IV. Detailed Description of Data Elements

1. Age in Years

Age in years for each patient is calculated as the number of days from the Date of Birth (UB-04 FL 10 or CMS-1500 FL 3) to:

- The Admission Date (UB-04 FL12) for Inpatient and Emergency Department data,
- The Date of Principal Procedure (UB-04 FL 74 or CMS-1500 FL 24A-1) for Outpatient Surgery Center data, or
- The “from” date in the statement covers period (UB-04 FL 6A) for Observation Visit and Other Hospital Outpatient data

The number of days is then divided by 365.25 and truncated to a whole number.

To maintain patient confidentiality, ages greater than 96 years were recoded to 96. Also, effective Q1 2018, the patient age may be modified by up to plus or minus 3 years. This change was made because adding census block group to the dataset makes it less difficult to identify the patient, if the exact patient age was always provided. The algorithm for age modification was designed such that aggregated data analysis which employs age will not be adversely affected.

2. Infant Age Groups – (Inpatient and Outpatient Surgery data only)

Infants' ages were coded into one of three groups based on days old at admission or date of procedure. Age in days was calculated as the number of days from the Date of Birth (UB-04 FL 10 or CMS-1500 FL 3) to:

- The Admission Date (UB-04 FL 12) for Inpatient data, or
- The Date of Principal Procedure (UB-04 FL 74 or CMS-1500 FL 24A) for Outpatient Surgery data and Observation with OPS data.
- The “from” date in the statement covers period (UB-04 FL 6A) for Observation Visit data

Infant Age Group codes and descriptions can be found in the relational data product data support table **tlkNewborn**.

3. ZIP Code

Indicates the USPS ZIP code of the patient's residence, derived from the Patient's ZIP code (UB-04 FL1 or CMS-1500 FL 5).

Values are suppressed to protect patient confidentiality as follows:

A blank is entered if:

- The ZIP code has a residential population less than 1,000 per record type, or
- The ZIP code appears on fewer than 30 discharges for Inpatient, Emergency Department, or Outpatient Surgery data. The Observation Visits and Other Hospital Outpatient data records will be combined prior to applying the fewer than 30 records in the current quarter.

Residences outside the United States are assigned the ZIP code '00000'. Missing (as when no permanent residence is available or the patient is homeless) ZIP codes are empty (NULL).

4. County/State Code

County or state of residence of patients derived from their USPS ZIP code.

- For Wisconsin residents, this is their county of residence. It is derived from their USPS ZIP code. Where a ZIP code straddles county boundaries, the patients from that ZIP code are assigned to the county containing the majority of the ZIP code's residents.

- For non-Wisconsin residents, ZIP code is used to identify and code residents of bordering states: Illinois, Iowa, Michigan, and Minnesota. Patients with other ZIP codes, including the non-U.S. resident ZIP code of '00000', were assigned county code '99'. Patients with missing ZIP codes were assigned county code '98'.

County and State codes and descriptions can be found in the relational data product data support table **tlkCounty**. Please refer to the Code Summary section.

5. Gender

Indicates the patient's gender (UB-04 FL 11 or CMS-1500 FL 3).

Code	Gender
1	Male
2	Female
3	Unknown

6. Length of Stay – (Inpatient data only)

Indicates number of days of inpatient stay. This is calculated by determining the number of days between the Admission Date (UB-04 FL 12) and the Discharge Date (UB-04 FL 6) and subtracting the number of Leave Days (UB-04 FLs 42 and 46); total units of service for all 18X revenue codes). When no value was reported for Leave Days, it was assumed to be zero. **Length of Stay is zero when Discharge and Admission Dates are the same**. Lengths of stay that are longer than 999 days were set to 999 days.

7. Year/Quarter

Indicates year and quarter (e.g., "131" for first quarter of 2013) of discharge, surgery, or "from" date in the statement covers period (UB Form locator 6) specified by data type. For Inpatient and, Emergency Department data, Discharge Year/Quarter is provided. For Outpatient Surgery Center data, Procedure Year/Quarter is provided. For Observation Visit and Other Hospital Outpatient data, "from" date in statement period covers date is provided.

