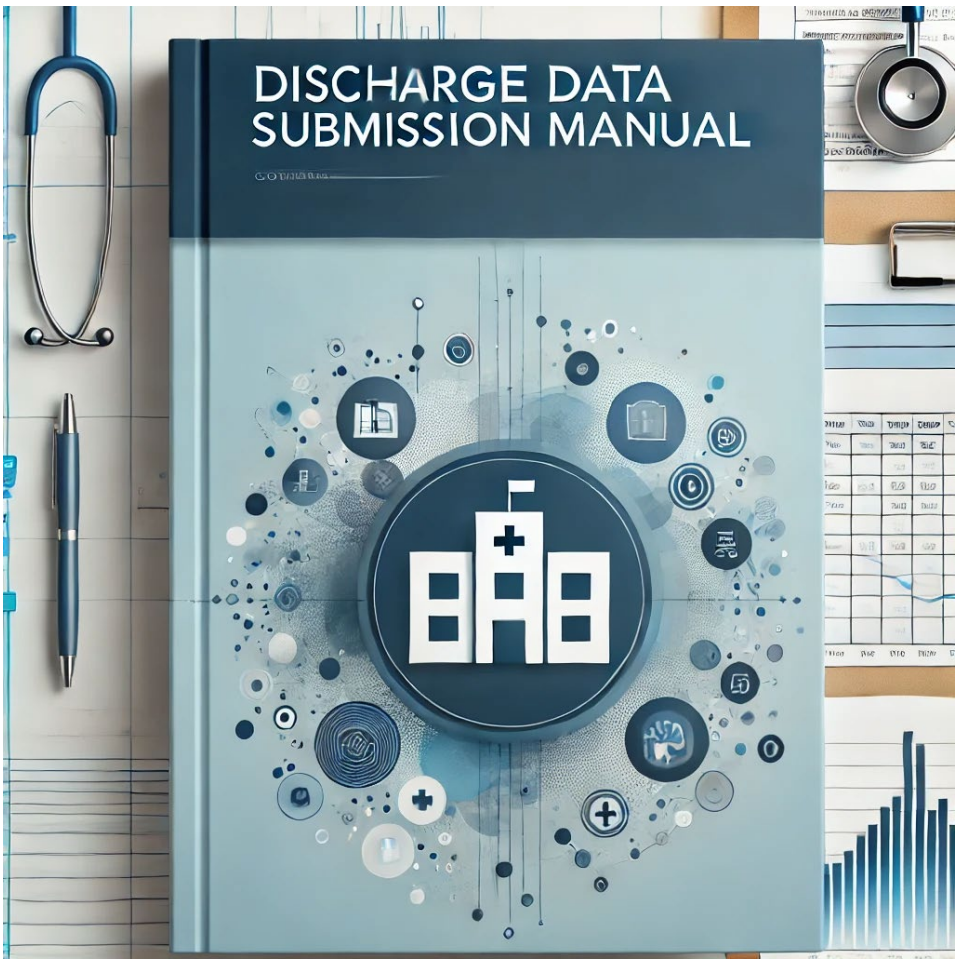
Discharge Data Submission Manual

Instructions Related to 837 Health Care Claim/Encounter Requirements and Companion Guide/Technical Specifications



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NOTICE:

Preface:

This Companion Guide (CG) contains two types of data: Instructions for electronic communications with WHAIC and **supplemental information for creating transactions for statutorily required data submissions** while ensuring compliance with the associated ASCX12 IG (Transaction Instructions).

Disclaimer:

WHAIC strives to make the information in this document as current and accurate as possible at the time of writing and distribution. WHAIC makes no claims, promises, or guarantees about the accuracy, completeness, or adequacy of the contents of this document. The manual and contents contained herein are for educational purposes only and do not purport to provide legal advice or advice on constructing an 837claim file.

