



Electronic Claims Submission Coordination of Benefits (COB) – Professional Examples

Aetna Provider eSolutionsSM

We prepared this COB Professional Claims Examples document to work in conjunction with the Aetna COB Overview document and the COB Final Addenda, and it will provide you with the following:

- Claim scenarios of professional COB claims, which include samples of professional payer-to-payer claims along with samples of professional Medicare-to-payer claims
- Examples of 837 claim detail for the primary payer, which correspond with the presented claim scenarios
- Correlating 837 examples of claim details to secondary payer
- Notes to help you understand how the 837 claims detail compares between the primary payer and the submission to the secondary payer

Note: This document contains technical language pertaining to 837 claims information. If you are not comfortable with 837 language, please refer to the Aetna COB Overview document, which can direct you to a variety of documents to assist you. At a minimum, you should be familiar with information housed in the 837 HIPAA Implementation Guide, which can be downloaded from:

<http://www.wpc-edi.com>

The 837 data found in this document is derived from Version 4010-A1 examples.

Questions?

Please contact us via email by visiting www.aetna.com. Select “Contact Us,” then “Doctors & Hospitals,” and then “Our Web Site.”

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COB Example #1 - Professional Format – Commercial Payers

Example is based on **Example 3 from the HIPAA Professional Implementation Guide.**

Scenario:

Coordination of benefits; patient is not the subscriber; payers are commercial health insurance companies, provider-to-payer COB model. Provider submits claims electronically and receives ERA from primary payer.

CASE: Patient came to office for routine hyperlipidemia check. DOS=10/03/97, POS=Office; Patient also complained of hay fever and heartburn.

SERVICES RENDERED: Patient incurred an office visit and received an injection for hay fever.

SERVICES RENDERED AND CHARGES:

CPT Code	Service Description	# of Units	Charges
99213	Office Visit – Established Patient	1	\$43.00
90782	Injection Administration	1	\$15.00
J3301	Triamcinolone Acetonide, 10 mg	1	\$21.04
		Total	\$79.04

Payer A returned an electronic remittance advice (835) to the billing provider with the following amounts and Claim Adjustment Reason Codes:

SUBMITTED CHARGES (CLP03): \$79.04

AMOUNT PAID (CLP04): \$39.15

PATIENT RESPONSIBILITY (CLP05): \$36.89

The primary payer's 835 ERA CAS at the Claims level was:
CAS*PR*1*21.89*3*15~

Claims level CAS indicates a \$15.00 co-payment and \$21.89 deductible are due from the patient. (Note – HIPAA Implementation Guide incorrectly refers to adjustment code 3 as coinsurance.)

In addition, Payer A adjusted the office visit (line 1) charges to \$40.00 by contractual agreement.

The ERA CAS on line 1 was:

CAS*CO*42*3~.

Because the other lines did not have adjustments, there were no 835 CAS segments for those lines.



On the following pages, you will find comparisons of 837 data for this claims example.

Column 1 is provider's 837 claims data sent to Payer A.

Column 2 is provider's 837 claims data sent to Payer B, which includes the primary carrier's adjustments, payments, etc.

Column 3 has notes on the differences between the claims, and (highlighted) comments on entries that would result in Aetna COB data capture screens.

Comparison of original claim and secondary claim, differences highlighted

Claim to Payer A	Claim to Payer B	Notes
4 1000A SUBMITTER NM1 SUBMITTER NAME NM1*41*2*PREMIER BILLING SERVICE*****46*567890~ 5 PER SUBMITTER EDI CONTACT INFORMATION PER**IC*JERRY*TE*3055552222~ 6 1000B RECEIVER NM1 RECEIVER NAME NM1*40*2*XYZ REPRICER*****46*66783JJT~ 7 2000A BILLING/PAY-TO PROVIDER HL LOOP HL - BILLING PROVIDER HL*1**20*1~ 8 2010AA BILLING PROVIDER NM1 BILLING PROVIDER NM1*85*2*PREMIER BILLING SERVICE*****XX*5876543211~ 9 N3 BILLING PROVIDER ADDRESS N3*1234 SEAWAY ST~ 10 N4 BILLING PROVIDER CITY/STATE/ZIP N4*MIAMI*FL*33111~ 11 REF BILLING PROVIDER SECONDARY IDENTIFICATION REF*EI*123456789~ 12 PER BILLING PROVIDER CONTACT INFORMATION PER*IC*CONNIE*TE*3055551234~	4 1000A SUBMITTER NM1 SUBMITTER NM1*41*2*PREMIER BILLING SERVICE*****46*12EEER000TY~ 5 PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*TE*3055552222~ 6 1000B RECEIVER NM1 RECEIVER NM1*40*2*REPRICER XYZ*****46*66783JJT~ 7 2000A BILLING/PAY-TO PROVIDER HL LOOP HL - BILLING PROVIDER HL*1**20*1~ 8 2010AA BILLING PROVIDER NM1 BILLING PROVIDER NM1*85*2*PREMIER BILLING SERVICE*****XX*5876543211~ 9 N3 BILLING PROVIDER ADDRESS N3*1234 SEAWAY ST~ 10 N4 BILLING PROVIDER CITY/STATE/ZIP N4*MIAMI*FL*33111~ 11 REF BILLING PROVIDER SECONDARY IDENTIFICATION REF*EI*123456789~ 12 PER BILLING CONTACT INFORMATION PER*IC*CONNIE*TE*3055551234~	