8. Admission Type – (Inpatient and Outpatient Surgery data only)

This code indicates the priority code of the admission (UB-04 FL 14). Admission Type codes and descriptions can be found in the relational data product data support table **tlkAdmitType**. Please refer to the Code Summary section.

9. Admission Source / Point of Origin – (Inpatient and Emergency data only)

This code indicates the source of the admission (UB-04 FL 15). The meaning of this code is dependent on the Type of Admission that was coded. Emergency, Urgent, Elective or Trauma center (Non-Newborn) admission types have one set of Admission Source codes; the Newborn admission type has another set. Admission Source codes and descriptions can be found in the relational data product data support table **tlkAdmitSource**. Please refer to the Code Summary

section. Newborn Admission Source codes and descriptions can be found in the relational data product data support table **tlkAdmitSourceNewborn**.

10. Discharge Status – (Inpatient and Emergency data only)

This code indicates the patient's arrangement or event ending a patient's stay in the hospital or emergency room (UB-04 FL 17). Discharge Status codes and descriptions can be found in the relational data product data support table **tlkDischargeStatus**. Please refer to the Code Summary section.

11. Total Charges

All data are provided in explicit decimal format, i.e., xxxxxx.xx. INP, ED, OBS and OPS center data was derived from UB-04 Field 47 or CMS-1500 FL 28.

For Inpatient data, this field indicates total facility charges for the entire length of stay. All of the charges should be either:

1) reported from admission through discharge; or
2) reported as accumulated across all of the interim bills for a stay

For Emergency Department data (not ED-INP, ED-OPS, or ED-OBS), this field indicates total facility charges for the emergency department visit only. Charges should be reported from admission through discharge from the emergency department. Charges in the ED-INP, ED-OPS, or ED-OBS may represent ED and inpatient, ED and outpatient surgery, or ED and Observation Visit data charges combined.

For Outpatient Surgery Center data (not OPS-INP or OBS-OPS), this indicates total facility charges for the outpatient surgery procedure. Charges in the OPS-INP or OBS-OPS files may represent outpatient surgery and inpatient or observation care charges combined.

12. Leave Days – (Inpatient data only)

The total number of days a room was held for a patient while the patient was away from the facility. Leave days consist of the total units of service for all 018X revenue codes. These are the leave days for the entire length of stay. The 018X units of service are from the 018X units of service from an "Admit Through Discharge Claim". When no leave days were reported, the field is blank.

13. First Payer Identifier Group

Identifies expected primary payer. Developed from UB-04 FL 50(a) or CMS-1500 FL 1 – primary payer identifier and category. First Payer Identifier Group codes and descriptions can be found in the relational data product data support table **tlkPayIdentifier**. Please refer to Section VII - the Payer Information section.

Code	Description
1	Medicare
2	Medical Assistance/BadgerCare
3	Other Government (51.42/51.437/46.23 Board, CHAMPUS/CHAMPVA/TRICARE, General Relief, WisconCare, other government)
4	Private Insurance (includes self-funded plans and workers' compensation)
5	Self Pay
6	Other or Unknown

When submitting data, facilities have a choice of assigning an 'Other' code and an 'Unknown' code to both Primary and Secondary payer information. WHA Information Center has assigned both identified 'Other' and 'Unknown' payers to Payer Identifier Group 6.

14. First Payer Category Group

Distinguishes between fee-for-service payers and alternative insurance plans such as HMOs. The payer category group is based on expected primary payer for the stay. Developed from, UB-04 FL 50(a) or CMS-1500 FL 1 – primary payer identifier and category. First Payer Category Group codes and descriptions can be found in the relational data product data support table. **tlkPayCategory.** Please refer to Section VII - the Payer Information section.

Code	Description
1	Fee-for-service, non-HMO Medicare or non-HMO Medicaid
2	Alternative Health Care Insurance Plans (includes HMO, PPO)
3	CHAMPUS/CHAMPVA/TRICARE
4	Unable to determine (payer identifier known but category not known)

15. First Payer Combined Code

Identifies expected primary payer coupled with the payer category group. Developed from UB-04 FL 50(a) or CMS-1500 FL 1 – primary payer identifier and category. First Payer Combined Codes and descriptions can be found in the relational data product data support table **tlkPayCombinedCode**. Please refer to the Code Summary section.

