field, enter the amount paid by the other insurance.
8. Do not enter a value in the **Total Noncovered Amount** field. The total noncovered amount should be entered only for authorized TPL exception billing. Refer to supplemental instructions in your provider manual appendix for conditions for which this field may be used.
9. Do not enter a value in the **Remaining Patient Liability** field. This is not a required field and is not necessary for claims adjudication.
10. In the **Claims Filing Indicator** field, select the appropriate code from the drop-down list.
11. In the **Release of Information** field, select the appropriate code from the drop-down list.
12. In the **Assignment of Benefits** field, select the appropriate code from the drop-down list.
13. In the **Relationship to Subscriber** field, select the appropriate code from the drop-down list.
14. If you selected “**18—SELF**” from the “**Relationship to Subscriber**” drop-down 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**” drop-down 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.

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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 only when there is a HIPAA Adjustment Amount applied to the entire claim that cannot be distributed at the service lines. This amount cannot be entered on both the **Coordination of Benefits** and the **Procedure** tabs.

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

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

On the **COB Reasons Detail** panel:

17. In the **Group Code** field, select the appropriate code identifying the category of payment adjustment from the drop-down list.
18. In the **Amount** field, enter the adjustment amount associated with the group/reason code.
19. In the **Unit of Service** field, enter the units of service being adjusted.
20. In the **Reason** field, enter the reason code identifying the detailed reason that the adjustment was made.
21. Click **Add** to save COB Reasons Detail.
Note: To report additional COB Reasons, repeat steps 16–21.
22. Click **Add** on the **Coordination of Benefits (COB) Detail Information** panel to save the COB information.
Note: To report multiple payers, click **New Item** on the **List of Coordination of Benefits** panel, and then repeat steps 1–22.

On the Procedure Tab

On the **Procedure** tab:

23. Click **New Item**.

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Enter Institutional Service Detail Panel

Providers should follow the instructions described in *Institutional Claim Submission with MassHealth* job aid to complete the **Institutional Service Detail** panel. Then providers should continue with the following steps.

For outpatient claims, the detail COB information must be entered 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.

On the **COB Line Details** panel:

25. In the **Carrier Code** field, the carrier code will populate with what has been entered on the “**Coordination of Benefits**” tab. If there are multiple carrier codes, select the appropriate code from the drop-down list.
26. In the **Bundled into Line number** field, enter the line number only when the other insurance has bundled or unbundled payment for a set of services.
27. In the **Remittance Date** field, enter the other insurance remittance date for outpatient claims.
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.

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

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

On the **COB Reasons Detail** panel:

35. In the **Group Code** field, select the appropriate code identifying the category of payment adjustment from the drop-down list.
36. In the **Amount** field, enter the adjustment amount associated with the group/reason code.
37. In the **Units of Service** field, enter the units of service being adjusted.
38. In the **Reason** field, enter the reason code identifying the detailed reason that the adjustment was made.
39. Click **Add** to save **COB Reasons Detail**.
40. Click **Add** again to save the **COB Line Details**.
Note: To report multiple payers, repeat steps 24–41.
41. Click **Add** again to save the **Institutional Service Detail** panel information.
Note: Refer to the *Institutional Claim Submission with MassHealth* job aid to complete a claim submission.

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COB Balancing Examples *(for reference purposes only)*

Example 1: Inpatient and Nursing Facility Room and Board Claims—Single Payer

Claim Billed Amount Balancing calculations for this example: The sum of the other Payer Paid Amount (\$690.02) plus the HIPAA Adjustment Amounts (\$983.53 + \$300.00 + \$6.49 = \$1,290.02) equals the Total Charges from the UB-04 claim form (\$1,980.04).

Billing and Services Tab

Data Field	Value	Reference
Total Charges	\$1,980.04	Total Provider Charges

Coordination of Benefits Tab

- List of Coordination of Benefits (COB) panel

Data Field	Value	Reference
Carrier Code	0084000	Carrier code for primary payer from Appendix C of provider manual
Carrier Name	Medicare A	Name of primary payer
Remittance Date	MM/DD/YYYY	Date of primary payer's adjudication (EOB date)
COB Payer Paid Amount	\$690.02	Other payer's total paid amount

- List of COB Reasons panel

Data Field	Value	Reference
Group Code	CO	Group code "CO" represents contractual obligation
Reason	45	HIPAA CARC "45" represents charge exceeds fee schedule/maximum allowable
Amount	\$983.53	Contractual obligation amount
Group Code	PR	Group code "PR" represents patient responsibility
Reason	1	HIPAA CARC "1" represents deductible amount
Amount	\$300.00	Deductible amount
Group Code	PR	Group code "PR" represents patient responsibility
Reason	2	HIPAA CARC "2" represents coinsurance amount
Amount	\$6.49	Coinsurance amount from other payer's EOB

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COB Balancing Examples *(for reference purposes only)*

Example 2: Inpatient and Nursing Facility Room and Board Claims—multiple payers

Claim Billed Amount Balancing calculations for this example:

Primary Payer—The sum of the other Payer Paid Amount (\$840.14) plus the HIPAA Adjustment Amounts (\$706.16 + \$37.17 + \$168.04=\$911.37) equals the Total Charges from the UB-04 claim form (\$1,751.51).

