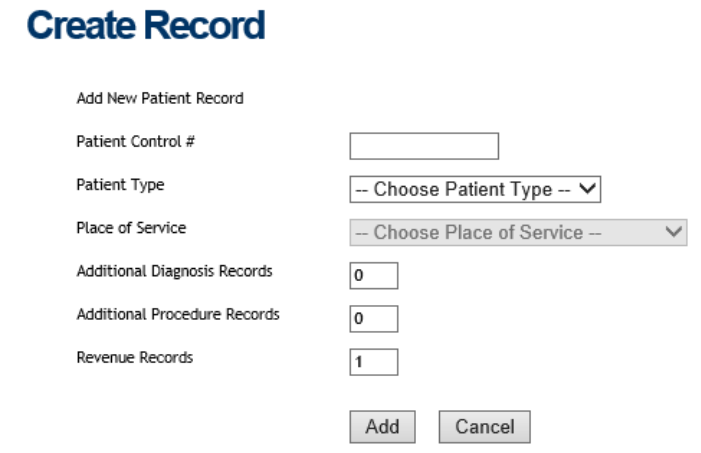
7.11 Manual Data Entry Instructions

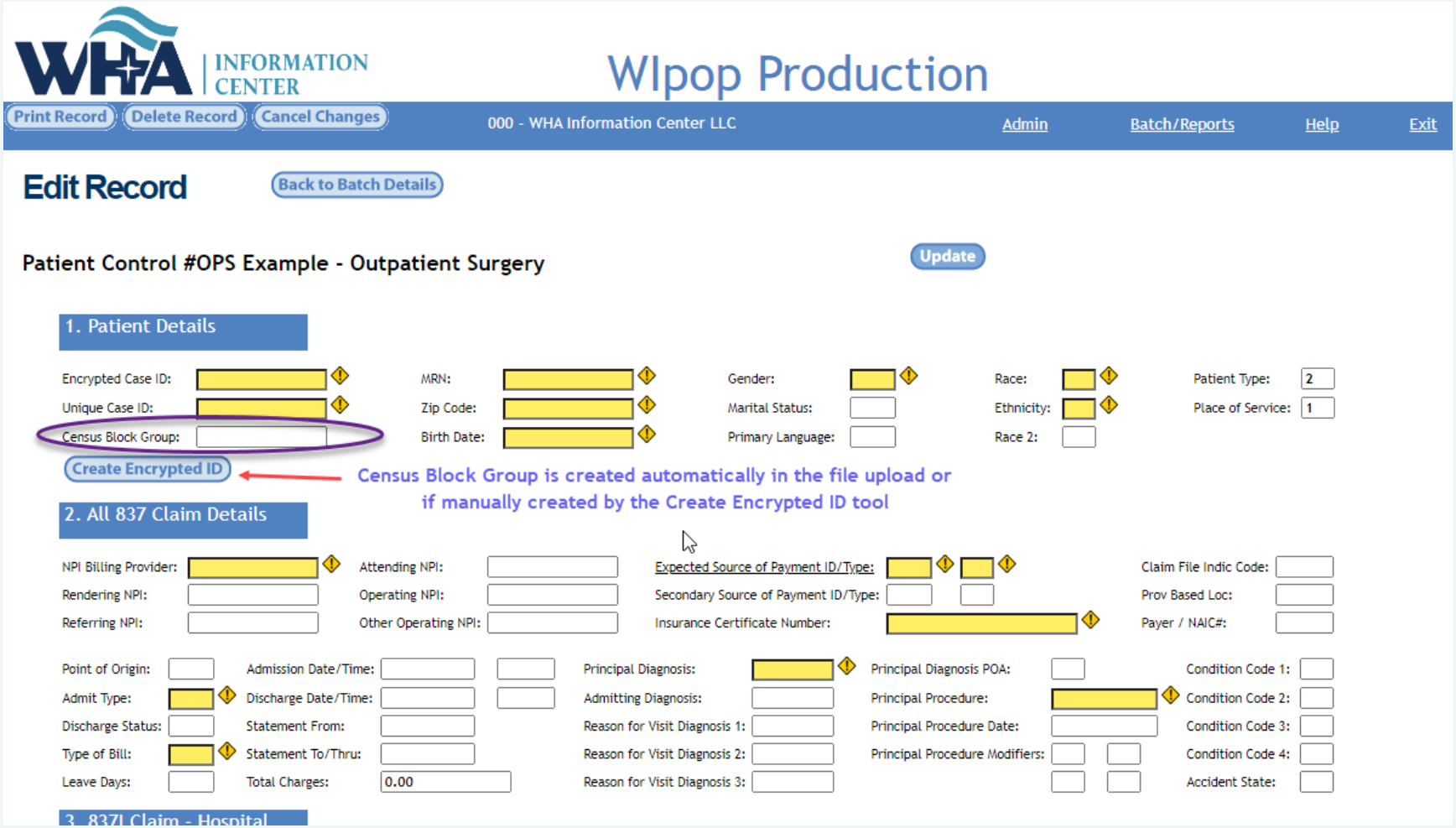
Click update in the record to begin, this highlights MOST of the required fields