This document provides only the segments, loops and elements which are relevant to WHAIC data collection specifications as defined by the WI State Statute and mapped / defined by a field in WIpop. **This document is not intended to serve as a complete 837 reference, and not all requirements for a valid 837 file are specified**. Elements not mentioned in this document will be discarded by WHAIC prior to the file processing in WIpop, if supplied. For more information: http://store.x12.org/store/healthcare-5010-original-guides or http://www.wpc-edi.com

ABOUT US

WHA Information Center (WHAIC) is dedicated to collecting, analyzing and disseminating complete, accurate and timely discharge data and reports about charges, utilization, and quality of care provided by Wisconsin hospitals, ambulatory surgery centers and other healthcare providers.

WHAIC is a wholly owned subsidiary of the **Wisconsin Hospital Association** and was incorporated on October 1, 2003. WHAIC began collecting data in January 2004 under contract with the Wisconsin Department of Administration.

The WHAIC Web site contains the latest information about WHAIC, hospital and ASC data reporting process, and other data collection events and publications. The WHAIC website also contains a Resource Tab related to Wisconsin legislation and your responsibilities to submit data. Chapter 153, Admin Code 120

As a subsidiary to the Wisconsin Hospital Association (WHA) we encourage all WHAIC data submitters to utilize the resources available to them as member hospitals and participate in educational opportunities and events such as Advocacy Day, Educational Webinars as well as other events located on the WHA website.

In addition to collecting discharge data, WHAIC staff also collects and posts hospital rate increases, Milwaukee County Hospital Utilization Data, hospital's annual and fiscal data, uncompensated care data, and other system survey information.

We Can Help You...

- Quickly turn data into actionable insights for timely and reliable decision-making with our visualization tools, dashboards, reports, and custom analytics.
- Leverage your existing data platform and analytics investment by providing our raw data sets in easy-to-use formats.
- Realize the benefits of a dedicated data program with tools and services that supplement your existing resources and infrastructure – even if you have none.
- Analyze data to evaluate health care services, patient populations, utilization, staffing, financial and market performance and much more.

CONTENTS

1. DATA SUBMISSION WITH A HIPAA COMPLAINT 837 CLAIMS FILE FORMAT

Wisconsin Hospital Association Information Center (WHAIC) collects data from **Medicare Certified Wisconsin Hospitals and Freestanding Ambulatory Surgery Centers.**

Pursuant to Chapter 153, Wisconsin Statutes , the WHAIC has been authorized by the Wisconsin Department of Administration to collect and report hospital and freestanding ambulatory surgery center data. WHAIC collects data quarterly and produces public use data sets, custom data sets and four annual publications.

Chapter 153 of the Wisconsin Statutes directs what information must be submitted to WHAIC. In 2016 sections of the statute were updated when the Wisconsin Health Care Data Modernization Act was passed. The Health Care Data Modernization Act removed outdated provisions in Chapter 153 and included an opportunity to bring Chapter 153 into greater alignment with the national ANSI 837 standard.

Hospitals and FASC, herein referred to as ("facilities") must submit data in a modified HIPAA Complaint 837 claims file format. Data collection is based on valid HIPAA ASC X12 837I and 837P transactions (including 837R – Reporting) electronic data interface reporting (EDI) format.

The WHAIC WIpop (Wisconsin Inpatient and Outpatient) Data Submission Manual and Technical Specification Guide follows the national ANSI 837 standards and provides specifications for the submission of inpatient and outpatient hospital data, and FASC data to the WHAIC. Failure to comply with the requirements outlined in the Statutes, or submission deadlines as referenced in this Companion Guide, may result in a non-compliance letter to the Wisconsin Department of Administration and may include significant penalties and forfeitures.