Secondary payer—The sum of the other Payer Paid Amount (\$0.00) plus the HIPAA Adjustment Amount (\$1,751.51) equals the Total Charges from the UB-04 claim form (\$1,751.51).

Billing and Services Tab

Data Field	Value	Reference
Total Charges	\$1,751.51	Total Provider Charges

PRIMARY PAYER

Coordination of Benefits Tab

- List of Coordination of Benefits (COB) panel

Data Field	Value	Reference
Carrier Code	0084000	Carrier code for primary payer from Appendix C of provider manual
Carrier Name	Medicare A	Name of primary payer
Remittance Date	MM/DD/YYYY	Date of primary payer’s adjudication (EOB date)
COB Payer Paid Amount	\$840.14	Other payer’s total paid amount

- List of COB Reasons panel

Data Field	Value	Reference
Group Code	CO	Group code “CO” represents contractual obligation
Reason	45	HIPAA CARC “45” represents charge exceeds fee schedule/maximum allowable
Amount	\$706.16	Contractual obligation amount
Group Code	PR	Group code “PR” represents patient responsibility
Reason	1	HIPAA CARC “1” represents deductible amount
Amount	\$37.17	Deductible amount
Group Code	PR	Group code “PR” represents patient responsibility
Reason	2	HIPAA CARC “2” represents coinsurance amount
Amount	\$168.04	Coinsurance amount from other payer’s EOB

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COB Balancing Examples *(for reference purposes only)*

Example 2 continued

SECONDARY PAYER

Coordination of Benefits Tab

- List of Coordination of Benefits (COB) panel

Data Field	Value	Reference
Carrier Code	0101001	Carrier code for primary payer from Appendix C of provider manual
Carrier Name	Tufts Health Plan	Name of secondary payer
Remittance Date	MM/DD/YYYY	Date of secondary payer's adjudication (EOB date)
COB Payer Paid Amount	0.00	Other payer's total paid amount

- List of COB Reasons panel

Data Field	Value	Reference
Group Code	PR	Group code "PR" represents patient responsibility
Reason	96	HIPAA CARC "96" represents charges not covered by payer
Amount	\$1751.51	Amount not covered by payer (amount applied to CARC "96")

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Example 3: Outpatient Claims—Single Payer

COB Payer Paid Amount Balancing calculations for this example:

The sum of the other Payer Paid Amounts for detail line 1 (\$591.22) and detail line 2 (\$0.00) balance to the total other Payer Paid Amount on the COB tab (\$591.22).

Service Line Billed Amount Balancing calculations for this example:

- Service line 1—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) equals the Provider Billed Amount for the service line (\$980.04).
- Service line 2—The sum of the other Payer Paid Amount (\$0.00) and the service line HIPAA Adjustment Amounts (\$363.17) equals Provider Billed Amount for the service line (\$363.17).

Coordination of Benefits Tab

- List of Coordination of Benefits (COB) panel
- Coordination of Benefits (COB) Detail panel

Data Field	Value	Reference
COB Payer Paid Amount	\$591.22	Other payer's total paid amount for both service line details

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Procedure Tab

- Service Detail Line #1—Billed amount \$980.04
- List of COB Line Items panel
- COB Line Details panel

Data Field	Value	Reference
Paid Amount	\$591.22	Other payer's paid amount associated with service detail line #1

- List of COB Reasons panel

Data Field	Value	Reference
Group Code	CO	Group code "CO" represents contractual obligation
Reason	45	HIPAA CARC "45" represents charge exceeds fee schedule/maximum allowable
Amount	\$217.20	Contractual obligation amount
Group Code	PR	Group code "PR" represents patient responsibility
Reason	1	HIPAA CARC "1" represents deductible amount
Amount	\$28.64	Deductible amount
Group Code	PR	Group code "PR" represent patient responsibility
Reason	2	HIPAA CARC "2" represents coinsurance amount
Amount	\$142.98	Coinsurance amount from other payer's EOB