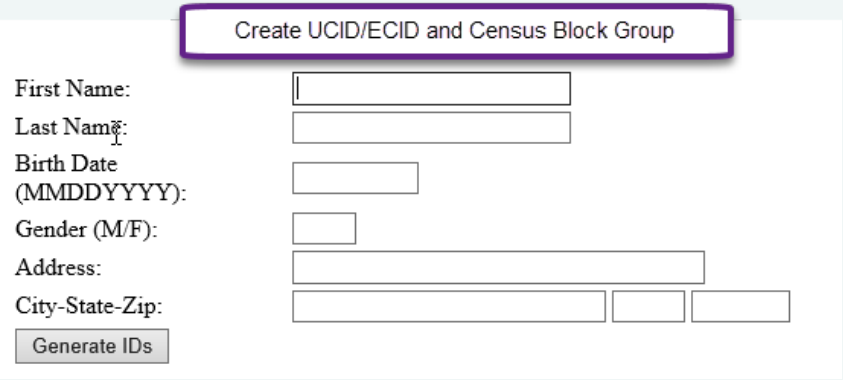
See Data Dictionary for field information and details

Data Element	Instructions to create a record and do manual data entry in WIpop
Patient Control Number	Patient's unique alphanumeric number assigned by the facility to facilitate retrieval of individual financial records and posting of the payment. Up to 24 digits allowed.
Type of Encounter	Identifies the status of the patient (inpatient or outpatient) at the time of discharge. **FASCs will always choose 'outpatient'.**
Place of Service	FASCs will always enter '1'.
Number of Additional Diagnoses Records	Number of diagnosis codes to be entered in the revenue record. Unlimited number allowed.
Number of Additional Procedure Records	Number of procedure codes to be entered in the procedure record. Unlimited number allowed.
Number of Additional Revenue Records	Number of revenue codes to be entered in the revenue record. Unlimited number allowed.



