<table>
<thead>
<tr>
<th>#</th>
<th>Amount Field</th>
<th>Form Type</th>
<th>837 Location</th>
<th>Rules/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COB Allowed AMT</td>
<td>I/P/D</td>
<td>2320/AMT01 = ‘B6’</td>
<td>4010 Institutional &amp; Professional &amp; Dental</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2320/AMT02 = $</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>COB Approved AMT</td>
<td>P/D</td>
<td>2320/AMT01 = ‘AAE’</td>
<td>4010 Professional &amp; Dental</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2320/AMT02 = $</td>
<td></td>
</tr>
</tbody>
</table>
| 3 |                      |           |                       | Background: With v5010, the 2320 COB Approved and 2320 COB Allowed Amount segments were removed from the 837 Transactions. 5010 Includes guidance to calculate the Approved amount. The process with which to select the appropriate values for AHCCCS to calculate the Health plan Approved amount has been challenging. It was identified that the calculation would only work for some plans and not others. As a result, AHCCCS will require that Health plans submit the amounts. Definitions:  

**Allowed Amount**
What would have paid under FFS before other payer

**Final Net Allowed Amount (Approved Amount)**
Final value of the encounter if paid as FFS after all other payments have been considered

Allowed Amount and Net Allowed Amount does not apply for Denied Encounters

Non-BHS Plans will continue to determine the applicable CN101 code to use as was done under v4010

9/19/12 update: Please note that it is not necessary to report the difference between the Line charge (SV102) and the HP Allowed amount (CN102) in a CAS segment. The CN1 segment is used for reporting purposes and is not used for Claim or line balancing. The Line charge, Payer paid amount and applicable adjustments are factors for balancing. (#13366)