<p>13 2010AB PAY-TO PROVIDER NM1 PAY-TO PROVIDER NAME NM1*87*2*KILDARE ASSOC*****XX*5812345671~ 14 N3 PAY-TO PROVIDER ADDRESS N3*2345 OCEAN BLVD~ 15 N4 PAY-TO PROVIDER CITY/STATE/ZIP N4*MIAMI*FL*33111~ 16 REF PAY-TO PROVIDER SECONDARY IDENTIFICATION REF*EI*123456789-ABA~ 17 2000B SUBSCRIBER HL LOOP HL - SUBSCRIBER HL*2*1*22*1~ 18 SBR SUBSCRIBER INFORMATION SBR*P*****CI~ 19 2010BA SUBSCRIBER NM1 SUBSCRIBER NAME NM1*IL*1*SMITH*JANE****34*111 223333~ 20 DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~ 21 REF SUBSCRIBER SECONDARY IDENTIFICATION REF*1W*JS00111223333~ 22 2010BB PAYER NM1 PAYER NAME NM1*IN*2*KEY INSURANCE COMPANY*****24*999996666~ 23 N3 PAYER ADDRESS N3*3333 OCEAN ST~</p>	<p>13 2010AB PAY-TO PROVIDER NM1 PAY-TO PROVIDER NAME NM1*87*2*KILDARE ASSOC*****XX*5812345671~ 14 N3 PAY-TO PROVIDER ADDRESS N3*2345 OCEAN BLVD~ 15 N4 PAY-TO PROVIDER CITY/STATE/ZIP N4*MIAMI*FL*33111~ 16 REF PAY-TO PROVIDER SECONDARY IDENTIFICATION REF*EI*123456789~ 17 2000B SUBSCRIBER HL LOOP HL - SUBSCRIBER HL*2*1*22*1~ 18 SBR SUBSCRIBER INFORMATION SBR*S*****CI~ 19 2010BA SUBSCRIBER NM1 SUBSCRIBER NAME NM1*IL*1*SMITH*JACK****34*222 334444~ 20 DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19431022*M~ 21 REF SUBSCRIBER SECONDARY IDENTIFICATION REF*1W*T55TY666~ 22 2010BB PAYER NM1 PAYER NAME NM1*IN*2*GREAT PRAIRIES HEALTH*****34*111223333~ 23 N3 PAYER ADDRESS N3*4456 SOUTH SHORE BLVD~</p>	<p>Subscriber is payer-specific and usually changes from primary to secondary claim.</p> <p>The demographic information usually changes also.</p> <p>The payer changes from primary to secondary claim.</p>
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<p>24 N4 PAYER CITY/STATE/ZIP N4*SOUTH MIAMI*FL*33000`</p> <p>25 2000C PATIENT HL LOOP HL - PATIENT HL*3*2*23*0~</p> <p>26 PAT PATIENT INFORMATION PAT*19~</p> <p>27 2010CA PATIENT NM1 PATIENT NAME NM1*QC*1*SMITH*TED***MI*JS01 111223333~</p> <p>28 N3 PATIENT ADDRESS N3*236 N MAIN ST~</p> <p>29 N4 PATIENT CITY/STATE/ZIP N4*MIAMI*FL*33413~</p> <p>30 DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~</p> <p>31 REF PATIENT SECONDARY IDENTIFICATION NUMBER REF*SY*000221111~</p> <p>32 2300 CLAIM CLM CLAIM LEVEL INFORMATION CLM*26407789*79.04***11::1*Y* A*Y*Y*B~</p> <p>33 HI HEALTH CARE DIAGNOSIS CODES HI*BK:4779*BF:2724*BF:2780*BF :53081~</p> <p>34 2310B RENDERING PROVIDER</p>	<p>24 N4 PAYER CITY/STATE/ZIP N4*CHICAGO*IL*44444~</p> <p>25 REF PAYER SECONDARY IDENTIFICATION REF*2U*567890~</p> <p>26 2000C PATIENT HL LOOP HL - PATIENT HL*3*2*23*0~</p> <p>27 PAT PATIENT INFORMATION PAT*19~</p> <p>28 2010CA PATIENT NM1 PATIENT NAME NM1*QC*1*SMITH*TED***MI*T55T Y666-01~</p> <p>29 N3 PATIENT ADDRESS N3*236 N MAIN ST~</p> <p>30 N4 PATIENT CITY N4*MIAMI*FL*33413~</p> <p>31 DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~</p> <p>32 REF PATIENT SECONDARY IDENTIFICATION NUMBER REF*SY*000221111~</p> <p>33 2300 CLAIM CLM CLAIM LEVEL INFORMATION CLM*26407789*79.04***11::1*Y* A*Y*Y*B~</p> <p>34 HI HEALTH CARE DIAGNOSIS CODES HI*BK:4779*BF:2724*BF:2780*BF :53081~</p> <p>35 2310B RENDERING PROVIDER</p>	