The Statute also states facilities that use a third-party vendor shall provide a copy of the trading partner agreement if the service of a third-party vendor is used to prepare and submit patient claims/records to WHAIC. As per *Wisconsin Administrative Code DHS 120.12 (5) (b) 6 (a) and 120.13(2) (d) 1. "To ensure confidentiality, hospitals and freestanding ambulatory surgery centers using qualified vendors to submit data shall provide to [WHAIC] **an original trading partner agreement that has been signed and notarized by the qualified vendor and the hospital or ambulatory surgery center**. 2. Hospitals and [ASC] shall be accountable for their qualified vendor's failure to submit and edit data in the formats required by [WHAIC]".*

1.1 Background and Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

Create better access to health insurance.
Limit fraud and abuse.
Reduce administrative costs.

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's implementation specification(s).

1.2 Intended Audience and Use

The intended audience for this document is hospitals and ASCs that are required to submit discharge data to WHAIC in the correct EDI format.

Compliance according to ASC X12 requirements include specific restrictions that prohibit trading partners from:

- ✓ Modifying any defining, explanatory, or clarifying content in the implementation guide.
- ✓ Modifying any requirement contained in the implementation guide.

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are **not intended to be stand-alone requirements documents**. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

1.3 References information

The WHAIC 837 claims file format used to submit discharge data into WIpop draws from the American National Standards Institutes (ANSI) standards and the Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: For more information: http://store.x12.org/store/healthcare-5010-original-guides or http://www.wpc-edi.com

- 837 Institutional Health Care Claim – ASC X12N 837 (005010X223A2)
- 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1)
- 837 Reporting Health Care Claim – ASC X12 837 (005010X225A2)

Only the sections required by the State of Wisconsin Statutory Requirements as defined in Chapter 153 and collected by WHAIC or situational ANSI 837 Institutional and Professional Guide sections are reproduced in this manual.

1.4 Communication with External Sources and Data Set Release/Caveats

If you or a representative from your facility receives inquiries or questions about the data, data sets, or publications we produce, refer the external party to the WHAIC Vice President or Director of Operations. WHAIC would like the opportunity to address any questions your facility may receive from an external party (newspaper, insurance company, researcher, or other news outlet, etc.)

We do not re-issue quarterly data sets to correct errors once the data sets have been made public. We maintain a comprehensive list of caveats to the data sets that informs data users of any data submission errors that were brought to light after the data sets were released. The caveats are intended to explain any changes in data or omissions and include as much detail as possible about the type of error, the facility involved, the quarter involved, and, if possible, a summary of the correct data. Exceptions to this general policy may be made when the error is a result of our own internal processing or transformation of raw data into data sets, in recognition of our warranty to data consumers that the data is an accurate reflection of the data submitted to us.

Data that is caveated or misrepresented is not added or corrected in other data sources provided by WHAIC such as KAAVIO, PricePoint, Check Point or any of the publications.

2. DISCHARGE DATA COLLECTION OVERVIEW

Quarterly discharge data is required by State Statute 153.

WHAIC uses a single sign-on process. All users must register to use the Secure Portal to submit and/or fix edits. Inpatient and outpatient discharge data for all encounters must be submitted on a HIPAA compliant modified 837 claim file as defined by WHAIC within 45 days of the quarter end; however, monthly data is encouraged. WHAIC sorts the data by record type, number of records in each data type, and valid/invalid records based on edits.

Correcting edits/errors Edits are based on current coding guidelines and use of the Medicare Coding Edits. Authorized WIpop users are responsible for correcting edits contained in the records within the timeline provided in the Data Submission Calendar. Once edits are worked, the batch must be marked complete. WHAIC encourages facilities to run real-time validation reports in WIpop.

Throughout the quarter and at the end of the quarter, WHAIC performs internal validation and focuses on historical trends within all datatypes in the data submission. Internal validation performed by WHAIC staff is intended to evaluate if the data is consistent with historical norms and if trending is plausible given expected quarterly and annual distributions of records within each data element. Inconsistencies are identified and shared with the facility. The facility must respond or take appropriate action within a reasonable period, preferably within 48 hours, and review the data in question, make corrections and/or verify the records are accurate.

