

## MN-ITS Help – 837P and 837D COB – TPL/Medicare

The table below describes the individual fields on the Coordination of Benefits (COB) screens. \* The Field Name column identifies X12 loops and elements only for fields that display in the MN-ITS screens. Refer to the X12 HIPAA Companion Guides available through the [WPC X12 Registry](#) for additional instruction when submitting batch claims.

Select [MN-ITS User Guides](#) to obtain additional instruction for submitting claims for specific services using MN-ITS Direct Data Entry (DDE).

[MN-ITS Interactive COB Tab, Field Completion Guide](#) is a supplemental guide that will help you complete the MN-ITS interactive Coordination of Benefits tab.

<b>Field Name*</b> <i>(X12 Loop &amp; Element)</i>	<b>Valid Values</b>	<b>Character Length</b>	<b>Field Description</b>
<b>Other Payer Name</b> <i>(Loop: 2330B, NM103)</i>		60 (alphanumeric)	Full name of the insurance carrier
<b>Other Payer Primary ID</b> <i>(Loop: 2330B, NM109)</i>		80 (alphanumeric)	Identifier of the insurance carrier or the Medicare contractor NPI
<b>Claim Filing Indicator</b> <i>(Loop: 2320, SBR09)</i>	Refer to the MN-ITS screen for values available		Code identifying type of insurance
<b>Payer Responsibility</b> <i>(Loop: 2320, SBR01)</i>	Refer to the MN-ITS screen for values available		Code identifying the insurance carrier's level of responsibility for payment of a claim
<b>Insured ID</b> <i>(Loop: 2330A, NM109)</i>		80 (alphanumeric)	The policy holder's identification number as assigned by the payer
<b>Relationship Code</b> <i>(Loop: 2320, SBR02)</i>	Refer to the MN-ITS screen for values available		The relationship of the MHCP subscriber (recipient) to the policy holder
<b>Claim Adjustment Group Code</b> <i>(Loop: 2320, CAS01)</i>	Refer to the MN-ITS screen for values available		Code identifying the general category used to describe the type of adjustment  Used for TPL only
<b>Adj Reason Code</b>	Refer to other	5	Code identifying the detailed reason the

<i>(Loop: 2320, CAS02, CAS05, CAS08, CAS11, CAS14, CAS17)</i>	payer EOB or EOMB	(alphanumeric)	claim paid differently than originally billed, by the provider, to the other payer  Used for TPL only
<b>Adj Amount</b> <i>(Loop: 2320, CAS03, CAS06, CAS09, CAS12, CAS15 CAS18)</i>		10 (numeric)	The dollar amount of the adjustment  Used for TPL only
<b>Adj Quantity</b> <i>(Loop: 2320, CAS04, CAS07, CAS10, CAS13, CAS16, CAS19)</i>		15 (numeric)	The units of service being adjusted  Used for TPL only
<b>Payer Paid Amount</b> <i>(Loop: 2320, AMT02)</i>		10 (numeric)	The total dollar amount paid by the other payer
<b>Non-Covered Charge Amount</b> <i>(Loop: 2320, AMT02)</i>		10 (numeric)	The total dollar amount the other payer did not pay
<b>Other Payers Claim Control Number</b> <i>(Loop: 2330B, REF02)</i>	Refer to Medicare EOMB	50 (alphanumeric)	The claim number reported on the Medicare EOMB
<b>Reimbursement Rate</b> <i>(Loop: 2320, MOA01)</i>	Refer to Medicare EOMB	10 (numeric)	Reimbursement rate from the EOMB  Report only if on the Medicare EOMB
<b>End Stage Renal Disease Payment Amount</b> <i>(Loop: 2320, MOA08)</i>	Refer to Medicare EOMB	10 (numeric)	End Stage Renal Disease (ESRD) payment amount from the EOMB  Report only if on the Medicare EOMB
<b>HCPC Payable Amount</b> <i>(Loop: 2320, MOA02)</i>	Refer to Medicare EOMB	10 (numeric)	The claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount from the EOMB  Report only if on the Medicare EOMB
<b>Non-Payable Professional Component Amount</b> <i>(Loop: 2320, MOA09)</i>	Refer to Medicare EOMB	18 (numeric)	Not used by MHCP
<b>Other Payers Claim Control Number</b>	Refer to Medicare EOMB	50 (alphanumeric)	The claim number reported on the Medicare EOMB

<i>(Loop: 2330B, REF02)</i>			
<b>Payment Remark Code</b> <i>(Loop: 2320, MOA03-MOA07)</i>	Refer to Medicare EOMB	50 (alphanumeric)	The remittance advice remark codes reported on the Medicare EOMB  Report only if on the Medicare EOMB
<b>Benefits Assignment</b> <i>(Loop: 2320, O103)</i>	Yes - Benefits assigned to the provider  No - Benefits not assigned to the provider  Not Applicable - Patient refuses to assign benefits		The determination of the policy holder or person authorized to act on their behalf, to give the other payer permission to pay the provider directly  Default is Yes
<b>Release of Information</b> <i>(Loop 2320, O106)</i>	Yes - Signature collected or required  Informed Consent - Signature not collected and not required		The determination of whether the provider has on file a signed statement by the recipient authorizing the release of medical data to other organizations  Default is Yes