16. Second Payer Identifier Group

Identifies expected secondary payer. Developed from UB-04 FL 50(b) or CMS-1500 FL 1 – secondary payer identifier and category.

For codes and descriptions see (13) First Payer Identifier Group. WHA Information Center does not assign a payer identifier or category group when a secondary payer is not reported. Second Payer Identifier Group codes and descriptions can be found in the relational data product data support table **tlkPayIdentifier**.

When submitting data, facilities have a choice of assigning an 'Other' code and an 'Unknown' code to both Primary and Secondary payer information. WHA Information Center has assigned both identified 'Other' and 'Unknown' payers to Payer Identifier Group 6.

17. Second Payer Category Group

Distinguishes between fee-for-service payers and alternative insurance plans such as HMOs. The payer category group is based on expected secondary payer. Developed from UB-04 FL 50 (b) or CMS-1500 FL 1 – secondary payer identifier and category.

For codes and description(s) see (14) First Payer Category Group. Second Payer Category Group codes and descriptions can be found in the relational data product data support table **tlkPayCategory**. WHA Information Center does not assign a category group when a secondary payer is not reported.

18. Second Payer Combined Code

Identifies expected secondary payer coupled with the payer category group. Developed from UB-04 FL 50(b) or CMS-1500 FL 1 – secondary payer identifier and category. Second Payer Combined Code codes and descriptions can be found in the relational data product data support

table **tlkPayCombinedCode**. Please refer to the Code Summary section.

19. Principal Diagnosis Code

The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care reported from, UB-04 FL 67 or CMS-1500 FL 21(1) - coded according to the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). Edit checks required fully specified codes, and age- and gender- consistent codes. Diagnosis codes specific to spontaneous, legally induced, illegally induced, or failed attempted termination of pregnancy were changed to unspecific termination of pregnancy codes to meet statutory requirements. The principal diagnosis code in the relational data product can be located in the data table **tblDiagnosis**. To identify the code, dx_order = 'P' for principal.

20. Other Diagnosis Codes (First through Ninth for fixed-width layout, all codes submitted for relational layout)

Other diagnoses were to be reported if the diagnoses contributed to substantiation of the length of stay, substantiation of total charges, or accurate classification of the DRG. Unlimited diagnosis codes were reported from each facility. Edit checks required fully specified codes, and age- and gender-consistent codes. Diagnosis codes specific to spontaneous, legally induced, illegally induced, or failed attempted termination of pregnancy were changed to unspecific termination of pregnancy codes to meet statutory requirements. Effective with the Q1 2013 data set release, up to 9 'other' diagnosis codes are provided in the fixed-width data set. All submitted 'other' diagnosis codes are provided in the relational data product data table **tblDiagnosis**. The dx_type field denotes what type of diagnosis code was submitted by the facility, while the dx_order field denotes in which order the diagnoses were submitted by the facility. When multiple types of diagnoses were submitted, the first submitted diagnosis code has a '1' in the dx_order field, the second has a '2' in the dx_order field, and so forth.

DX_Type field values	DX_Type Descriptions
A	Admitting Diagnosis
E	External Cause of Injury Diagnosis – *No longer valid with Q113 data*
R	Reason for Visit Diagnosis
P	Principal Diagnosis
S	Additional (Other) Diagnosis

21. 'E' Code

'E' code is a requirement if an injury diagnosis code in the range 800-995.89 (except codes 995.1, 995.2, 995.3, 995.60-995.69, and 995.7) is reported beginning with April 1, 1994, discharges reported from, UB-04 FL 72 or CMS-1500 FL 21. An 'E' Code is accepted when used appropriately with codes outside the injury range. Up to twelve E-Codes are now allowed on the Primary record, and can be found in their entirety in the relational data product data table **tblDiagnosis**. To identify the code, dx_type = 'E' for 'E' Code, dx_order = '1'. Additional 'E' Codes submitted by a facility may also be found in the relational data product data table **tblDiagnosis**, with the dx_order attached according to the facility's submission order of the additional 'E' Code.