Validating quarterly data Approximately 4 to 6 weeks after the data submission deadline, each facility will receive multiple validation reports via the secure portal. The facility staff should run internal census or abstract or audit reports to compare data based on patient volume, charges, percentage of change within the dataset, and unusually high or low monetary figures.

Potential problems or inconsistencies identified by the facility must be corrected as explained on the report download.

Reviewing the profile and electronically submitting the affirmation statement Finally, at the completion of the validation process the facility is required to submit an electronic Affirmation Statement affirming the accuracy of the data. DHS statutorily requires this.

WHAIC does not create user accounts or add users, this is a secure application that houses facility discharge data. **WIPOP users must register for and have an active user account**. Hospitals and ASCs are responsible for managing access to WIpop and all registered users. Any changes to the list of users must be corrected within WIpop or communicated to WHAIC staff.

Data submission files must be created using a modified 837 claim file format. They must pass basic formatting and compliance checks to be processed in the WIpop database. If a file is rejected for failing the format requirements an email notification will be sent to the submitter and primary contact detailing the reason for failed formatting. For more information on file failures see section 6.1. The WHAIC discharge data submission site includes both a *WIpop Test* site and a WIpop Production site. **Do not work EDITS in the test site unless the facility is verifying something specific.*

Types of format failures:

- The file contains PHI - patient name or social security number.
- More than 10% of records missing address to complete the census block group detail.
- More than 25% of records with a race or ethnicity of unavailable / denied.
- Structurally insufficient or missing segments, facility ID is wrong, etc.
- File size is over 100Meg.
- Duplicating patient control numbers/encounters in the file.

Data must be reported quarterly, within 45 days of the close of the quarter. Calendar quarters end on March 31, June 30, September 30, and December 31. **Monthly files are encouraged**.

Discharge data includes the following patient type of records and place of service:
**Do not include data provided for the sole purpose of drug testing, ambulance transfer/service, professional fees, patient convenience items or reference lab.*

Patient Type Assigned by WHAIC	Place of Service Assigned by WHAIC	Acronym	Description
1	Blank	INP	Inpatient Encounter

2	1	OPS	Ambulatory/Outpatient Surgery/Same Day surgery
2	2	ER or ED	Emergency Department
2	3	OBS	Observation Status
2	4	PT/OT/ST	Physical Therapy, Speech Therapy, Occupational Therapy
2	5	OLR	Outpatient Lab and Radiology
2	6	OHO/PBL	Other Outpatient Hospital Data, PBL Data, Urgent Care, etc.

2.1 Discharge Data Parameters and Limitations

The following data parameters and limitations **apply to all records/claims** data submitted to WHAIC:

- Limitation on some Bill Types (TOBs): as much as possible, do **not send replacement, voided, or corrected claims/records in any of the data.** Unlike insurance companies, we have no mechanisms in place to search and replace a previously submitted encounter or record. *The data is submitted and released for use by hospitals, policy makers, researchers and consumers based on calendar quarters, therefore it is impractical to replace a record/claim from a previous quarter once the data is released.*
- **Exclude revenue codes 096X to 098X**. As per state statute, we do not collect data for Professional Services.
- State Statute required the collection of Race, Ethnicity, and patient sex.
- Include collection of Marital Status and Language.
- Patient Sex may be listed as M, F, X, O or U. **If** O or U, Condition Code 45 must be on the record.
- **Place of service (POS)** is assigned by WHAIC based on revenue codes and hierarchy defined in Appendix 7.5.
- External Cause of Injury (ECI) Codes V-Y are required, as per state statute, with a diagnosis code in S (T) section codes.
  - External Cause Code required when there is an injury diagnosis code see section 4.6.
  - External Cause Codes are required on INP, ER, OPS (FASC) and OBS only (Place of Service (POS) of 1-3).
- Social Determinants of Health (SDOH) codes are required if coded and available. The codes may be in the EMR or on the claim, verify they are getting into the file.
- NPI numbers are not required in all fields for every datatype: If an NPI number is provided in the operating NPI field, WHAIC will look for a valid CPT code to populate the principal procedure. *If a valid CPT or HCPCS is not found, an edit will occur on the operating NPI field.*