- Service Detail Line #2—Billed amount \$363.17
- List of COB Line Items panel
- COB Line Details panel

Data Field	Value	Reference
Paid Amount	\$0.00	Other payer's paid amount associated with service detail line #2

- List of COB Reason panel

Data Field	Value	Reference
Group Code	PR	Group code "PR" represents patient responsibility
Reason	96	HIPAA CARC "96" represents noncovered charge
Amount	\$363.17	Noncovered amount

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COB Balancing Examples *(for reference purposes only)*

Example 4: Outpatient Claims—Multiple Payers

COB Payer Paid Amount Balancing calculations for this example:

For each payer reported on the claim, the total other Payer Paid Amount on the COB tab must equal the sum of the other Payer Paid Amounts for all detail lines.

Primary Payer: The sum of the other Payer Paid Amounts for detail line 1 (\$25.06) and detail line 2 (\$17.00) balance to the total other Payer Paid Amount on the COB tab (\$42.06).

Secondary Payer: The sum of the other Payer Paid Amounts for detail line 1 (\$2.21) and detail line 2 (\$2.00) balance to the total Payer Paid Amount on the COB tab (\$4.21).

Service Line Billed Amount Balancing calculations for this example:

For each payer reported on the claim, the sum of the other Payer Paid Amount and the service line HIPAA Adjustment Amounts must equal the Provider Billed Amount for the service line.

Primary Payer

- Service line 1—The sum of the other Payer Paid Amount (\$25.06) and the service line HIPAA Adjustment Amounts ($\$108.52 + \$12.42 = \$120.94$) equals the Provider Billed Amount for the service line (\$146.00).
- Service line 2—The sum of the other Payer Paid Amount (\$17.00) and the service line HIPAA Adjustment Amounts ($\$45.00 + \$2.00 = \$47.00$) equals Provider Billed Amount for the service line (\$64.00).

Secondary Payer

- Service line 1—The sum of the other Payer Paid Amount (\$2.21) and the service line HIPAA Adjustment Amounts ($\$140.01 + \$3.78 = \$143.79$) equals the Provider Billed Amount for the service line (\$146.00).
- Service line 2—The sum of the other Payer Paid Amount (\$2.00) and the service line HIPAA Adjustment Amounts ($\$62.00 = \62.00) equals Provider Billed Amount for the service line (\$64.00).

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Example 4 continued

Coordination of Benefits Tab

- List of Coordination of Benefits (COB) panel

Data Field	Value	Reference
Carrier Code	0084000	Carrier code for primary payer from Appendix C of provider manual
Carrier Name	Medicare A	Name of primary payer
COB Payer Paid Amount	\$42.06	Total of all primary payer payments

Data Field	Value	Reference
Carrier Code	0101001	Carrier code for secondary payer from Appendix C of provider manual
Carrier Name	Tufts Health Plan	Name of secondary payer
COB Payer Paid Amount	\$4.21	Total of all secondary payer payments

PRIMARY PAYER

Procedure Tab

- Service Detail Line #1—Billed amount \$146.00
- List of COB Line Items Detail panel
- COB Line Details panel

Data Field	Value	Reference
Carrier Code	0084000	Carrier code for primary payer from Appendix C of provider manual
Remittance Date	MM/DD/YYYY	Date of primary payer's adjudication (EOB date)
Paid Amount	\$25.06	Primary payer's paid amount associated with detail line

- List of COB Reasons Detail panel

Data Field	Value	Reference
Group Code	CO	Group code "CO" represents contractual obligation
Reason	45	HIPAA CARC "45" represents charge exceeds fee schedule/maximum allowable
Amount	\$108.52	Contractual obligation amount
Group Code	PR	Group code "PR" represents patient responsibility
Reason	2	HIPAA CARC "2" represents coinsurance amount
Amount	\$12.42	Coinsurance amount from primary payer's EOB

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Example 4 continued

Procedure Tab

- Service Detail Line #2—Billed amount \$64.00
- List of COB Line Items Detail panel
- COB Line Details panel

Data Field	Value	Reference
Carrier Code	0085000	Carrier code for primary payer from Appendix C of provider manual
Remittance Date	MM/DD/YYYY	Date of primary payer's adjudication (EOB date)
Paid Amount	\$17.00	Primary payer's paid amount associated with detail line

- List of COB Reasons Detail panel

Data Field	Value	Reference
Group Code	CO	Group code "CO" represents contractual obligation
Reason	45	HIPAA CARC "45" represents charge exceeds fee schedule/maximum allowable
Amount	\$45.00	Contractual obligation amount
Group Code	PR	Group code "PR" represents patient responsibility
Reason	2	HIPAA CARC "2" represents coinsurance amount
Amount	\$2.00	Coinsurance amount from primary payer's EOB

