



## ***Electronic Claims Submission***

# ***Coordination of Benefits (COB) Data Fields for Aetna Secondary Claim Processing***

***Aetna Provider eSolutions<sup>SM</sup>***

### **Overview of Document Content**

This document lists COB data that Aetna needs 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 837 implementation guides.

Loop/Segment – Provides the exact location in the 837 format for each data element (for example, 2330B/NM1).

Requirements - Aetna'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).



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### Claim Level – Professional Format

Data Elements	Loop/Segment	Requirements	Comments
Other Subscriber Name	2330A/NM1	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration.	Already exists on CMS 1500 form – likely to be supported on the providers claim submission software. This is the “Insured’s Name” from the previous payer.
Other Payer Name  <i>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.</i>	2330B/NM1	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	Already exists on CMS 1500 form – likely to be supported on the providers claim submission software. 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.	Some information already exists on CMS 1500 form – likely to be supported on the providers claim submission software. This is the “Relationship Code”, “Insurance Plan Name or Program Name”, “Insured’s Policy Group or FECA Number”, “Insurance Type Code” (Form Locator 1) and “Claim Filing Indicator” (Form Locator 1) 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.	Information not on CMS 1500 form. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Report at line level if primary payer EOB provides at line level. Do not include in claim level amounts any amounts reported at 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.

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#### Claim Level – Professional Format (cont'd)

Data Elements	Loop/Segment	Requirements	Comments
Other Subscriber Demographic Information	2320/DMG	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration. Required when 2330A NM102 = 1 (person).	Information not on CMS 1500 form. Aetna may need date of birth of other plan subscriber to determine which payer is primary. This is the previous payer's "Insured's Sex Code" and "Insured's Date Of Birth".
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 copay amount, negotiated/contractual rate reduction, R&C reduction. Do not enter at claim level any amounts included at line level.

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#### Claim Level – Institutional Format

Data Elements	Loop/Segment	Requirements	Comments
Other Subscriber Name	2330A/NM1	The 2330 loop is HIPAA required when Loop ID-2320- Other Subscriber Information is used.	Already exists on UB 92 form – likely to be supported on the providers claim submission software. This is the “Insured’s Name” from the previous payer.
Other Payer Name  <i>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.</i>	2330B/NM1	The 2330 loop is HIPAA required when Loop ID-2320- Other Subscriber Information is used.	Already exists on UB 92 form – likely to be supported on the providers claim submission software. This is the “Payer” from the previous payer.
Other Subscriber Information	2320/SBR	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration.	Most information already exists on UB 92 form – likely to be supported on the providers claim submission software. This is the “Patient Relationship”, “Insurance Group Name” and “Insurance Group Number” 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.	Information not on UB04 form. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Report at line level if primary payer EOB provides at line level. Do not include in claim level amounts if any amounts reported at line level.
Payer Prior Payment Amount	2320/AMT (AMT01=C4)	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration when primary payer has considered an amount to the provider towards the bill.	Already exists on UB04 form – likely to be supported on the providers claim submission software. This is the “Prior Payments” from the previous payer(s).

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#### Claim Level – Institutional Format (continued)

Data Elements	Loop/Segment	Requirements	Comments
Other Subscriber Demographic Information	2320/DMG	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration. Required when 2330A NM102 = 1 (person).	Information is not on the UB04 form. Aetna may need date of birth of other plan subscriber to determine which payer is primary. This is the previous payer's "Insured's Sex Code" and "Insured's Date Of Birth".
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 UB04 form. Can normally be based on that already collected on the previous payer's UB04 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 UB04 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 UB04 form. Shows why the other payer paid less than billed. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Do not enter at claim level any amounts included at line level.



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#### Claim Level – Dental Format

Data Elements	Loop/Segment	Requirements	Comments
Other Subscriber Name	2330A/NM1	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration.	Already exists on ADA dental form – likely to be supported on the providers claim submission software. This is the “Primary Insured” from the previous payer.
Other Payer Name <i>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.</i>	2330B/NM1	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	Already exists on ADA dental claim form – likely to be supported on the providers claim submission software. This is the “Primary Payer Information” from the previous payer.
Other Subscriber Information	2320/SBR	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	Some information already exists on ADA dental form – likely to be supported on the providers claim submission software. This is the “Relationship to Primary Insured”, “Primary Employer Name” and “Primary Group Number” 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.	Information not on ADA dental claim form. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Report at line level if primary payer EOB provides at line level. Do not include in claim level amounts any amounts reported at 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.

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#### Line Level – Dental Format (continued)

Data Elements	Loop/Segment	Requirements	Comments
Other Subscriber Demographic Information	2320/DMG	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration. Required when 2330A NM102 = 1 (person).	Already exists on ADA dental form – likely to be supported on the providers claim submission software. Aetna may need date of birth of other plan subscriber to determine which payer is primary. This is the “Primary Insured Gender” and “Primary Insured Date of Birth” from the previous payer.
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 ADA dental form. This is the “Accept Assignment”, “Patient Signature” and “Release Information” and can normally be based on that already collected on the previous payers ADA dental 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 ADA dental claim 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 ADA dental claim form. Shows why the other payer paid less than billed. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Do not enter at claim level any amounts included at line level.