*** Effective with Q1 2013 data sets, there is no longer a data field specific for E codes. The external cause of injury codes are now included with the additional diagnosis codes.*

22. Present on Admission (POA) Indicator – (Available in Relational Format only)

***** Effective with Q3 2013 Data Sets.***

The POA indicator is the eighth digit of UB-04 FL 67 – Principal Diagnosis, each of the secondary diagnosis fields FLs 67a-q, and FL – 72 External Cause of Injury on the UB-04 paper claim and the 837I electronic claim.

The POA Indicator applies to the diagnosis codes for records involving inpatient admission to general acute-care hospitals. The POA indicator is based not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place.

Present on admission is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission.

The POA Indicator is applied to the principal diagnosis as well as all secondary diagnoses (including external cause codes) that are reported.

The five reporting options for all diagnosis reporting are as follows:

Code	Definition
Y	Yes, diagnosis was present at time of inpatient admission
N	No, diagnosis was not present at time of inpatient admission
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
Blank	Exempt from POA reporting

The American Health Information Management Association, American Hospital Association, CMS and the National Center for Health Statistics (known as the “Cooperating Parties”) published a list of ICD-10-CM codes for which the POA indicator does not apply. The indicator can be left unreported only for the codes on this list. This list is included in the POA guidelines published annually in October in the ICD-10-CM Official Guidelines for Coding and Reporting and will be updated online as needed.

23. Admitting Diagnosis – (Inpatient data only)

The ICD-10-CM Diagnosis Code provided at the time of admission as stated by the physician. Edit checks required fully specified codes, and age- and gender-consistent codes. Diagnosis codes specific to spontaneous, legally induced, illegally induced, or failed attempted termination of pregnancy were changed to unspecific termination of pregnancy codes to meet statutory requirements. The admitting diagnosis code in the relational data product can be located in the data table **tblDiagnosis**. To identify the code, dx_type = ‘A’ for admitting.

24. Reason for Visit Diagnoses – (Emergency and Observation data only)

The ICD-10-CM Diagnosis Code provided as the reason for visit (up to three diagnoses) as stated by the physician. Edit checks required fully specified codes, and age- and gender-

consistent codes. Diagnosis codes specific to spontaneous, legally induced, illegally induced, or failed attempted termination of pregnancy were changed to unspecific termination of pregnancy codes to meet statutory requirements. The first submitted reason for visit diagnosis code in the fixed width data product can be found in the **Admitting Diagnosis/Reason for Visit** field. The reason for visit codes in the relational data product can be located in the data table **tblDiagnosis**. To identify the code, dx_type = 'R' for reason for visit, and dx_order identifies the order in which the diagnosis data were submitted.

25. Principal Procedure Code – ICD-10-CM

Identifies the ICD-10-CM code for the patient's Principal Procedure, if any (UB-04 FL 74 for inpatient records). The Principal Procedure is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or which was necessary to take care of a complication. The Principal Procedure is usually that procedure most related to the Principal Diagnosis. Procedure codes that explicitly referenced induced termination of pregnancy were modified to eliminate distinctions between induced and spontaneous termination, as required by statute. WHAIC does not convert codes in this range since they are not codes that are specific to induced termination of pregnancy. The principal procedure code in the relational data product can be located in the data table **tblProcedure**, in the pr_icd field. To identify the code, pr_order = 'P' for principal.

The ICD Procedure Conversion Files produced by Truven Health Analytics are no longer available to WHAIC in the transition to ICD-10.

26. Other Procedure Codes – ICD-10-CM (First through Fifth for fixed-width layout, all codes submitted for relational layout)

Identifies the ICD-10-CM codes for unlimited additional other procedures. These are additional procedures performed during the principal operative episode or during the length of stay that may include diagnostic or exploratory procedures. Procedures that impact accurate DRG categorization were required (UB-04 FL 74 for inpatient records). Procedure codes that explicitly referenced induced termination of pregnancy were modified to eliminate distinctions between induced and spontaneous termination, as required by statute. WHAIC does not convert codes in this range since they are not codes that are specific to induced termination of pregnancy. Up to 5 'other' procedures codes are provided in the fixed-width data set. All submitted 'other' procedure codes are provided in the relational data product data table **tblProcedure**. The pr_order field denotes in which order the procedures were submitted. The first additional or other procedure code has a '1' in the pr_order field, the second has a '2' in the pr_order field, and so forth.

