



Electronic Claims Submission

Coordination of Benefits (COB) Data Fields for Aetna Secondary Claim Processing (5010)

Aetna Provider eSolutionsSM

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	The 2330A 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 2330B 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 2320 loop is HIPAA required when other payers are potentially involved in paying for the claim.	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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer 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 the claim has been adjudicated by the payer identified in the 2330B loop.	Should equal total charges minus claim and line level adjustments.

Edition Date: March 2010



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Claim Level – Professional Format (cont'd)

Data Elements	Loop/Segment	Requirements	Comments
Adjudication information	2430/SVD	Segment is HIPAA required when the claim has been previously adjudicated by the payer identified in the 2330B loop and the payer has payments and/or 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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer applied claim 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 2330A 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 2330B 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 Loop ID-2320-Other Subscriber Information is used..	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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer 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=D)	Segment is HIPAA required when the claim has been adjudicated by the payer identified in the 2330B loop.	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
Adjudication information	2430/SVD	Segment is HIPAA required when the claim has been previously adjudicated by the payer identified in the 2330B loop and the payer has payments and/or 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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer applied claim 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	The 2330A loop is HIPAA required when Loop ID-2320- Other Subscriber Information is used.	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 2330B 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	Segment 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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer 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 the claim has been adjudicated by the payer identified in the 2330B loop.	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
Adjudication information	2430/SVD	Segment is HIPAA required when the claim has been previously adjudicated by the payer identified in the 2330B loop and the payer has payments and/or 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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer applied claim 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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For claims where Medicare was primary

Claim Level – Medicare Part B – Professional Format

Data Elements	Loop/Segment	Requirements	Comments
Other Subscriber Name	2330A/NM1	The 2330A 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 2330B 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 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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer 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 the claim has been adjudicated by the payer identified in the 2330B loop.	Should equal total charges minus claim and line level adjustments.

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For Claims where Medicare was primary

Line Level – Medicare Part B – Professional Format

Data Elements	Loop/Segment	Requirements	Comments
Adjudication information	2430/SVD	Segment is HIPAA required when the claim has been previously adjudicated by the payer identified in the 2330B loop and the payer has payments and/or 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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer applied claim 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
Medicare Inpatient Adjudication Information - Lifetime Psychiatric Days Count	2320/MIA03	Segment is HIPAA required when the payer identified in 2330B loop supplied the Lifetime Psychiatric Days Count 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 Inpatient Adjudication Information - Claim Indirect Teaching Amount	2320/MIA18	Segment is HIPAA required when the payer identified in 2330B loop supplied the Claim Indirect Teaching Amount 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 - End Stage Renal Disease Payment Amount	2320/MOA08	Segment is HIPAA required when the payer identified in 2330B loop supplied the End Stage Renal Disease Payment Amount 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 2330A 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 2330B 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 Loop ID-2320-Other Subscriber Information is used...	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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For claims where Medicare was primary
 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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer 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=D)	Segment is HIPAA required when the claim has been adjudicated by the payer identified in the 2330B loop	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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For Claims where Medicare was primary
Line Level – Medicare Part A – Institutional Format

Data Elements	Loop/Segment	Requirements	Comments
Adjudication information	2430/SVD	Segment is HIPAA required when the claim has been previously adjudicated by the payer identified in the 2330B loop and the payer has payments and/or 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 the claim has been adjudicated by the payer identified in the 2330B loop and the payer applied claim 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.