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## Electronic Claims Submission

### Coordination of Benefits (COB) Data Fields for Aetna Secondary Claim Processing

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For claims where Medicare was primary

#### Claim Level – Medicare Part B – Professional Format

Data Elements	Loop/Segment	Requirements	Comments
Provider Accept Assignment Code	2300/CLM07	Element is HIPAA required for the claim. The value indicates whether the provider accepts Medicare assignment.	Already exists on the CMS 1500 form – likely to be supported on the providers claim submission software. This is the “Accept Assignment” and can normally be based on that already collected on the previous payers.
Other Subscriber Name	2330A/NM1	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	Already exists on CMS 1500 form – likely to be supported on the providers claim submission software. This is the “Insured’s Name” from the previous payer.
Other Payer Name  <i>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.</i>	2330B/NM1	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	Already exists on CMS 1500 form – likely to be supported on the providers claim submission software. This is the “Insurance Plan Name or Program Name” from the previous payer.
Other Subscriber Information	2320/SBR	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration.	Some information already exists on CMS 1500 form – likely to be supported on the providers claim submission software. This is the “Relationship Code”, “Insurance Plan Name or Program Name”, “Insured’s Policy Group or FECA Number”, “Insurance Type Code” (Form Locator 1) and “Claim Filing Indicator” (Form Locator 1) from the previous payer.
Adjustment codes and associated amounts	2320/CAS	Segment is HIPAA required by Aetna 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.	Information not on CMS 1500 form. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Report at line level if primary payer EOB provides at line level. Do not include in claim level amounts any amounts reported at

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			line level.
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#### Claim Level – Medicare Part B – Professional Format (continued)

Data Elements	Loop/Segment	Requirements	Comments
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 to the provider towards the bill.	Should equal total charges minus claim and line level adjustments.
Allowed Amount	2320/AMT (AMT01=B6)	While submission of this information will assist in validating the primary payer's benefits determination, this segment is optional.	Information is not on the CMS 1500, but should be present on the Medicare Explanation of Benefits.
Patient Responsibility Amount	2320/AMT (AMT01=F2)	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and the patient is responsible for payment according to Medicare's adjudication.	Information is not on the CMS 1500, but should be present on the Medicare Explanation of Benefits.
Other Subscriber Demographic Information	2320/DMG	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration. Required when 2330A NM102 = 1 (person).	Information not on CMS 1500 form. Aetna may need date of birth of other plan subscriber to determine which payer is primary. This is the previous payer's "Insured's Sex Code" and "Insured's Date Of Birth".
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.

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#### Line Level – Medicare Part B – Professional Format

Data Elements	Loop/Segment	Requirements	Comments
Approved Amount	2400/AMT (AMT01=AAE)	While submission of this information will assist in validating the primary payer's benefits determination, this segment is optional.	Information is not on the CMS 1500 form. This is displayed on the Medicare Explanation of Benefits as the "Allowed Amount."
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. Shows why the other payer paid less than billed. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Do not enter at claim level any amounts included at line level.



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For claims where Medicare was primary

#### Claim Level – Medicare Part A – Institutional Format

Data Elements	Loop/Segment	Requirements	Comments
Provider Accept Assignment Code	2300/CLM07	Element is HIPAA required for the claim. The value indicates whether the provider accepts Medicare assignment.	Information is not on the UB04 form. Can normally be based on that already collected on the previous payers.
Patient Estimated Amount Due	2300/AMT (AMT01=F3)	Segment is HIPAA required when the Patient Responsibility Amount is applicable to the claim.	Information is not on the UB04, but should be present on the Medicare Explanation of Benefits.
Medicare Inpatient Adjudication Information	2320/MIA	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration when Medicare Inpatient Adjudication Information was supplied on the Medicare Explanation of Benefits.	Information is not on the UB04 form, but should be present on the Medicare Explanation of Benefits when applicable.
Medicare Outpatient Adjudication Information	2320/MOA	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration when Medicare Outpatient Adjudication Information was supplied on the Medicare Explanation of Benefits.	Information is not on the UB04 form, but should be present on the Medicare Explanation of Benefits when applicable.
Other Subscriber Name	2330A/NM1	This 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	Already exists on UB 92 form – likely to be supported on the providers claim submission software. This is the “Insured’s Name” from the previous payer.
Other Payer Name  <i>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.</i>	2330B/NM1	This 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	Already exists on UB 92 form – likely to be supported on the providers claim submission software. This is the “Payer” from the previous payer.
Other Subscriber Information	2320/SBR	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration.	Most information already exists on UB 92 form – likely to be supported on the providers claim submission software. This is the “Patient Relationship”, “Insurance Group Name”, “Insurance Group Number” from the previous payer.

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#### Claim Level – Medicare Part A – Institutional Format (continued)

Data Elements	Loop/Segment	Requirements	Comments
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.	Information not on UB04 form. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Report at line level if primary payer EOB provides at line level. Do not include in claim level amounts if any amounts reported at line level.
Payer Prior Payment Amount	2320/AMT (AMT01=C4)	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration when primary payer has considered an amount to the provider towards the bill.	Already exists on UB04 form – likely to be supported on the providers claim submission software. This is the “Prior Payments” from the previous payer(s).
Allowed Amount	2320/AMT03 (AMT01=B6)	While submission of this information will assist in validating the primary payer’s benefits determination, this segment is optional.	Information is not on the CMS 1500, but should be present on the Medicare Explanation of Benefits.
Other Subscriber Demographic Information	2320/DMG	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration. Required when 2330A NM102 = 1 (person).	Information is not on the UB04 form. Aetna may need date of birth of other plan subscriber to determine which payer is primary. This is the previous payer’s “Insured’s Sex Code” and “Insured’s Date Of Birth”.
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 UB04 form. Can normally be based on that already collected on the previous payers UB04 form. Separate collection of this information only needed when it differs by payer.



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#### Line Level – Medicare Part A – Institutional Format

Data Elements	Loop/Segment	Requirements	Comments
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 UB04 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 UB04 form. Shows why the other payer paid less than billed. Information most commonly required is deductible amount, coinsurance or copay amount, negotiated/contractual rate reduction, R&C reduction. Do not enter at claim level any amounts included at line level.