  Attending NPI is required for inpatient and emergency department records. If subpart NPI numbers are used, and an edit occurs, contact WHAIC to add the subpart NPI to our tables.
- **Alerts** are intended to generate discussion and allow submitters to find improvement in the data before the end of the quarter. ***Alerts are not Edits or Errors.*** *Alerts create an opportunity to review the data more closely and timely and update records.*

  * The **Alert bell** may draw a submitters attention to specific areas of race, ethnicity, payer, inpatient and observation stays. *Examples might include patients over 65 reported as non-Medicare, other/unknown payer, race declined/unavailable, OBS over 5 days, IP under 2 days, unknown payer, etc.*

2.2 Inpatient Discharge Records (INP)

Acute care, critical access, orthopedic, children's hospitals, mental and psychiatric/behavioral health, and other specialty hospitals are required to submit selected items or aggregations of items for each patient discharged including records of self-pay patients as per the definition of hospital. The use of a claims file is intended to provide a full representation of what services were provided in your facility for all inpatient claims. If your hospital provides inhouse swing bed patient care, you may include those encounters in the data – specifically swing bed type of bill 18X – SNF.

- **Discharge date** is used to determine which quarter to use when reporting to WHAIC. For example, if service started on 06/30 and ended on 07/01, the record should be included in the 3rd quarter data submission.
- Data are required for inpatient discharges whose three-digit "Type of Bill" (TOB) begins with "11x" or "12x." **Leading zero may or may not be used – depending on direct data entry from a claim form or 837 electronic files.*

- **Exclude Inpatients for the following:** Skilled Nursing patients, Intermediate Care Facility Patients, Religious Institutions, Intermediate Care Level I and II, Hospice patients, Residential Facility, and Specialty Facility.
- **Exclude Inpatient Revenue Codes**: 055X – Skilled Nursing, 065X – Hospice, 096X – 099X Professional Fees.
- WHAIC will assign Inpatient Place of Service using the following revenue codes: 0100-0189, and 0200-0219.
- **Hospitals only**
  - *Value codes:* A code structure to relate amounts or values to identify data elements necessary to process the claim as qualified by the payer organization. The Value Code fields allow for the reporting of numeric expressions. These expressions can be categorized as monetary amounts as well as percentages, units, integers, and other identifiers. Value codes required in WIpop data file uploads if supplied on the claim.
  - *Occurrence Code:* The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date and are required in the WIpop file if supplied on the claim.

- **Common INP errors and fixes:** Inpatient records that **change to outpatient** after the claim has been generated and data submitted. The fix and change are easy if the CPT codes and DOS are on the record.
  1) Make sure that batch is open and not in read only status. Otherwise, you will not be able to move the records to the correct data type.
  2) Update patient type from 1 to 2 and change the Place of Service (POS) to either 1 = OPS or 3 = OBS – refer to the POS Appendix.
  3) Change the INP rev code for room and board from 011X to 0762 for Observation and remove any POA codes.
  4) Hit update.

2.3 Outpatient (Ambulatory) Surgery Records (OPS) POS = 1

Hospital outpatient departments, hospital-affiliated ambulatory surgery centers and freestanding ambulatory surgery centers (FASC) are required to submit selected items or aggregation of items on all ambulatory surgeries***, including records of self-pay patients***.

Outpatient surgery records submitted based on procedure date i.e., what quarter did the surgical procedure or service take place in. The **procedure date** (*not admit/discharge or statement from/through*) is used to determine which quarter to use when reporting OPS.

The date of services may cross a quarter by a day or two as long as the principal procedure falls in the current quarter.