Click update in the record to begin, this highlights MOST of the required fields


INFORMATION CENTER
WIpop Production
Print Record
Delete Record
Cancel Changes
000 - WHA Information Center LLC
Admin
Batch/Reports
Help
Exit
Edit Record
Back to Batch Details
Patient Control #OPS Example - Outpatient Surgery
Update
1. Patient Details
Encrypted Case ID:
Unique Case ID:
Census Block Group:
MRN:
Zip Code:
Birth Date:
Gender:
Marital Status:
Primary Language:
Race:
Ethnicity:
Race 2:
Patient Type: 2
Place of Service: 1
Create Encrypted ID
Census Block Group is created automatically in the file upload or if manually created by the Create Encrypted ID tool
2. All 837 Claim Details
NPI Billing Provider:
Rendering NPI:
Referring NPI:
Attending NPI:
Operating NPI:
Other Operating NPI:
Expected Source of Payment ID/Type:
Secondary Source of Payment ID/Type:
Insurance Certificate Number:
Claim File Indic Code:
Prov Based Loc:
Payer / NAIC#:
Point of Origin:
Admit Type:
Discharge Status:
Type of Bill:
Leave Days:
Admission Date/Time:
Discharge Date/Time:
Statement From:
Statement To/Thru:
Total Charges: 0.00
Principal Diagnosis:
Admitting Diagnosis:
Reason for Visit Diagnosis 1:
Reason for Visit Diagnosis 2:
Reason for Visit Diagnosis 3:
Principal Diagnosis POA:
Principal Procedure:
Principal Procedure Date:
Principal Procedure Modifiers:
Condition Code 1:
Condition Code 2:
Condition Code 3:
Condition Code 4:
Accident State:
3. 837I Claim - Hospital



Patient Detail and Claim Information	
MRN: Medical Record Number	The unique number assigned to each patient by the facility that distinguishes the patient and their medical record from all other patients.
Insurance Cert #	Patient insurance number assigned by the payer organization. The primary payer insurance ID / Member number or group policy number is recorded. Leave blank for self-pay.
Birth Date	The patient's month, day, and year of birth (mmddyyyy).
Gender	F = Female M = Male *Gender may be U if patient has an ambiguous gender or is transgender. Condition Code 45 must be used in any Condition Code field to override edit in WIpop.*
Marital Status	Optional – populate if collected – see Appendix 7.14 for codes.
Race	See **7.2** for the appropriate one-digit code.

Patient Detail and Claim Information	
Race 2 (optional)	If patient identified two races, enter the first chosen in race 1, followed by race 2 code.
Ethnicity	See 7.2 for the appropriate one-digit code.
ZIP Code	The five-digit code assigned by the US Postal Service. The field should be zero-filled ('00000') for a person with an address that does not include a valid US ZIP code. If the ZIP code is unknown, such as for homeless patients, this field should be left blank and populate a Condition Code with '17'.
Encrypted Case ID	An encrypted code based on the patient's last name and initial of first name. The case ID generator automatically assigns the code. It is designed to help protect the confidentiality of the patient. Once you click the generate ECID the data of birth and the gender of the patient automatically populates in the HTML page.
Unique Case ID	The case ID generator automatically assigns the code. It is designed to help protect the confidentiality of the patient. Once you click the generate ECID the data of birth and the gender of the patient automatically populates in the HTML page.
Admit Date/Time	Not required for FASCs.
Point of Origin	Not required for FASCs.
Admit Type	Not required for FASCs.
Principal Diagnosis	The ICD-10-CM diagnosis code describing the condition established after study to be chiefly responsible for the services provided during the visit. *Do not enter decimals.*

Patient Detail and Claim Information	
Present on Admission (POA) Indicator	Not applicable for FASCs.
Discharge Status	Not required for FASCs.
Admitting Diagnosis	Not required for FASCs.
Reason for Visit 1	Not required for FASCs.
Reason for Visit 2	Not required for FASCs.
Reason for Visit 3	Not required for FASCs.
Leave Days	Not applicable for FASCs.
Discharge Date / Time	Not required for FASCs.
Attending Provider NPI	Not required for FASCs.
Rendering NPI	Provide if available
Referring NPI	Provide if available
Operating Provider NPI 1	The NPI number of the operating provider who performed the principal procedure.
Other provider NPI 2	The NPI number of the second procedure provider that participated in procedure.