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<p>NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN****XX*99 99966661~ 35 PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~ 36 2310D SERVICE FACILITY LOCATION NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES****XX*5812345671~ 37 N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~ 38 N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~</p>	<p>NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN****XX*99 99966661~ 36 PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~ 37 2310D SERVICE FACILITY LOCATION NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES****XX*5812345671~ 38 N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~ 39 N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~ 40 2320 OTHER SUBSCRIBER INFORMATION SBR OTHER SUBSCRIBER INFORMATION SBR*P*32***CI****CI~ 41 CAS CLAIM LEVEL ADJUSTMENTS AND AMOUNTS CAS*PR*1*21.89**3*15~ 42 AMT COORDINATION OF BENEFITS - PAYOR PAID AMOUNT AMT*D*39.15~ 43 AMT COORDINATION OF BENEFITS - PATIENT RESPONSIBILITY AMT*F2*36.89~</p>	<p>Information on primary payer's subscriber is sent to secondary payer.</p> <p>Information on primary payer's claims level adjustments is sent to secondary payer. In example, a \$21.89 deductible and a \$15.00 co-payment are due from the patient under the primary plan.</p> <p>Indicates primary payer paid \$39.15.</p> <p>Patient responsibility under primary plan is \$36.89.</p>
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<p>39 2400 SERVICE LINE LX*1~ 40 SV1 PROFESSIONAL SERVICE SV1*HC:99213*43*UN*1***1:2:3: 4**N~ 41 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~</p>	<p>44 DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~ 45 OI OTHER INSURANCE COVERAGE INFORMATION OI***Y*B**Y~ 46 2330A OTHER SUBSCRIBER NAME NM1 OTHER SUBSCRIBER NAME NM1*IL*1*SMITH*JANE****MI*JS0 0111223333~ 47 N3 OTHER SUBSCRIBER ADDRESS N3*236 N MAIN ST~ 49 N4 OTHER SUBSCRIBER CITY N4*MIAMI*FL*33111~ 49 2330B OTHER SUBSCRIBER/PAYER NM1 OTHER PAYER NAME NM1*IN*2*KEY INSURANCE COMPANY*****24*999996666~ 50 2400 SERVICE LINE LX*1~ 51 SV1 PROFESSIONAL SERVICE SV1*HC:99213*43*UN*1***1:2:3:4** N~ 52 DTP DATE - SERVICE DATE(S) DTP*472*D8*19981003~ 53 2430 LINE ADJUDICATION INFORMATION SVD LINE ADJUDICATION INFORMATION SVD*111223333*39.15*HC:99213* *1~</p>	<p>Other (primary)payer name</p> <p>Payer A adjusted the office visit charges to</p>
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<p>42 2400 SERVICE LINE LX SERVICE LINE COUNTER LX*2~ 43 SV1 PROFESSIONAL SERVICE SV1*HC:90782*15*UN*1***1:2**N ~ 44 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~</p> <p>45 2400 SERVICE LINE LX SERVICE LINE COUNTER LX*3~ 46 SV1 PROFESSIONAL SERVICE SV1*HC:J3301*21.04*UN*1***1:2 **N~ 47 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~</p>	<p>54 CAS LINE ADJUSTMENT CAS*CO*42*3~ 56 DTP LINE ADJUDICATION DATE DTP*573*D8*19981015~</p> <p>55 2400 SERVICE LINE LX SERVICE LINE COUNTER LX*2~ 56 SV1 PROFESSIONAL SERVICE SV1*HC:90782*15*UN*1***1:2**N ~ 57 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~</p> <p>58 2400 SERVICE LINE LX SERVICE LINE COUNTER LX*3~ 59 SV1 PROFESSIONAL SERVICE SV1*HC:J3301*21.04*UN*1***1:2 **N~ 60 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~</p>	<p>\$40.00 by contractual agreement. (CAS01=CO). Code 42 indicates this is an amount in excess of negotiated fee.</p> <p>Since the billed amount was \$43.00, the adjustment on service line 1 is \$3.00, indicated by CAS*CO*42*3~</p>
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COB Example #2 - Professional Format - Commercial Payers