WHAIC uses the revenue line-item detail (Revenue codes 036X (not 0361), 0481, 049X or 0750) and dates of service to pull out the principal and additional procedure codes and dates. If a date on the record includes dates into the next quarter for OPS, it should not throw an edit if the procedure date is in the right quarter and the revenue line-item dates match (if facility populates) the Adm/Discharge dates or Statement from/Through.

  - For example, if the procedure is performed on 06/30, but the patient was discharged on 7/1, it should still be included in the Q2 data submission because the procedure happened in Q2.

WHAIC will assign the record to Place of Service (POS) '1' for services related to the definition of ambulatory/day/same day or outpatient surgery, including FASC when the following UB Revenue Codes are on the record/encounter:

Outpatient surgery is surgery that is completed in **one day** and does not require the patient to be hospitalized overnight.

036X – OR Services *not 0361*	0481 – Cardiac Cath	049X – Ambulatory Surgical Care	0750 – GI Services

- *A **principal procedure code is required on outpatient surgery records*** as per statutory requirements. WHAIC will assign and populate the principal procedure field and procedure date using the revenue line-item detail as described above.
  - *Assignment of principal procedure is based on the highest qualifying CPT/HCPCS **code charge**. If two or more revenue line items have the same (high) charge, the earliest service date will be marked as the principal procedure.*
  - *Assignment of the procedure code will be based on official CPT and HCPCS coding guidelines, and when necessary, use of historical data and algorithms.*
- For OPS, the principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.
  - *For purposes of discharge data submissions WHAIC considers most CPT codes located in the surgical section 15999 – 69979, with limited exceptions, eligible for assignment of a principal procedure.*

- Freestanding ambulatory surgery centers - (FASC) are not required to use OP revenue codes.
  - FASC bill on an 837P with the appropriate CPT or HCPCS codes for services, supplies, or other items.
  - *FASCs are not required to report type of bill on the claim; however, this field is required in WIpop per state statute. Facilities should map the data to 0999 or 0831 or a version of this. Under certain circumstances as defined in the manual, WHAIC will automatically assign an acceptable TOB to this field in WIpop – see the 837P specification for more information.*
- *Exception Rules OPS:* Records for claims that occur within the 90-day global surgical period (such as cataract surgeries that are often performed on both eyes within the 90-day global surgery period), are exempt from the edit.
  - A service date up to 90 days after the principal procedure date will be allowed if a Left (LT) or Right (RT) modifier is on record.

2.4 Emergency Room/Department Records (ER/ED) POS = 2

Emergency departments (ED) are required to submit selected items or aggregations of items for all visits to the emergency department including records of self-pay patients.

- **Discharge date** determines selection for emergency department records**.** For example, if service started on 06/30 and ended on 07/01, the record would be included in the 3rd quarter data submission.
- Place of Service code "2" is assigned to records that have at least one ED Revenue Code (0450, 0451, 0452 or 0459).
- When an ED visit results in an inpatient discharge or an outpatient surgery, the facility can choose to submit the ED services as a separate record or combine them with the inpatient or outpatient surgery record.
  - Medicare requires that critical access hospitals (CAH) bill emergency department services separate from the inpatient record. WHAIC will honor this requirement.
- For hospitals that perform minor outpatient surgery procedures (revenue code 0361) such as a suture in the ED, the record will be counted and included in the ED data provided there is also a ED rev code.
- *Exception Rules ER/ED:* To accommodate the wide variety of services that occur in the ED for both GMS and CAH hospitals that provide recurring specialty type services e.g., injections, infusions, or dialysis:
  - Bypass edits are set-up for ED records with multiple dates of service, i.e., a statement 'From and Through' date has a seven-day span of service, and that span matches the service dates in the revenue line-item detail.

    To clarify:
    - If the encounter/record has less than seven (7) days of service line items, the record is ED.
    - If the encounter/record has more than seven (7) days of service line items, the place of service will be determined by the POS hierarchy and revenue codes.