9/25/12 update: For a “fee schedule reimbursement arrangement”, plans may use the CN101 Contract type code of ‘03’ (Variable per diem). This does not
<table>
<thead>
<tr>
<th>#</th>
<th>Amount Field</th>
<th>Form Type</th>
<th>837 Location</th>
<th>Rules/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a</td>
<td>HP Paid Amount</td>
<td>Inst</td>
<td>2320/AMT01 = 'D' 2320/AMT02 = $</td>
<td>Institutional</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>FFS Claim:</strong> HP Paid Amount = Final Net Allowed Amount  <strong>CAP Claim:</strong> HP Paid Amount = $0</td>
</tr>
<tr>
<td>4b</td>
<td>HP Paid Amount</td>
<td>Prof Dental</td>
<td>2320/AMT01 = 'D' 2320/AMT02 = $</td>
<td>Institutional &amp; Professional &amp; Dental</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2430/SVD01 = Payer ID 2430/SVD02 = $</td>
<td><strong>FFS Claim:</strong> HP Paid Amount = Final Net Allowed Amount  <strong>CAP Claim:</strong> HP Paid Amount = $0</td>
</tr>
<tr>
<td>5a</td>
<td>Billed Charges</td>
<td>Inst</td>
<td>2300/CLM01 = Patient Acct # 2300/CLM02 = $</td>
<td>Institutional</td>
</tr>
<tr>
<td>5b</td>
<td>Billed Charges</td>
<td>Prof</td>
<td>2400/SV1 (service info) 2400/SV102 = $</td>
<td>Professional</td>
</tr>
<tr>
<td>5c</td>
<td>Billed Charges</td>
<td>Dental</td>
<td>2400/SV3 (service info) 2400/SV302 = $</td>
<td>Dental</td>
</tr>
<tr>
<td>6a</td>
<td>Allowed</td>
<td>Inst</td>
<td>2300/CN102 = $</td>
<td>Institutional</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Claim Level - report for each encounter  - Line Level segment does not exist for 837I (2400/CN1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Example: CLM<em>01234567</em>31676.50***11</td>
</tr>
<tr>
<td>6b</td>
<td>Allowed</td>
<td>Prof Dental</td>
<td>2400/CN102 = $</td>
<td>Professional &amp; Dental</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Report for each service line in the encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Example: LX<em>1 SV1</em>HC</td>
</tr>
<tr>
<td>#</td>
<td>Amount Field</td>
<td>Form Type</td>
<td>837 Location</td>
<td>Rules/Notes</td>
</tr>
<tr>
<td>---</td>
<td>--------------</td>
<td>-----------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CN1###&lt;ALLOWED AMOUNT$&gt;</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>**SVD<em>PLANID0812</em>0*HC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><em><em>CAS<em>CO</em>24</em>&lt;FINAL NET ALLOWED$&gt;</em>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>DTP<em>573</em>D8*20110727</strong></td>
</tr>
</tbody>
</table>
| 7a | **Final Net Allowed (Approved)** | **Inst (Cap)** | 2320/CAS01 = ‘CO’ 2320/CAS02/05/08/11/14/17 (Trio) = ‘24’ 2300/CAS03/06/09/12/15/18 (Trio) = $ | **Institutional - Claim Level – ** | **Capitated**  
**Capitated = Amount Paid $0, use CAS*CO*24 segment**  
CAS01 = Group code - ‘CO’ = contractual obligation  
CAS02 (trio) – CARC – ‘24’ = Capitated Agreement  
Example:  
CLM*50210121739*6422.95***11|A|1**A*Y*Y  
DTP*096**TM*1600  
DTP*434*RD8*20120210-20120214  
DTP*435*DT*201202100100  
CL1*1*1*01  
CN1*###<Allowed Amount$>  
REF*EA*AC062796M0  
HI*BK|29622  
HI*B|2989  
HI*BJ|2989  
HI*BH|42|D8|20120214  
NM1*71*1*PROVIDERLAST*PROVIDERFIRST***XX*1437194109  
SBR*P*18*******MC  
CAS*CO*24*<Final Net Allowed$>  
**AMT*D*0 (Plan paid $0)** |
|---|---|---|---|---|
| 7b | **Final Net Allowed (Approved)** | **Inst (FFS)** | **Institutional - FFS**  
FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported  
Example:  
CLM*50214120841*11190.26***11|A|1**A*Y*Y  
DTP*096**TM*1200  
DTP*434*RD8*20120214-20120221  
DTP*435*DT*201202142000  
CL1*1*1*01  
CN1*###<Allowed Amount$>  
REF*EA*1101071528  
HI*BK|29690  
HI*B|2989  
HI*BJ|2989  
HI*BH|42|D8|20120221  
NM1*71*1*PROVIDERLAST*PROVIDERFIRST***XX*1538201779  
SBR*P*18*******MC  
CAS*CO*45*5412.6 <CO*24 Final Net Allowed not used for FFS  
**AMT*D*5777.66 (Plan paid )** |
| 7c | Final Net Allowed (Approved) | Prof Dental (CAP) | 2430/CAS01 = ‘CO’  
2430/CAS02/05/08/11/14/17 (Trio) = ‘24’  
2430/CAS03/06/09/12/15/18 (Trio) = $ | Professional & Dental - Line Level - Capitated  
**Capitated = Amount Paid $0, use CAS*CO*24 segment**  
CAS01 = Group code - ‘CO’ = contractual obligation  
CAS02(trio) – CARC – ‘24’ = Capitated Agreement  
Example:  
LX*1  
SV1*HC|T1016|HN*26.25*UN*1****1***Y  
DTP*472*RD8*20110708-20110708  
CNI*###<Allowed Amount$>  
SVD*PLANID0812*0*HC|T1016|HN**1 (Plan paid $0)  
CAS*CO*24*<Final Net Allowed$>  
DTP*573*D8*20110727 |
|---|---|---|---|
| 7d | Final Net Allowed (Approved) | Prof Dental (FFS) | Professional & Dental - FFS  
**FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported**  
LX*1  
SV1*HC|T1016|HN*26.25*UN*1****1***Y  
DTP*472*RD8*20110708-20110708  
CNI*###<Allowed Amount$>  
SVD*PLANID0812*21*HC|T1016|HN**1 (Plan Paid $21)  
CAS*CO*45*5.25 (CO*24 Final Net Allowed not used for FFS)  
DTP*573*D8*20110727 |
|   | Denied Encounter example | Type   | Allowed and Net Allowed amount does not apply | Professional & Dental - Line Level