Example is based on **Commercial Medical Sample** from COB Screen Overview presentation.

Scenario:

Coordination of benefits; patient is not the subscriber; payers are commercial health insurance companies, provider-to-payer COB model. Provider received paper EPP from primary payer, submitted computer-printed CMS 1500 with paper EPP attached to secondary payer (Aetna).

CASE: Child Junior Doe with fever received chest X-ray. DOS=04/20/02,
POS=Hospital emergency room

SERVICES RENDERED: Reading of X-ray (Professional component)

CHARGE: \$38.00

Provider submitted a claim to Payer A (TML) under subscriber John Doe.

Payer A returned a paper remittance advice to the billing provider with the following information:

SUBMITTED CHARGE: \$38.00

Covered Expenses: \$38.00

Pay Percent: 80

Payable Amount: \$30.40

Other Carrier Adjustment: 0

Total Benefit: \$30.40

PATIENT RESPONSIBILITY:

Amount Not Covered: 0

Co-pay Amount: 0

Deductible: 0

Out of Pocket: \$7.60

Patient's Total Responsibility \$7.60

Other: 0

Provider then submitted claim to Payer B (Aetna) on paper under subscriber Jane Doe, with TML paper remittance advice attached. Below is claim as received by Aetna:

AETNA US HEALTHCARE 020617140568
 PO BOX 981107
 EL PASO, TX 79998

X
 08 17 1998 X
 X
 X
 X

X
 X
 X

AETNA US HEALTHCARE
 X

SIGNATURE ON FILE 06/05/2002 SIGNATURE ON FILE

780.4

04202002 04202002 23 4 71020 26 1 38.00 1 X

EOB ATTACHED

EC044324 X 38.00 30.40 7.40
 STEPHENVILLE, TX 75401 ROCKWALL, TX 75087
 06/05/2002

Report # / 923 Form (REC) Line (RT) Demand CR (AM) 06/05/02

Reminder:


A paper copy of the previous payer's explanation of benefits (EOB) is not needed if you submit your COB claims data electronically. If COB claims data is sent electronically, sending a paper EOB will only result in Aetna rejecting the claim as a duplicate.

Helpful Hint:

Primary payer payment information should be sent using industry standard code values. When working with paper EOBs, please refer to our "Adjustment Reason and Adjustment Group Code Categorization Table". This table can assist you in converting payment information found on an EOB into industry standard coding.

It is possible your paper remittance may already contain standard code values. If so, please use the codes furnished by the primary payer.

Below is the primary payer (TML) explanation of benefits as received by Aetna:



Explanation of Benefits

020617140568

Date: 06/20/2007
Page: 1 of 1

Emp No: [REDACTED] SSN: [REDACTED] Patient: [REDACTED] Group: NTEREU Location Code: A Claim No.: 02417758 03 Informed Date: 04/20/2002-04/20/2002		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">Patient Responsibility</th> </tr> <tr> <td>Amount Not Covered:</td> <td style="text-align: right;">0.00</td> </tr> <tr> <td>Copay Amount:</td> <td style="text-align: right;">0.00</td> </tr> <tr> <td>Deductible:</td> <td style="text-align: right;">0.00</td> </tr> <tr> <td>Out of Pocket:</td> <td style="text-align: right;">0.00</td> </tr> <tr> <td>Patient's Total Responsibility:</td> <td style="text-align: right;">0.00</td> </tr> <tr> <td>Other (See back):</td> <td style="text-align: right;">0.00</td> </tr> </table>	Patient Responsibility		Amount Not Covered:	0.00	Copay Amount:	0.00	Deductible:	0.00	Out of Pocket:	0.00	Patient's Total Responsibility:	0.00	Other (See back):	0.00
Patient Responsibility																
Amount Not Covered:	0.00															
Copay Amount:	0.00															
Deductible:	0.00															
Out of Pocket:	0.00															
Patient's Total Responsibility:	0.00															
Other (See back):	0.00															

Date	Total Charge	Ineligible	C.D.	Cost Management Savings	Copay	Deductible Amount	Covered Expenses	Pay %	Amount Payable
04/20	38.00	4.45 & 7.34					33.21	RT	33.40
Totals	38.00						33.21		33.40

ATTENTION MEDICAL PROVIDERS: Claims may be submitted electronically to TML/EBP using payer number 74214. For additional information, please contact TML at 1-877-755-5430 or ENVIVO at 1-800-245-4562.

For automated benefit verification, please visit <http://www.aetna.com> or call 1-800-282-5186.

