Wellmark Blue Cross and Blue Shield

HIPAA Transaction Standard Companion Guide
Section 2, 837 Institutional

Refers to the X12N Technical Report Type 3 ANSI Version 5010A2

Version Number: 1.0

This *Companion Guide* is a work in progress. Wellmark reserves the right to make changes to this *Companion Guide* at any time without notice. Changes appear in blue text and may be accompanied by a yellow note in the margin.

November 01, 2011

1 Introduction

Wellmark places high priority on making it easy for you to do business with us. Electronic claims submission is one way we can do this. Electronic claims facilitate the transfer of information from your organization to ours in a standard data format. This Section 2-837I of the *Wellmark Companion Guide* provides information about the American National Standards Institute (ANSI) 837 Institutional Health Care Claims transaction, Version 5010A2. This transaction is the accepted standard of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Section 1 of the Wellmark Companion Guide provides further information about the process of sending electronic transactions to Wellmark.

The *Wellmark Companion Guide* is to be used alongside the *HIPAA 837I Technical Report Type 3 (TR3)*, which provides comprehensive information needed to create an ANSI 837I transaction. The *Wellmark Companion Guide* does not change the specifications of the *HIPAA TR3;* rather, it is intended to clarify the areas where the technical report document provides options or choices to be made. The *HIPAA-TR3* can be downloaded from the following Internet address: http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

The purpose of HIPAA-AS is to standardize transactions as much as possible. However, transactions may have some data elements that are treated differently by different payers. There may be some instances where the submitter is required to transmit data to us that we do not require to conduct business. In these instances, we may store the data sent to us, but we may not use the data for our business purposes.

Billing the Appropriate 837 Version

There are four versions of the 837 transaction:

- **837I (Institutional)**
- **837P (Professional)**
- **837D (Dental)**
- **837COB (Coordination of Benefits claims in all three of the above versions are now accepted by Wellmark. See the Wellmark 837 Coordination of Benefits Companion guide for additional information.)**

Please review the chart below to verify that the 837I is the form you should use when filing clams to Wellmark based on your provider type. In general, facilities bill use 837I, practitioners utilize the 837P and dentists use the 837D.

837 Institutional Transaction Version	Iowa	South Dakota
Ambulatory Surgery Center	X	X
Dialysis Center	X	X
Freestanding Substance Abuse Facility	X	X
Home Health Agency	X	X
Hospice	X	X
Hospital	X	X
Psychiatric Medical Institute for Children	X	
Skilled Nursing Facility	X	X

See the 837P or 837D if your provider type is not listed above.

LEGEND for Wellmark Matrix for the 837I

***SHADED* rows represent "segments"; *NON-SHADED* rows represent "data elements."**

"Loop – specific" comments are found in the first segment of the loop.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
71	1000A	NM1	Submitter Name			
72		NM109	Identification Code		9	Use leading zero's to make a 9-digit code
76	1000B	NM1	Receiver Name			
77		NM109	Identification Code		5-7	Wellmark Receiver ID – 88848
84	2010AA	NM1	Billing Provider Name			
86		NM108	Identification Code Qualifier	XX		
86		NM109	Identification Code		10	National Provider Identifier (NPI) as assigned by NPPES. *Your NPI must be reported to Wellmark prior to submission of claims. Claims will not be processed for reimbursement until the NPI has been communicated to Wellmark and loaded to Wellmark's Provider System.*
87	2010AA	N3	Billing Provider Address			
87		N301	Address Information		9	Provider must submit a street address, do not submit PO Box in Address 1. *Wellmark utilizes the provider's billing/accounting address from Wellmark's provider files to remit claims payment.* *When the provider does not have a contract with Wellmark and the claim is a Medicare Crossover claim, Wellmark will use the billing provider address on the incoming claim record to remit payment.*
88	2010AA	N4	Billing Provider City, State, Zip Code			
89		N403	Postal Code		9	Providers must submit the 9-digit zip code *When the last 4-digits are unknown, Wellmark will accept 9998 as gap fill.*

