Joint Venture Hospital Laboratories

Companion Guide

Electronic Submission of Coordination of Benefits (COB) Claim Information in the 837 Professional And 837 Institutional File Formats

Version 2.2.1
December 2022

General Information / Introduction

This information is provided by Joint Venture Hospital Laboratories (JVHL) and is to be used as a reference in preparation of claims/encounter data submitted in conjunction with services contracted to Joint Venture Hospital Laboratories (JVHL). These instructions must be used as an adjunct to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated ANSI X12N 5010 HIPAA Professional Implementation X222A1 Guides and ANSI X12N 5010 HIPAA Institutional Implementation X223A2 Guides all of which are available from the Washington Publishing Company web site at: www.wpc-edi.com.

The Washington Publishing Company documentation was prepared for use by all health insurance payers in the United States. The JVHL ANSI Companion Document is a supplement, but does not contradict any requirements in the ASC X12N 837 (005010X222A1 or 005010X223A2) data standards, as mandated by Health and Human Services.

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Overview of Document Content

This document lists COB data JVHL requires for secondary claim consideration. The data values should be available from the previous payer's adjudication of the claim. The content of the document contains the following information in each column for each 837 format:

- Data Element – Provides the names used in the ASC X12N 5010 837 implementation guides.
- Loop/Segment – Provides the exact location in the 837 format for each data element (for example, 2330B/NM1).
- Requirements – JVHL's COB data requirements align with HIPAA situational usage guidelines. For convenience, we have summarized the situations where the data is needed.
- Comments - Provides information on where a COB data field may have originated from the previous payers claim submission form (e.g., Other Subscriber Name), and direction for deriving values from the previous payer's remittance (e.g., Payer Paid Amount).

Tips for Submitting Coordination of Benefits (COB) Claims Electronically

To submit COB claims, your data processing system/clearinghouse must be able to:

- Create or forward claims in the full HIPAA standard format (837)
- Include payment information received from the primary payer's HIPAA standard electronic remittance advice (ERA).

Types of COB claims that can be sent electronically

Insurance claims billed using the **837P or 837I** format, and where another payer is primary and one of the following JVHL payers is secondary:

- Aetna (J1)
- Aetna Better Health Premier Plan(M5)
- Aetna Better Health – Medicaid (**J8** - DOS on/after 1/1/2017)
- AmeriHealth Caritas VIP Care Plus (MD)
- BCBSM (KC)
- BCN (J9, JJ, JQ, JY, KA, KB, KP,KS, MJ)
- BEHP (JE)
- Blue Cross Complete (**CC**)
- CIGNA (non-HAP) (KD, KQ)
- Community Care Assoc. (Health Choice) (JW)
- Consumer's Mutual Insurance (KW)
- DMC Care (JS -Only Claims With DOS Prior to 2/1/2015)
- Genesee County Health Plan (MB)
- HAP (JG, JH)
- HAP ASR (MR) – DOS 6/1/2021 and later
- HAP Empowered (Midwest) (JB)
- HealthPlus (KE) – No claim level adjustments/payments allowed
- Humana (KV)
- McLaren Health Plan (K7)
- Meridian Health Plan of Michigan (J2)
- Priority Health (JZ)

- Reliance HMO (MK)
- United Health Care (J5)
- United Heath Care Community Plan (JR)
- **VA Community Care (MS)**
- WellCare (MM)

Payment information required for commercial electronic COB claims

- Adjustment amounts – at both claim level and service line level
- Adjustment reasons – contractual obligations, deductible, coinsurance, etc.
- Primary payer paid amount – at both claim level and service line level

Other adjudication edits

- Procedures need to be bundled before billing COB to JVHL
- Service line amounts must balance
- Claim amounts must balance
- All services lines must pass adjudication edits for claim to process