PATIENT IS RESPONSIBLE FOR ALL DEDUCTIBLES, COPAYMENTS, AND CERTAIN INELIGIBLE AMOUNTS

Description of Codes (CD) and/or Comments
PdLF 00014324

	Other Carrier Adjustment	
	Total Benefit:	30.40

You have 90 days in which to file an appeal. Please see the back of this form for more information.

On the following pages, you will find comparisons of 837 data for this claims example. Only those lines needed to illustrate points not shown in the prior example have been included.

Column 1 is selected lines from provider's claim to Payer A as it *would have appeared if it had been sent electronically*.

Column 2 shows how these lines and additional lines created from information on TML paper remittance could have been used to send an EDI (837) claim to Payer B (Aetna).

Column 3 has notes on the differences between the claims, and (highlighted) comments on entries that would result in Aetna COB data capture screens.

Comparison of original claim and secondary claim, differences highlighted

Claim to Payer A	Claim to Payer B	Notes
	<p>41 2320 OTHER SUBSCRIBER INFORMATION SBR OTHER SUBSCRIBER INFORMATION SBR*P*19***CI***CI~ 43 AMT COORDINATION OF BENEFITS - PAYOR PAID AMOUNT AMT*D*30.40~ 44 AMT COORDINATION OF BENEFITS - PATIENT RESPONSIBILITY AMT*F2*7.60~ 45 DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*461213501*M~ 46 OI OTHER INSURANCE COVERAGE INFORMATION OI***Y*B**Y~</p> <p>47 2330A OTHER SUBSCRIBER NAME NM1 OTHER SUBSCRIBER NAME NM1*IL*1*DOE*JOHN***MI*461-21-3501~ 48 N3 OTHER SUBSCRIBER ADDRESS N3*123 MAIN ST~ 49 N4 OTHER SUBSCRIBER CITY N4*SMALLVILLE*TX*76401~</p> <p>50 2330B OTHER</p>	<p>Indicates primary payer paid \$30.40.</p> <p>Patient responsibility under primary plan is \$7.60, due to coinsurance applied at the line level.</p> <p>Primary payer's adjustment for coinsurance was made at line level, so no CAS segment is sent at claims level.</p>

<p>40 2400 SERVICE LINE LX*1~ 41 SV1 PROFESSIONAL SERVICE SV1*HC:71020:26*38*UN*1***1 ~ 42 DTP DATE - SERVICE DATE(S) DTP*472*D8*20020528~</p>	<p>SUBSCRIBER/PAYER NM1 OTHER PAYER NAME NM1*IN*2*TML IEBP*****PI*74214~ 51 2400 SERVICE LINE LX*1~ 41 SV1 PROFESSIONAL SERVICE SV1*HC:71020:26*38*UN*1***1~ 42 DTP DATE - SERVICE DATE(S) DTP*472*D8*20020528~ 54 2430 LINE ADJUDICATION INFORMATION SVD LINE ADJUDICATION INFORMATION SVD*74214*30.40*HC:71020:26**1 ~ 55 CAS LINE ADJUSTMENT CAS*PR*2*7.60~ 56 DTP LINE ADJUDICATION DATE DTP*573*D8*20020528~</p>	<p>Other (primary) payer name & ID</p> <p>Payer A made <u>no</u> adjustment to the charges by contractual agreement or due to R&C. (Code 2 in the CAS indicates this is a coinsurance-based adjustment of \$7.60.)</p>
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COB Example #3 - Medicare Part B Primary - Professional Format

Example is based on **Example 3 from HIPAA Professional Implementation Guide.**

Scenario:

Coordination of benefits; patient is the subscriber; payers are Medicare and commercial health insurance companies, provider-to-payer COB model. Provider submits claims electronically and receives ERA from Medicare.

CASE: Patient came to office for routine hyperlipidemia check. DOS=10/03/97, POS=Office; Patient also complained of hay fever and heartburn.

SERVICES RENDERED and CHARGES

CPT Code	Service Description	# of Units	Charges
99213	Office Visit – Established Patient	1	\$43.00
90782	Injection Administration	1	\$15.00
J3301	Triamcinolone Acetonide, 10 mg	1	\$21.04
		Total	\$79.04

Payer A returned an electronic remittance advice (ERA - 835) to the billing provider with the following amounts and Claim Adjustment Reason Codes:

SUBMITTED CHARGES (CLP03): \$79.04

AMOUNT PAID (CLP04): \$43.32

PATIENT RESPONSIBILITY (CLP05): \$32.72

Payer A did not make any claims level adjustments.

Payer A adjusted the office visit (service line 1) charges to \$40.00 due to Medicare reduction, and also applied a deductible and coinsurance. Payer A adjusted the injections (service lines 2 and 3) due to the 80 percent coinsurance.