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SECONDARY PAYER

Procedure Tab

- Service Detail Line #1—Billed amount \$146.00
- List of COB Line Items Detail panel
- COB Line Details panel

Data Field	Value	Reference
Carrier Code	0101001	Carrier code for secondary payer from Appendix C of provider manual
Remittance Date	MM/DD/YYYY	Date of secondary payer’s adjudication (EOB date)
Paid Amount	\$2.21	Secondary payer’s paid amount associated with detail line

- List of COB Reasons Detail panel

Data Field	Value	Reference
Group Code	CO	Group code “CO” represents contractual obligation
Reason	45	HIPAA CARC “45” represents charge exceeds fee schedule/maximum allowable
Amount	\$140.01	Contractual obligation amount
Group Code	PR	Group code “PR” represents patient responsibility
Reason	2	HIPAA CARC “2” represents coinsurance amount
Amount	\$3.78	Coinsurance amount from secondary payer’s EOB

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Example 4 continued

Procedure Tab

- Service Detail Line #2—Billed amount \$64.00
- List of COB Line Items Detail panel
- COB Line Details panel

Data Field	Value	Reference
0101001	0101001	Carrier code for primary payer from Appendix C of provider manual
Remittance Date	MM/DD/YYYY	Date of primary payer's adjudication (EOB date)
Paid Amount	\$2.00	Primary payer's paid amount associated with detail line

- List of COB Reasons Detail panel

Data Field	Value	Reference
Group Code	CO	Group code "CO" represents contractual obligation
Reason	45	HIPAA CARC "45" represents charge exceeds fee schedule/maximum allowable
Amount	\$62.00	Contractual obligation amount

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COB Balancing Examples *(for reference purposes only)*

Example 5: Outpatient Claims—single payer when there is a HIPAA Adjustment Amount applied to the entire claim that cannot be distributed at the service lines.

COB Payer Paid Amount Balancing calculations for this example:

The sum of the other Payer Paid Amount for detail line 1 (\$150.00) and detail line 2 (\$20.00)) minus the claim level_HIPAA adjustment amount (\$15.00) entered on the **COB** tab balance to the total other Payer Paid Amount_on the COB tab (\$155.00)

Service Line Billed Amount Balancing calculations for this example:

- Service line 1—The sum of the other Payer Paid Amount (\$150.00) and the service line HIPAA Adjustment Amounts (\$60.00 + \$30.00= \$90.00) equals the Provider Billed Amount for the service line (\$240.00).
- Service line 2—The sum of the other Payer Paid Amount (\$20.00) and the service line HIPAA Adjustment Amounts (\$35.00 + \$5.00= \$40.00) equals Provider Billed Amount for the service line (\$60.00).

Coordination of Benefits Tab

- List of Coordination of Benefits (COB) panel
- Coordination of Benefits (COB) Detail panel

Data Field	Value	Reference
COB Payer Paid Amount	\$155.00	Other payer’s total paid amount for both service line details minus the header level HIPAA ARC amount
Group Code	PR	Group code “PR” represents patient responsibility
Reason	1	HIPAA CARC “1” represents deductible amount
Amount	\$15.00	Deductible amount

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Example 5 continued

Procedure Tab

- Service Detail Line #1—Billed amount \$240.00
- List of COB Line Items panel
- COB Line Details panel

Data Field	Value	Reference
Paid Amount	\$150.00	Other payer's paid amount associated with service detail line #1

- List of COB Reasons panel

Data Field	Value	Reference
Group Code	CO	Group code "CO" represents contractual obligation
Reason	45	HIPAA CARC "45" represents charge exceeds fee schedule/maximum allowable
Amount	\$60.00	Contractual obligation amount
Group Code	PR	Group code "PR" represents patient responsibility
Reason	2	HIPAA CARC "2" represents coinsurance amount
Amount	\$30.00	Coinsurance amount from other payer's EOB

- Service Detail Line #2—Billed amount \$60.00
- List of COB Line Items panel
- COB Line Details panel

Data Field	Value	Reference
Paid Amount	\$20.00	Other payer's paid amount associated with service detail line #2

- List of COB Reason panel

Data Field	Value	Reference
Group Code	CO	Group code "CO" represents contractual obligation
Reason	45	HIPAA CARC "45" represents charge exceeds fee schedule/maximum allowable
Amount	\$35.00	Contractual obligation amount
Group Code	PR	Group code "PR" represents patient responsibility
Reason	2	HIPAA CARC "2" represents coinsurance amount
Amount	\$5.00	Coinsurance amount from other payer's EOB