

# NEBLUE *connect*



Institutional and Professional  
Coordination of Benefits (COB)  
Health Care Claim  
ANSI ASC X12N 837I and 837P

Companion Document  
Health Insurance Portability and Accountability Act



**BlueCross BlueShield  
of Nebraska**

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# ANSI ASC X12N 837I and 837P Institutional and Professional Coordination of Benefits (COB) Health Care Claim

Companion Document  
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The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS). The ANSI X12N 837I and 837P implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at [www.wpc-edi.com](http://www.wpc-edi.com).

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837I and 837P implementation guides. The use of this document is solely for the purpose of clarification. This companion document supplements, but does not contradict any requirements in the X12N 837I and 837P implementation guides.

This document is subject to change as new information is available. Please check the BCBSNE Provider Web Site at [www.bcbsneprovider.com](http://www.bcbsneprovider.com) for updated documents. Just click on the NEBLUECONNECT link to find all of the BCBSNE Companion Guides.

# Tips for Submitting 837 COB Claims Electronically

Billing tips for submitting 837 COB professional and institutional claims:

All COB amounts received from primary payer should be reported at the level received i.e.: claim level (2320) vs. line level (2430).

Professional Medicare balances: BCBSNE requires the approved amount at the line level in loop 2430 (AMT 01 = AAE).

All COB dollar amounts must balance. For example, Other Carrier Payments + Adjustments = Total Charge.

When billing primary submissions indicating other insurance as secondary or tertiary, there should be no COB dollar amounts present in loops 2320, 2400 and 2430 (other carrier paid amount, other carrier allowed amount or patient paid amount).

All other payers that are submitted in loop 2330B must have unique payer ids.

Billing tips for when Blue Cross and Blue Shield of Nebraska (BCBCNE) is the secondary payer and the primary payer is Medicare:

- Providers that are receiving an 835 from Medicare should check the Remittance Remark Code to verify that an MA18 was passed to them. The MA18 Remittance Remark Code indicates that the claim was crossed-over (electronically sent by Medicare to BCBSNE). To avoid duplicates being submitted, Providers should **not** resubmit the claim to BCBSNE if they have received an MA18.
- Please note - Medicare secondary claims will be edited to restrict submission during an appropriate waiting period. Appropriate Waiting Period is defined by BCBSNE as 60 calendar days from Medicare's adjudication date to the date the Secondary Payer receives the claim.

Please be aware that submitting claims with the following criteria will slow processing of your secondary balance through BCBSNE:

1. Submitted claims are not balanced:
  - Submitting other carrier paid amounts without indicating adjustments. (Claim paid amount does not equal charge.)
  - Primary carrier denial did not include denial adjustment reason code
  - Indicating coinsurance, deductible or co-pay as **OA** group code instead of **PR** group code.
2. Use of only Value Codes on Institutional submissions to indicate Medicare deductible or co-insurance.

## BCBSNE Requirements

### Institutional 837I COB

#### 2320 Claim Level COB Adjudication Information:

If COB information is at the claim-level, the following fields are critical for ensuring accurate payment:

- Allowed Amount - Submit the Prior Payer Allowed Amount in the Allowed Amount field (Loop 2320, AMT02, where AMT01=B6 (Allowed-Actual)). If there are multiple prior payers, submit multiple 2320 loops.
- Payer Paid Amount - Submit the Prior Payer Paid Amount in the Payer Prior Payment Paid Amount field (Loop 2320, AMT02, where the AMT01=C4 (Payer Payment-Actual)), regardless of whom the prior payer paid and regardless of whether or not the prior payer was Medicare. If there are multiple payers, submit multiple 2320 loops.
- COB Total Submitted Charges – Submit the Coordination of Benefits Total Claim Level Submitted Charge Amount (Loop 2320, AMT02, where AMT01=T3 (Total Submitted Charges)).
- Adjusted Amount - Submit unpaid dollars for a prior payer in Adjusted Amount-Claim Level (Loop 2320, CAS03, CAS06, CAS09, CAS12, CAS15, CAS18). Unpaid dollars include deductible, coinsurance, co-pays, non-covered dollars and provider contractual obligation. If there are multiple prior payers, submit multiple 2320 loops.

## **2400/2430 Line Level COB Adjudication Information:**

If COB information is available at the line-level, the following data fields are critical for ensuring accurate payment.

- Allowed Amount - Submit the Prior Payer Allowed Amount at the claim-level. See Loop 2320 for instructions.
- Payer Paid Amount - Submit the Prior Payer Paid Amount in the Service Line Payer Prior Payment Paid Amount field (Loop 2430, SVD02). If there are multiple payers, submit multiple 2430 loops.

Adjusted Amount - Submit unpaid dollars for a prior payer in Adjusted Amount (Loop 2430, CAS03, CAS06, CAS09, CAS12, CAS15, CAS18). Unpaid dollars include deductible, coinsurance, co-pays, non-covered dollars and provider contractual obligation. If there are multiple prior payers, submit multiple 2430 loops.

## **Professional 837P COB**

### **2320 Claim Level COB Adjudication Information:**

Provide COB information at the line level if available. If line-level information is not available, submit at the claim-level. If both claim-level and line-level information is submitted, only line-level information will be utilized. COB information can be retrieved from the prior payers 835 or paper EOB. If COB information is only available at the claim-level, the following fields are critical for accurate payment:

- Allowed Amount - Submit the Prior Payer Allowed Amount in the Allowed Amount field (Loop 2320, AMT02, where AMT01=B6 (Allowed-Actual)). If there are multiple prior payers, submit multiple 2320 loops.
- Payer Paid Amount - Submit the Prior Payer Paid Amount in the Payer Paid Amount field (Loop 2320, AMT02, where the AMT01=D (Payer Amount Paid)), regardless of whom the prior payer paid. If there are multiple prior payers, submit multiple 2320 loops.
- Adjusted Amount - Submit unpaid dollars for a prior payer in Adjusted Amount-Claim Level (Loop 2320, CAS03, CAS06, CAS09, CAS12, CAS15, CAS18). Unpaid dollars include deductible, coinsurance, co-pays, non-covered dollars and provider contractual obligation. If there are multiple prior payers, submit multiple 2320 loops.

## **2400/2430 Line Level COB Adjudication Information:**

If COB information is available at the line-level, the following data fields are critical for ensuring accurate payment.

- Approved Amount - Submit the Prior Payer Allowed Amount in the Approved Amount field (Loop 2400, AMT02, where the AMT01=AAE (Approved Amount)). If there are multiple prior payers, submit the allowed amount for the primary payer in this field.
- Payer Paid Amount - Submit the Prior Paid Amount in the Payer Paid Amount field (Loop 2430, SVD02). If there are multiple payers, submit a 2430 loop for each prior payer.
- Adjusted Amount - Submit unpaid dollars for a prior payer in Adjusted Amount-Line Level (Loop 2430, CAS03, CAS06, CAS09, CAS12, CAS15, CAS18). Unpaid dollars include deductible, coinsurance, co-pays, non-covered dollars and provider contractual obligation. If there are multiple prior payers, submit multiple 2430 loops.