The ERA for service line 1 was:
PRIMARY PAYER BILLED AMOUNT: SVC*HC:99213*43*14.49
LINE LEVEL ADJUSTMENTS: CAS*CO*42*3*PR*1*21.89*2*3.62~.
APPROVED AMOUNT: AMT*B6*40~

The ERA for service line 2 was:
PRIMARY PAYER BILLED AMOUNT: SVC* HC:90782*15*12~
LINE LEVEL ADJUSTMENT: CAS*PR*2*3~
APPROVED AMOUNT: AMT*B6*15~

The ERA for service line 3 was:
PRIMARY PAYER BILLED AMOUNT: SVC*HC:J3301*21.04*16.83~
LINE LEVEL ADJUSTMENT: CAS*PR*2*4.21~
APPROVED AMOUNT: AMT*B6*21.04~



On the following pages, you will find comparisons of 837 data for this claims example.

Column 1 is provider's 837 claims data sent to Payer A.

Column 2 is provider's 837 claims data sent to Payer B, which includes the primary carrier's adjustments, payments, etc.

Column 3 has notes on the differences between the claims, and (highlighted) comments on entries that would result in Aetna COB data capture screens.

Comparison of original claim and secondary claim, differences highlighted

Claim to Payer A	Claim to Payer B	Notes
<p>32 2300 CLAIM CLM CLAIM LEVEL INFORMATION CLM*26407789*79.04***11::1*Y* A*Y*Y*B~ 33 HI HEALTH CARE DIAGNOSIS CODES HI*BK:4779*BF:2724*BF:2780*BF :53081~ 34 2310B RENDERING PROVIDER NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN***XX*99 99966661~ 35 PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~ 36 2310D SERVICE FACILITY LOCATION NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES*****XX*581234567~ 37 N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~ 38 N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~</p>	<p>33 2300 CLAIM CLM CLAIM LEVEL INFORMATION CLM*26407789*79.04***11::1*Y* A*Y*Y*B~ 34 HI HEALTH CARE DIAGNOSIS CODES HI*BK:4779*BF:2724*BF:2780*BF :53081~ 35 2310B RENDERING PROVIDER NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN***XX*99 99966661~ 36 PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~ 36 2310D SERVICE FACILITY LOCATION NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES*****XX*5812345671~ 38 N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~ 39 N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~ 40 2320 OTHER SUBSCRIBER INFORMATION SBR OTHER SUBSCRIBER INFORMATION SBR*P*18***MB***MB~ 41 AMT COORDINATION OF BENEFITS - PAYOR PAID</p>	<p>Total claim charges are \$79.04. The bolded “A” indicates the provider has accepted Medicare’s assignment.</p> <p>Payer’s ID for rendering provider changes.</p>