The ICD Procedure Conversion Files produced by Truven Health Analytics are no longer available to WHAIC in the transition to ICD-10.

27. Principal Procedure Code – CPT

Identifies the CPT code for the patient's Principal Procedure, if CPT code was submitted. The principal procedure is the one procedure most related to the principal diagnosis. If there is more than one procedure and both are equally related to the principal diagnosis, the most resource-intensive or complex procedure, or one that is necessary to care for a complication is usually designated as the principal procedure. If the only clinically significant procedure performed is diagnostic or exploratory in nature (i.e. cardiac catheter) it should be reported in the principal procedure field. When more than one procedure is reported, the principal procedure should be identified by the one that relates to the principal diagnosis. WHAIC does not recognize routine

venipuncture (36415) codes or evaluation and management codes as acceptable principal procedure codes.

Procedure codes that explicitly referenced induced termination of pregnancy were modified to eliminate distinctions between induced and spontaneous termination, as required by statute.

The principal procedure code in the relational data product is located in the data table **tblProcedure**, in the pr_cpt field. To identify the code, pr_order = 'P' and pr_type = 'P' for principal.

28. Other Procedure Codes – CPT (First through Fifth for fixed-width layout, all codes submitted for relational layout)

Identifies the CPT codes for additional other procedures, if CPT codes were submitted. These are additional procedures performed during the principal operative episode of care or during the length of stay that may include diagnostic or exploratory procedures. Procedures that impact accurate DRG categorization were required (UB-04 FL 44 or CMS-1500 FL 24D). Procedure codes that explicitly referenced induced termination of pregnancy were modified to eliminate distinctions between induced and spontaneous termination, as required by statute. Up to 5 'other' procedure codes are provided in the fixed-width data set. All submitted 'other' procedure codes are located in the relational data product data table **tblProcedure**. The pr_order field denotes in which order the procedures were submitted. The first additional or other procedure code has a '1' in the pr_order field, the second has a '2' in the pr_order field, and so forth. Pr_type = 'S' for additional.

> ***A note about the codes****: The numbers listed in the tables refer to the Current Procedural Terminology (CPT) procedure code that represents the service or procedure. CPT codes are produced by the American Medical Association. Codes that begin with an alpha character are called HCPCS codes (Health Care Procedural Coding System) produced by the Center for Medicaid and Medicare Services.*

29. Bilateral Principal Procedure – CPT

For CPT code submissions only, identifies bilateral principal procedure based upon submission of modifier '50' on outpatient surgery or emergency department records. If CPT code submitted has bilateral procedure modifier, then field equals '**Y**', otherwise field equals '**N**'. In the relational data product, actual modifier information (up to four modifiers per CPT code) submitted by facilities is included for all procedures submitted. For the principal procedure, this information can be found in relational data product data table **tblProcedure**. In **tblProcedure**, principal procedures are indicated by a 'P' in the pr_order field.

30. Bilateral Other Procedure – CPT (First through Fifth for fixed-width layout, all codes submitted for relational layout)

For CPT code submissions only, identifies bilateral principal procedure based upon submission of modifier '50' on outpatient surgery or emergency department records. If CPT code submitted has bilateral procedure modifier, then field equals '**Y**', otherwise field equals '**N**'. In the relational data product, actual modifier information (up to four modifiers per CPT code) submitted by facilities is included for all procedures submitted. For additional procedures, this information can be found in relational data product data table **tblProcedure**. In **tblProcedure**, the order of the other procedures submitted by a facility is contained within the pr_order field.