Coordination of Benefits (COB) Professional/Institutional Claims

Coordination of Benefits (COB) Claims			
Data Elements	**Loop/Segment**	**Requirements**	**Comments**
Other Subscriber Name	2330A/NM1	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration.	This is the "Insured's Name" from the previous payer.
Other Payer Name **Note***: Until national payer IDs are assigned, ID values can be chosen by the sender, but must match the value sent in the line level adjudication information for this payer.*	2330B/NM1	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	This is the "Insurance Plan Name or Program Name" from the previous payer.
Other Subscriber Information	2320/SBR	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	This is the "Relationship Code", "Insurance Plan Name or Program Name", "Insured's Policy Group or FECA Number", "Insurance Type Code" and "Claim Filing Indicator" from the previous payer.
Adjustment codes and associated amounts	2320/CAS	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and the primary payer(s) applied claim level adjustments that cause the amount considered to differ from the amount originally charged.	Do not include claim level amounts. Any amounts reported should be reported at the service line level.
Payer Paid Amount	2320/AMT (AMT01=D)	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and when the primary payer has considered an amount towards this bill.	Should equal total charges minus claim and line level adjustments.

Coordination of Benefits (COB) Claims (cont'd)			
Data Elements	**Loop/Segment**	**Requirements**	**Comments**
Other Insurance Coverage Information	2320/OI	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration. All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It allows for information specific only to that payer.	Information not on the CMS 1500 form. This is the "Accept Assignment", "Patient Signature" and "Release Information" and can normally be based on that already collected on the previous payers CMS 1500 form. Separate collection of this information only needed when it differs by payer.
Adjudication information	2430/SVD	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and the primary payer(s) applied line level adjustments that cause the amount considered to differ from the amount originally charged.	Information not on CMS 1500 form. This is the amount the primary payer paid for the service line and the procedure code and modifiers used to determine that payment.
Line level adjustment reason codes and associated amounts	2430/CAS	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and the primary payer(s) applied line level adjustments that cause the amount considered to differ from the amount originally charged.	Information not on CMS 1500 form. This shows why the other payer paid less than billed. Information most commonly required is deductible amount, coinsurance or co-pay amount, negotiated/contractual rate reduction, R&C reduction. Do not enter at claim level any amounts included at line level.

Change Summary

This section describes the differences between the current Companion Guide and previous guide(s).

Date	Version	Description
6/17/2014	2.0.	i. Modified COB information to reflect that secondary claims can be submitted electronically in the 837I format ii. Updated formatting
9/2014	2.0.1	i. Removed references to Molina payer code JV, which has been retired. ii. Added information for Harbor Health
9/23/2014	2.0.2	Removed references to Harbor Health as we discovered they do not accept eCOB claims.
10/31/2014	2.0.3	Added HAP as a payer that accepts electronic COB claims.
3/27/2015	2.0.4	Updated information on DMC Cares, as only claims with a DOS prior to 2/1/2015 can be submitted electronically.
3/30/2015	2.0.5	Removed McLaren HP from the list of payers that can accept eCOB claims.
5/18/2015	2.0.6	Added Aetna Better Health Premier Plan to list of COB plans.
10/16/2015	2.0.7	Added HAP Midwest to list of COB plans.
11/5/2015	2.0.8	Updated contact information
2/9/2016	2.0.9	Updated contact information
4/19/2017	2.1.0	Updated Logo Updated COB allowed payer list (added Blue Cross Complete, McLaren and Aetna Better Health Medicaid)
6/29/2017	2.1.1	Added AmeriHealth Caritas VIP Care Plus to the COB list
7/13/2017	2.1.2	Added Bay, Genesee, and Saginaw County Health Plans
3/26/2018	2.1.3	Updated logo
4/18/2019	2.1.4	Updated name of HAP Midwest to HAP Empowered
5/22/2019	2.1.5	Added new BCN Payer Code MJ to the document (Critical Access and Small Volume)
1/28/2020	2.1.6	Added new payer Reliance HMO as a COB capable payer Removed termed payers Bay and Saginaw County Added payer code for Blue Cross Complete (CC)
4/1/2020	2.1.7	Added new payer WellCare as a COB capable payer (MM)
7/13/2020	2.1.8	Update the Aetna Better Health line to include the Payer Code (J8)
1/8/2021	2.1.9	Removed references to Molina as they have been termed for over 90 days
11/19/2021	2.2.0	Added entry for HAP ASR (MR)
12/5/2022	2.2.1	Added entry for VA Community Care (MS)