<p>39 2400 SERVICE LINE LX*1~ 40 SV1 PROFESSIONAL SERVICE SV1*HC:99213*43*UN*1***1:2:3: 4**N~ 41 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~</p>	<p>AMOUNT AMT*D*43.32~ 42 AMT COORDINATION OF BENEFITS - PATIENT RESPONSIBILITY AMT*F2*32.72~ 43 DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~ 44 OI OTHER INSURANCE COVERAGE INFORMATION OI***Y*B**Y~ 45 2330A OTHER SUBSCRIBER NAME NM1 OTHER SUBSCRIBER NAME NM1*IL*1*SMITH*JANE***MI*JS0 0111223333~ 46 N3 OTHER SUBSCRIBER ADDRESS N3*236 N MAIN ST~ 48 N4 OTHER SUBSCRIBER CITY N4*MIAMI*FL*33111~ 47 2330B OTHER SUBSCRIBER/PAYER NM1 OTHER PAYER NAME NM1*IN*2*MEDICARE*****24*9999 96666~ 48 2400 SERVICE LINE LX*1~ 49 SV1 PROFESSIONAL SERVICE SV1*HC:99213*43*UN*1***1:2:3: 4**N~ 50 DTP DATE - SERVICE DATE(S) DTP*472*D8*19981003~ 51 APPROVED AMOUNT AMT*AAE*40~</p>	<p>Indicates Medicare paid \$43.32 for the services on the claim.</p> <p>Indicates a patient responsibility of \$32.72, due to the coinsurance and deductible.</p> <p>Medicare's adjustment (coinsurance) was made at line level, so no CAS segment is sent at claims level.</p> <p>Information on primary payer's subscriber is sent to secondary payer.</p> <p>Other (primary) payer name</p> <p>The billed amount for service line 1 was \$43.00.</p> <p>Medicare approved \$40.00 for service line 1.</p>
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<p>42 2400 SERVICE LINE LX SERVICE LINE COUNTER LX*2~ 43 SV1 PROFESSIONAL SERVICE SV1*HC:90782*15*UN*1***1:2**N ~ 44 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~</p> <p>45 2400 SERVICE LINE LX SERVICE LINE COUNTER LX*3~</p>	<p>52 2430 LINE ADJUDICATION INFORMATION SVD LINE ADJUDICATION INFORMATION SVD*111223333*14.49*HC:99213* *1~ 53 CAS LINE ADJUSTMENT CAS*CO*42*3*PR*1*21.89*2*3.62 ~ 54 DTP LINE ADJUDICATION DATE DTP*573*D8*19981015~</p> <p>55 2400 SERVICE LINE LX SERVICE LINE COUNTER LX*2~ 56 SV1 PROFESSIONAL SERVICE SV1*HC:90782*15*UN*1***1:2**N ~ 57 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~ 58 APPROVED AMOUNT AMT*AAE*15~ 59 2430 LINE ADJUDICATION INFORMATION SVD LINE ADJUDICATION INFORMATION SVD*111223333*12*HC:90782**2~ 60 CAS LINE ADJUSTMENT CAS*PR*2*3~ 61 DTP LINE ADJUDICATION DATE DTP*573*D8*19981015~</p> <p>62 2400 SERVICE LINE LX SERVICE LINE COUNTER LX*3~ 63 SV1 PROFESSIONAL SERVICE</p>	<p>Medicare paid \$14.49 for service line 1.</p> <p>The total adjustments for service line 1 are \$28.51, as indicated by the CAS line adjustment: CAS*CO*42*3*PR*1*21.89*2*3.62. The adjustments include a \$3.00 contractual write-off, \$1.21 toward patient's deductible, and \$3.62 in coinsurance applied to service line 1.</p> <p>The billed amount for service line 2 was \$15.00.</p> <p>Medicare approved \$15.00 for service line 2.</p> <p>Medicare paid \$12.00 for service line 2.</p> <p>The adjustment for service line 2 is \$3.00 for coinsurance, as indicated by CAS*PR*2*3~.</p>
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<p>46 SV1 PROFESSIONAL SERVICE SV1*HC:J3301*21.04*UN*1***1:2 **N~ 47 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~</p>	<p>SV1*HC:J3301*21.04*UN*1***1:2 **N~ 64 DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~ 65 APPROVED AMOUNT AMT*AAE*21.04~ 66 2430 LINE ADJUDICATION INFORMATION SVD LINE ADJUDICATION INFORMATION SVD*111223333*16.83*HC:J3301* *3~ 67 CAS LINE ADJUSTMENT CAS*PR*2*4.21~ 68 DTP LINE ADJUDICATION DATE DTP*573*D8*19981015~</p>	<p>The billed amount for service line 3 was \$21.04.</p> <p>Medicare approved \$21.04 for service line 3.</p> <p>Medicare paid \$16.83 for service line 3.</p> <p>The adjustment for service line 3 is \$4.21 for coinsurance, as indicated by CAS line adjustment CAS*PR*2*4.21~.</p>
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COB Example #4 - Medicare Part B Primary - Professional Format

Example is based on **Commercial Medical Sample from COB Screen Overview presentation.**

Scenario:

Coordination of benefits; patient is the subscriber; payers are Medicare and commercial health insurance companies, provider-to-payer COB model. Provider received paper EPP from Medicare, submitted computer printed CMS-1500 with paper EPP attached to secondary payer (Aetna).

CASE: Member Annabelle Doe DOS=04/24/02
POS=Hospital

SERVICES RENDERED: Procedure Code 93010 Electrocardiogram (Professional component)

CHARGE: \$16.00

Provider submitted a claim to Payer A (Medicare) under subscriber Annabelle Doe.

Payer A returned a paper remittance advice to the billing provider with the following information:

SUBMITTED CHARGE: \$16.00

Allowed Expenses: \$8.34

Pay Percent: 80

Payable Amount: \$6.67

Amount Not Covered (Contractual Adjustment): \$7.66

Co-pay Amount: 0

Deductible: 0

Patient's Total Responsibility (due to coinsurance): \$1.67

Provider then submitted claim to Payer B (Aetna) on paper under subscriber Annabelle Doe, with Medicare paper remittance advice attached.

Claim as received by Aetna:

[REDACTED]

AETNA 0200
PO BOX 129108
SAN DIEGO CA 92112-9108

0527020028

[REDACTED]	[REDACTED]	H 05 11 30	X	[REDACTED]	
[REDACTED]	[REDACTED]		X	[REDACTED]	
TULSA		OK		TULSA	UK
74145-1428	918 664 1331			74145-1428	918 664 1331
[REDACTED]	[REDACTED]			397390 03 00	
[REDACTED]			X	05 19 30	X
05 19 30		X		OCCIDENTAL PETROLEUM	
OCCIDENTAL PETROLEUM			X	AETNA	
MEDICARE				X	

SIGNATURE ON FILE

051302

SIGNATURE ON FILE

[REDACTED]

04 29 02 05 05 02
X

401 9

223 0

04 24 02

21 1 93010

1

16 00 01

[REDACTED]

X 4661692 X

16 00 0 00 16 00

[REDACTED]

TULSA UK 74136

DEPT 91
TULSA UK 74182-0091

[REDACTED]

Reminder:

A paper copy of the previous payer's explanation of benefits (EOB) is not needed if you submit your COB claim data electronically. If COB claims data is sent electronically, sending a paper EOB will only result in Aetna rejecting the claim as a duplicate.