31. Pre-Procedure Days – (Inpatient data only)

The number of days between the admission and the date of the principal procedure are calculated by subtracting the Admission Date from the Principal Procedure Date. The WHA Information Center enters a blank in this field when there are no pre-procedure days. When the procedure date is prior to the date of admission a negative value (i.e., –1) is entered in this field. This occurs when a procedure is performed in an outpatient surgery area or emergency department and the patient is subsequently admitted.

32. Major Diagnostic Category (MDC) – (Inpatient data only)

Indicates Major Diagnostic Category, as computed by the DRG grouper program. In the relational data product, this information is contained within data support table **tblDRG**. MDC codes and descriptions can be found in the relational data product data support table **tlkMDC**.

33. Diagnosis Related Group (DRG) – (Inpatient data only)

Indicates Diagnosis Related Group, as computed by the DRG grouper program. As of October 1, 2007 with version 25, the CMS DRG system re-sequenced the groups, so that for instance "Ungroupable" is no longer 470 but is now 999. To differentiate it, the newly re-sequenced DRGs are now known as MS-DRGs. In the relational data product, this information is contained within data table **tblDRG**. MDC codes and descriptions can be found in the relational data product data support table **tlkDRG**. Please refer to the Code Summary section.

***Effective Q4 2012 Data Sets, DRG (version 24) is no longer provided; Only MS-DRGs.*

34. Attending Physician Specialty Code – (Emergency data only)

The Wisconsin Department of Safety and Professional Services assigns a code representing the physician's primary specialty. Specialty codes and descriptions can be found in the relational data product data support table **tlkSpecialty**. Please refer to the Code Summary section. In the physician-enhanced data, the physician's name and license(s) are provided.

*** Effective 2017 Q1; Using AMA / NUCC Provider Taxonomy for specialty codes.*

35. Other (Procedure) Physician Specialty Code – (Emergency data only)

The Wisconsin Department of Safety and Professional Services assigns a code representing the physician's primary specialty. Specialty codes and descriptions can be found in the relational data product data support table **tlkSpecialty**. Please refer to the Code Summary section. In the physician-enhanced data, the physician's name and license(s) are provided.

*** Effective 2017 Q1; Using AMA / NUCC Provider Taxonomy for specialty codes.*

36. Second Other (Procedure) Physician Specialty Code – (Emergency data only)

The code assigned by the Wisconsin Department of Safety and Professional Services representing the second other (procedure) physician's primary specialty. Specialty codes and descriptions can be found in the relational data product data support table **tlkSpecialty**. Please refer to the Code Summary section. In the physician-enhanced data, the physician's name and license(s) are provided.

*** Effective 2017 Q1; Using AMA / NUCC Provider Taxonomy for specialty codes.*

37. Facility Identification Number

This is a three-digit identification number assigned by WHA Information Center to each reporting facility. Facility openings, closings, and mergers, in addition to facility demographic information can be found in the relational data product data support table **tlkFacility.** Please refer to the Code Summary section.

38. Record Number (fixed-width layout only)

A five-digit number that, when used in conjunction with "Facility Identification Number" and "Discharge Year/Quarter" or “Surgery Year/Quarter”, uniquely identifies a record in WHA Information Center’s permanent data base. This allows records to be linked so that data items such as physician license number/NPI can be added at a later date. In the relational data product, this field is not provided. A unique identifier is provided as a Generated Globally Unique ID, or GUID.

39. Type of Bill (TOB) (Relational Only)

A code indicating the specific type of bill for the type of services rendered and where (e.g. hospital inpatient, outpatient, replacement, voids, etc.). The first digit is a leading zero, the second digit is type of facility, the third digit is bill classification and the fourth digit is frequency definition. An example is 0111 – meaning Hospital Inpatient (including Medicare Part A) claim. *Please refer to Section VIII for additional details related to the code look up tables.*

0 - leading zero
1 – Hospital
1 – Inpatient
1 – Admit Through Discharge Claim

40. Record ID (relational layout only)

Unique record identifier for linking individual records across relational database tables provided as a Generated Globally Unique ID, or GUID.