CAS01 = Group code - ‘CO’ = contractual obligation
CAS02(trio) – CARC – ‘24’ = Capitated Agreement, not used
Use applicable Claim adjustment reason code for denial

Example:

- LX*1
- SV1*HC|T1016|HN*26.25*UN*1**1**Y
- DTP*472*R2D8*20110708-20110708
- SVD*PLANID0812*0*HC|T1016|HN**1 (Plan paid $0 (denied))

CAS*CO*45*26.25 (Use of CO*24 does not apply)
DTP*573*D8*20110727 |
| 8b | Denied Encounter example | Inst   | Allowed and Net Allowed amount does not apply | Institutional - Claim Level

CAS01 = Group code - ‘CO’ = contractual obligation
CAS02(trio) – CARC – ‘24’ = Capitated Agreement, not used
Use applicable Claim adjustment reason code for denial

Example:

- CLM*50210121739*6422.95***11|A|1**A*Y*Y
- DTP*096*TM*1600
- DTP*434*R2D8*20120210-20120214
- DTP*435*DT*201202100100
- CL1*1**1*01
- REF*EA*AC062796M0
- HI*BK|29622
- HI*BJ|2989
- HI*BH|42|D8|20120214
- NM1*71*PROVIDERLAST*PROVIDERFIRST****XX*1437194109
- SBR*P*18*******MC

CAS*CO*45*6422.95 (Use of CO*24 does not apply)
AMT*D*0 (Plan paid $0 (denied)) |
| 9  |   |   |   | Claim Adjustment Group Codes and common CARC usage:

- ‘PR’ Patient Responsibility – Includes ‘3’ Co-pay
- ‘OA’ Other Adjustment – Includes ‘23’ Other Payer paid amounts
- ‘CO’ Contractual Obligations – Includes ‘45’ Charge exceeds fee schedule, ‘24’ Charges covered under a Capitation agreement |
| 837P CAP | In the scenario where Medicare (or other payer) paid more than the HP Allowed amount, it would be appropriate for the plan to only report the difference between the Line charge and other payer payments with a group code ‘CO’ (Contractual Obligations) and an adjustment code of ‘45’ (Charge exceeds) in order to balance the line since there are no further payments to be made. See example below. Although this is a capitated encounter, the HP paid amount is $0 and therefore, the CO*24 (Capitated agreement) to report the Final Net Allowed Amount would not apply. This scenario would be treated the same as a FFS and Denied encounter per the matrix. We will include this scenario in the next version of the HP Approved Amount matrix. AHCCCS also expects that plans report this type of scenario in a paid encounter file and not in a denied file. | Example:  
CLM{111181162}[126.5]MEDICARE PART B[1]{Y}{Y}{Y}{P}<Claim charge $126.50  
SBR{P}[1][MEDICARE PART B][MB]  
AMT[D][100.98]<Medicare Paid $100.98  
SBR{S}[1][AZ HEALTH PLAN][MC]  
AMT[D][0]<HP Paid $0  
LX[1]  
SV{HC|99214}[126.5]<Line charge $126.50  
DTP{472}{RD}[20120301-20120301]  
CN[05][83.57]<CN102=HP Allowed amount  
REF[6R][54567420]  
**Medicare Line adjudication loop:**  
SVD{MEDICARE PART B}[100.98][HC|99214]  
CAS{CO}[45]<45-Charge exceeds (126.50 charge - 100.98 paid = 25.52)  
DTP{573}{D}[20110506]  
**Health Plan Line adjudication loop:**  
SVD[AZ HEALTH PLAN][HC|99214]  
CAS{CO}[45]<45-Charge exceeds (126.50-100.98=25.52)  
CAS{OA}[22]<22-Covered by another payer  
DTP{573}{D}[20110506]  
(Note: The CO*24 to report the HP Final Net Allowed Amount does not apply due to $0 payment. Additional lines followed but not shown.) |