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
90	2010AA	REF	Billing Provider Tax Identification			
90		REF01	Reference Identification Qualifier	EI		EI - Employer's Identification Number (TIN)
90		REF02	Reference Identification		9	Provider submit 9-digit TIN *Wellmark uses the billing provider TIN along with the claim service dates and the reported NPI to positively identify the billing provider.*
96	2010AB	N3	Pay To Address-Address			
96		N301	Address Information			*Wellmark utilizes the provider's billing/accounting address from Wellmark's provider files to remit claims payment.* *When the provider does not have a contract with Wellmark and the claim is a Medicare Crossover claim, Wellmark will use the billing provider address on the incoming claim record to remit payment.*
109	2000B	SBR	Subscriber Information			
111		SBR09	Claim Filing Indicator Code	BL	2	BL - Blue Cross/Blue Shield
118	2010BA	DMG	Subscriber Demographic Information			
119		DMG03	Gender Code	M F	1	Submit when the subscriber is also the patient. *Wellmark does not recognize "U" for "unknown."*
122	2010BC	NM1	Payer Name			
123		NM108	Identification Code Qualifier	PI		
123		NM109	Identification Code		5	Wellmark Receiver ID – 88848
140	2010CA	DMG	Patient Demographic Information			
141		DMG03	Gender Code	M F	1	Submit when the patient is different than the subscriber. *Wellmark does not recognize "U" for "unknown."*
143	2300	CLM	Claim Information			
145		CLM02	Monetary Amount			*Wellmark requires the total charge to be greater than zero.*
150	2300	DTP	DTP-Statement Dates			
150		DTP03	Date Time Period		8	From and Through dates (CCYYMMDD-CCYYMMDD) must equal total of accommodation units on inpatient claims.

151	2300	DTP	Admission Date / Hour			
151		DTP03	Date Time Period		8	*Date of Admission required on all inpatient claims.*
184	2300	HI	Principal Diagnosis			
184		HI01-1	Code List Qualifier Code		2	BK – ICD9
185		HI01-9	Yes/No Condition or Response (Present on Admission Indicator)		1	*Required on all Inpatient claims. Blank is not a valid value.*

Page #	Loop ID	Reference	Name	Codes	Length	*Notes/Comments*
187	2300	HI	Admitting Diagnosis			
188		HI01-1	Code List Qualifier Code		2	BJ – ICD9
189	2300	HI	Patient's Reason For Visit			
190		HI01-1	Code List Qualifier Code		2	PR – ICD9 *Required on all outpatient claims.*
193	2300	HI	External Cause of Injury			
190		HI01-1	Code List Qualifier Code		2	BN – ICD9
195		HI01-9	Yes/No Condition or Response (Present on Admission Indicator)		1	Required on all Inpatient claims. Blank is not a valid value.
220-238	2300	HI	Other Diagnosis Information			
221		HI01-1	Code List Qualifier Code		2	BF – ICD9
221		HI01-9	Yes/No Condition or Response (Present on Admission Indicator)		1	*Required on all Inpatient claims. Blank is not a valid value.*
239	2300	HI	Principal Procedure Information			
240		HI01-1	Code List Qualifier Code	BR		ICD-9-CM codes are required on inpatient surgical claims. *For outpatient claims, see 'Institutional Service Line' SV202*
240		HI01-2	Industry Code		5	Principal Procedure Code: Values > 5 will be truncated.
242-257	2300	HI	Other Procedure Information			
243		HI01-1	Code List Qualifier Code	BQ		ICD-9-CM codes are required on inpatient surgical claims. When multiple procedures are performed, use qualifier 'BQ' to report each additional ICD-9-CM code. For outpatient claims, see 'Institutional Service Line'SV202
243		HI01-2	Industry Code		5	Principal Procedure Code: Values > 5-digits will be truncated.
294	2300	HI	Condition Information			
294-303		HI01-HI12	Health Care Code Information			See Wellmark Values at the end of this Matrix.
424	2400	SV2	Institutional Service Line			

424		SV201	Product / Service ID			The revenue code is required.
425		SV202	Composite Medical Procedure Identifier			See Wellmark Values for revenue codes that require CPT/HCPCS in SV202.
425		SV202-1	Product / Service ID Qualifier	HC or HP		Wellmark accepts only HCPCS and HIPPS codes in this field.
428		SV204	Unit or Basis for Measurement Code			Wellmark accepts whole integers only. Units are required for each service billed.
433	2400	DTP	Service Line Date			
434		DTP03	Date Time Period		8	Required on outpatient claims when the statement covers date is a date span such as when series billing therapy or rehab services. Do not bill outpatient surgeries with non consecutive encounter dates on the same claim. Dates submitted must fall within the statement covers period.

2 Wellmark Values

Revenue Codes

Bill CPT/HCPCS with one of the following revenue codes on all hospital outpatient claims:

030X
031X
032X
033X
034X
035X
036X
040X
049X
061X
075X
0943