41. Data ID (relational layout only)

Unique data type identifier for identifying records that cross data types. For example, a record of a patient who presents at the emergency department and is admitted as an inpatient would have a record in **tblDatatype** with a data_id of 0 (Inpatient) with ‘Y’ in the ER field in tblDataType. Data Type codes and descriptions can be found in the relational data product data support table **tlkDataType**.

0 - Inpatient
Services for which the patient is admitted to the hospital.

3 - Observation
Any record with revenue codes in categories 0760 and/or 0762.

1 – Outpatient Surgery
Any record not classified as Observation Care **AND** with outpatient surgery revenue codes in categories that include one of the following: 036X, 0481, 049X and 0750.

2 – Emergency Department Visit

Any record not classified as Outpatient Surgery or Observation Care **AND** with revenue codes 0450, 0451, 0452 and 0459.

4 - Therapies:
Any record not classified as Emergency Room, Outpatient Surgery or Observation Care AND with revenue codes in categories 041X-044X, or 093X-095X. This includes Respiratory, Physical, Occupational and Speech Therapies, Medical Rehabilitation (eg. cardiac rehab), Therapeutic Rehabilitation or Athletic Training respectively.

5 - Outpatient Lab/Radiology:
Any record not classified as Emergency Room, Outpatient Surgery, Observation Care, or Therapies AND with revenue codes in categories 030X, 031X, 032X-035X, 040X, 0480, 061X, 073X-074X or 092X. This includes Diagnostic and Routine Laboratory Testing, Diagnostic and Therapeutic Radiology, Nuclear Medicine, CAT Scans, Imaging, MRIs, EKGs and ECGs, EEGs.

This excludes reference diagnostic laboratory services (non-patient laboratory specimens), type of bill 014X.

6 - Other Outpatient:
Includes all records not previously designated and may include but not limited to records with revenue codes in categories 026X, 028X, 038X-039X, 0456, 046X-047X, 048X except 0480, 051X-052X, 058X-060X, 064X-066X, 0761 and 0769, 077X, 082X-085X, or 088X, 090X-092X. This includes Oncology, Blood Products and Storage, Audiology and Pulmonary, Clinics (facility charges), Urgent Care (facility charges), Home Health visits & units, Home Health oxygen & IV, Preventive Care, 0761 – treatment room and 0769 – other specialty services, Hemodialysis, peritoneum and miscellaneous dialysis. Excludes pharmacy only records.

Effective January 1, 2014, CMS will recognize HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPPS for outpatient hospital clinic visits. Effective January 1, 2014, CPT codes 99201-99205 and 99211-99215 will no longer be recognized for payment under the OPPS. WHAIC will accept records coded according to each facility's policies.

7 - Repetitive Services ***(Obsolete Q1 2018)***
Repetitive services Includes records of services that recur for an individual outpatient. These services may be reported monthly, quarterly, or at the end of the individual's treatment. Outpatient surgery and emergency department services may be reported on the repetitive services record (POS 7) or they may be reported separately. If they are reported on the repetitive services record the OPS and ED edits will not apply, however if the principal procedure field is filled, the principal procedure date and the Operating physician NPI 1 field must be filled. The only edits that apply are those, which apply to the other hospital outpatient categories (specialty services, therapies, lab/x-ray and other).

Repetitive services records may be submitted with a place of service 4, 5 or 6 if there is not an outpatient surgical or emergency department revenue code on the record. However, the hierarchy for the place of service must be followed accordingly. For example, repetitive physical therapy services could be submitted with place of service 4 or it could be submitted with a place of service 7, depending on the facility classification, discharge procedures and claims processing.

42. Start Date (relational layout only)

Date identified code was effective.

43. End Date (relational layout only)

Date identified code was no longer effective.

44. OPS (relational layout only)

Record flag that identifies an Outpatient Surgery Revenue Code was submitted on record, if data type identifier does not signify Outpatient Surgery data type.

45. ER (relational layout only)

Record flag that identifies an Emergency Room Revenue Code was submitted on record, if data type identifier does not signify Emergency Room data type.

46. OBS (relational layout only)

Record flag that identifies an Observation Revenue Code was submitted on record, if data type identifier does not signify Observation data type.