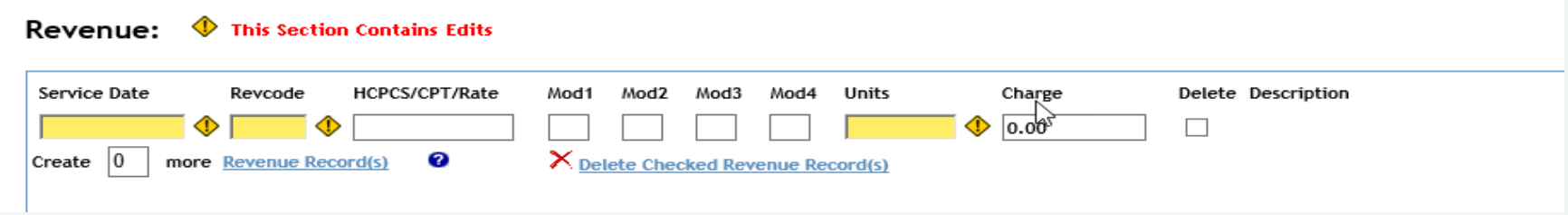
Patient Detail and Claim Information	
Principal Procedure Date	Record the month, day and year the principal procedure was performed. (mmddyyyy).
Principal Procedure	The CPT procedure most related to the principal diagnosis performed during the episode of care.
Modifier 1 -4	CPT or HCPCS Level II modifiers. Enter if available in the 4 modifier fields as appropriate. The modifier that has the most impact on payment should be entered in the Modifier 1 field.
Expected Source of Payment (SOP) ID	The first three characters from the primary payer code. See Appendix 7.3 for appropriate codes. Example MED or T19 for Medicare.
Expected Source of Payment (SOP) Type	The fourth and fifth characters of the payer code. See Appendix 7.3 for appropriate codes. Example a 2 digit code **'01'** if Medicaid fee for service or non HMO or '41' for Work comp.
Secondary SOP ID	The first three characters from the secondary payer code when there is a secondary payer. See above.
Secondary SOP Type	The fourth and fifth characters of the secondary payer code. See above.
NPI Billing Provider	National Provider ID (NPI) number of billing provider – Facility Billing NPI number.
Type of Bill	A code indicating the specific type of bill. Please see Appendix 7.4 for appropriate codes. Typically FASCs use Code '999' because the type of bill code is not supplied on the HCFA 1500.
Total Charges	Total covered and non-covered charges related to the episode of care that is being reported, excluding the professional component. Assumed to be positive. Field = ('0.00') if no charges.

Patient Detail and Claim Information	
Statement Covers From	Not required for FASCs.
Statement Covers Through	Not required for FASCs.
Condition Code 1 - 4	**Code '17'** should be entered for all inpatient and outpatient cases where a patient is homeless at the date of service when there is an unknown ZIP code. Remaining condition codes apply to hospitals. **Condition Code 45** should be used for gender unknown.

Additional Diagnosis (Dx) Record and External Cause Codes	
ICD-10 Code	The ICD-10-CM codes corresponding to additional conditions that co-exist in addition to the principal diagnosis (include External Cause Codes). Add line items as appropriate.
POA - Additional Dx	Only applies to Inpatient Records - Not applicable for FASCs.

Additional Procedure Record	
Additional Procedure Code	The CPT or HCPCS codes corresponding to additional procedures in addition to the principal procedure listed on the Primary Record, that were performed during the episode of care. Unlimited number allowed.
Modifier 1 - 4	CPT or HCPCS Level II modifiers recorded on claim/record. The modifier that has the most impact on payment should be entered in the Modifier 1 field.

Additional Procedure Record	
Procedure Date	Date the secondary or additional procedure was performed.



Revenue Record detail required	
Service Date	Record the month, day, and year that the outpatient service was provided. Format = (mmddyyyy).
Revenue Code	Not required for FASCs if using the 837P or direct data entry.
CPT/HCPCS/Rate	HCPCS/CPT Level I and II codes applicable to the service provided.
Modifier 1 - 4	CPT or HCPCS modifiers that affect payment most should be entered in the Modifier 1 field.
Units	The value defined as a positive number '**a minimum of '1'** regardless if the charge is zero or greater than zero.
Charge	Total charges related to the HCPCS/CPT code or rate recorded on a specific line.