Helpful Hint:

Primary payer payment information should be sent using industry standard code values. When working with paper EOBs, please refer to our "Adjustment Reason and Adjustment Group Code Categorization Table". This table can assist you in converting payment information found on an EOB into industry standard coding.

It is possible your paper remittance may already contain standard code values. If so, please use the codes furnished by the primary payer.

Primary payer (Medicare) EOB, as received by Aetna:

OKLAHOMA/NEW MEXICO MEDICARE SERVICE
05/29/02

PERF	PROV	SEVY	DATE	FOR	NOB	PRDC	MDR	BILLER	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PRDY	PR
NAME								ACNT 04465951-95054305	ICN 110213726800	ASG Y	NDA MA01	HA18		
44634								30.00	8.34	0.00	1.67	CO-42	21.66	6.67
44636								30.00	8.34	0.00	1.67	CO-42	21.66	6.67
PT RESP		8.54						60.00	16.68	0.00	3.34		43.32	13.34
														13.34
														NET
NAME								ACNT 044660091-95055216	ICN 1102137267710	ASG Y	NDA MA01	HA19		
4984605860P	0501	050102	22				1	95010						
PT RESP								30.00	8.34	0.00	1.67	CO-42	21.66	6.67
								30.00	8.34	0.00	1.67	CO-42	21.66	6.67
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Comparison of original claim and secondary claim, differences highlighted

Claim to Payer A	Claim to Payer B	Notes – information for Aetna COB entry screens highlighted
	<p>41 2320 OTHER SUBSCRIBER INFORMATION SBR OTHER SUBSCRIBER INFORMATION SBR*P*18*****MB~ 42 AMT COORDINATION OF BENEFITS - PAYOR PAID AMOUNT AMT*D*6.67~ 43 AMT COORDINATION OF BENEFITS - PATIENT RESPONSIBILITY AMT*F2*1.67~ 44 DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*461213501*F~ 45 OI OTHER INSURANCE COVERAGE INFORMATION OI***Y***Y~</p> <p>46 2330A OTHER SUBSCRIBER NAME NM1 OTHER SUBSCRIBER NAME NM1*IL*1*DOE*ANNABELLE****MI* 461-21-3501~ 47 N3 OTHER SUBSCRIBER ADDRESS N3*123 MAIN ST~ 48 N4 OTHER SUBSCRIBER CITY N4*SMALLVILLE*TX*76401~</p> <p>49 2330B OTHER SUBSCRIBER/PAYER</p>	<p>Indicates Medicare paid \$6.67.</p> <p>Patient responsibility (coinsurance) under primary plan is \$1.67.</p> <p>Medicare adjustments (coinsurance and contractual adjustment) were made at line level, so no CAS segment is sent at claims level.</p>

<p>40 2400 SERVICE LINE LX*1~ 41 SV1 PROFESSIONAL SERVICE SV1*HC:71020:26*23*UN*1***1 ~ 42 DTP DATE - SERVICE DATE(S) DTP*472*D8*20020528~</p>	<p>NM1 OTHER PAYER NAME NM1*PR*2*MEDICARE CARRIER*****PI*74214~</p> <p>50 2400 SERVICE LINE LX*1~ 51 SV1 PROFESSIONAL SERVICE SV1*HC:93010*16*UN*1***1~ 52 DTP DATE - SERVICE DATE(S) DTP*472*D8*20020424~ 53 APPROVED AMOUNT AMT*AAE*8.34~ 54 2430 LINE ADJUDICATION INFORMATION SVD LINE ADJUDICATION INFORMATION SVD*111223333*6.67*HC:93010** 1~ 55 CAS LINE LEVEL ADJUSTMENT CAS*CO*42*7.66*PR*2*1.67~ 56 DTP LINE ADJUDICATION DATE DTP*573*D8*20020528~</p>	<p>Other (primary)payer name & ID</p> <p>The billed amount for the service line was \$16.00.</p> <p>Medicare approved \$8.34 for the service.</p> <p>Medicare paid \$6.67 for the service.</p> <p>The line-level adjustment indicates a contractual write-off of \$7.66, as well as patient responsibility (coinsurance) of \$1.67.</p>
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