47. All Patient Refined Diagnosis Related Group (APR-DRG) (relational layout only)

All Patient Refined Diagnosis Related Group assigned to record utilizing 3M APR-DRG Grouper software. (Available upon request and must have contract with 3M for APR-DRG Grouper software)

48. Severity of Illness (relational layout only)

Severity of Illness indicator assigned to record utilizing 3M APR-DRG Grouper software. (Available upon request and must have contract with 3M for APR-DRG Grouper software)

49. Risk of Mortality (ROM) (relational layout only)

Risk of Mortality indicator assigned to record utilizing 3M APR-DRG Grouper software. (Available upon request and must have contract with 3M for APR-DRG Grouper software)

50. Procedure Modifiers (1 – 4) (relational layout only)

Used with CPT or HCPCS Level II codes when applicable. A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code. Up to four modifiers per CPT/HCPCS code may be reported.

51. Revenue Code (relational layout only)

A code which identifies a specific accommodation, ancillary service or billing calculation. Revenue codes are not required for freestanding ambulatory surgery centers.

52. HCPCS / Rate Code (relational layout only)

For Inpatient records, this data element represents the room and board rates. For Outpatient records, the HCPCS/CPT codes are reported for services provided.

53. Units of Service (relational layout only)

A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, pints of blood, or renal dialysis treatments.

54. Revenue Line Item Charge (relational layout only)

Total charges related to the revenue code or HCPCS/CPT code recorded. Total charges include both covered and non-covered charges.

55. Provider ID (relational layout only)

The National Provider Identifier (NPI) assigned to the facility submitting the bill. When the billing provider is an organization health care provider, the organization's health care provider's NPI or its subpart's NPI is reported. When a health care provider organization has determined that it needs to enumerate its subparts, the subparts are reported.

56. Provider-Based Location ID (relational layout only)

This is an identification number assigned by WHA Information Center to each reporting provider-based location (PBL) of a hospital. PBL openings and closings, in addition to facility demographic information, can be found in the relational data product data support table **tlkProviderBasedLocations.**

57. Race (relational layout only)

This information is based on self-identification and obtained from the patient, relative or responsible party. Race is defined as a population or group of people divided on various sets of physical characteristics from genetic ancestry.

58. Race 2 (relational layout only)

This information is based on self-identification and obtained from the patient, relative or responsible party. Race is defined as a population or group of people divided on various sets of physical characteristics from genetic ancestry. Race 2 is an optional field and is used for multiracial patients.

59. Ethnicity (relational layout only)

This information is based on self-identification and obtained from the patient, relative or responsible party. Ethnicity is a population of human beings whose members identify with each other, on the basis of a real or presumed common genealogy or cultural traits.

60. Census Block Group (relational layout only)

This information is derived by geocoding the patient's residential address. A Census Block Group is a geographical unit used by the U.S. Census Bureau which is between the Census Tract and the Census Block. Census block group is more precise and consistent in population size than a ZIP code. Typically, Block Groups have a population of 600 to 3,000 people. Every Census Block Group has a unique 12-digit FIPS code. The Block Group's unique identifier is the 12th digit of the FIPS Code. Refer to the U.S. Census Bureau, for more information on block groups.

To protect patient privacy, the Block Group value may be either altered to another Block Group within the same Tract, or masked entirely. This determination is made by an algorithm which attempts to determine how unique the patient's demographics are within the Block Group.

Block Group is assigned only for patient addresses in Wisconsin and its border states. It is not assigned for post office box addresses. The Block Group definitions have been updated from 2010 to the 2020 definitions starting with the 2023 Q1 Data Release.

61. Primary Payer ID

Identifies the code of expected commercial primary payer. Enabling users to identify commercial payer names.

62. Primary Payer Type

Distinguishes between fee-for-service payers and alternative insurance plans such as HMOs. The payer category group is based on expected primary payer for the stay.

63. Secondary Payer ID

Identifies the code of expected commercial secondary payer. Enabling users to identify commercial payer names.

64. Secondary Payer Type

Distinguishes between fee-for-service payers and alternative insurance plans such as HMOs. The payer category group is based on expected secondary payer for the stay.