2.5 Observation Records (OBS) POS = 3

Observation *encounters are outpatient services* commonly *ordered for* patients who typically present to the emergency department and subsequently require a significant period (24-48 hours) of monitoring to allow for attending provider to decide if patient should be admitted or discharged.

- Place of Service (POS) '3' assigned to records with **revenue code 0762**
- The **statement covers period** is used to determine the beginning and ending service dates of the period included on the record submitted. For services received on the same day, the "From" and "Through" dates will be the same.
- When an outpatient surgery or emergency room encounter results in a transfer to observation care and has Revenue Code 0762, WHAIC will assign it to an observation record type (POS 3), as defined by the POS hierarchy.
- *OBS: **Fixing INP records that change to OBS*** – in general, most INP to OBS records have OP codes on them i.e. use of CPT/HCPCS codes.
  - User will have to change the revenue code from INP room and board such as 0111 to 0762 and remove and POA codes of Y,N,U, W, and update POS to 3 and Pt. Type to 2.

2.6 Other Hospital Outpatient Records (OHO) POS 4-6

Hospital outpatient departments are required to submit selected items or aggregations of items for all outpatient visits, *except* hospital reference diagnostic services (TOB 0141). **Records of self-pay patients must be included**. Most of these items are from uniform billing forms (UB-04). *Records from a hospital outpatient department (AKA Provider Based Location (PBL)) with the same Medicare provider number see 2.7.*

- Exclude Professional Services (revenue codes 096x-098x).

- Exclude services that are not a direct face-to-face encounter (does not include telehealth) such as ambulance transport, supplies or DME exchanges.
- The **statement covers period** is used to determine the 'from and through' service dates on the record submitted.
- For services received on the same day, the "From" and "Through/To" dates will be the same.
- Repetitive Series accounts may be submitted at the end of treatment, monthly, or according to billed services, etc.
- Interim bill types are acceptable.
- Place of Service is assigned based on the Revenue Code on the record and hierarchy as defined by *Appendix 7.5.* this includes services for therapies, lab/radiology and other outpatient hospital encounters.
- If the encounter is not classified as OPS, but an operating NPI is supplied, the system will look for a valid CPT/HCPCS code in the revenue line- item detail. If a valid code is found, the code with the highest charge is assigned as principal procedure.
- Encounters that have an operating NPI number but do not have an acceptable principal procedure code will receive edit 1375 on the Principal Procedure. "1375 = *Principal Procedure required if Operating Provider NPI 1 is reported*." *To fix, delete the operating NPI.*

2.7 Provider-based location (PBL) ID

Hospitals that have off-campus, outpatient, provider-based department must bill the correct service facility PBL ID and address on the file. Splitting a hospital outpatient charge into professional and facility components is called "provider-based billing." Patients receive two charges on the bill for services provided; one charge represents the facility or hospital charge, and the other charge represents the professional or physician fee. Since PBLs are outpatient departments of the hospital WHAIC is required by statute to collect the facility component of all services and claims billed **regardless of whether the payer accepts provider-based billing or not**.

> *Records from a hospital outpatient department/PBL with the same Medicare provider number should be submitted according to the 837I or R Technical specifications outlined in Loop 2310E, Element NM101, NM108 and NM109.*

WHAIC assigns PBLs a unique site number in a simple 1,2,3…format. This number, combined with the parent hospital facility ID, forms a unique identifier for each PBL. Hospitals that acquire, add, or intend to change internal practices to submit claims using provider-based billing, or close / no longer bills as PB, should contact WHAIC to update our tables.

Provider-Based Clinics/Locations

The bottom line, if your hospital bills for an off-campus provider-based clinic and you are not reporting it correctly, it could affect payment to your facility, click here to link to the NGS Medicare documentation for more information. This article specifically references how providers billing for Provider-Based services must include the applicable and appropriate modifiers to the claim and file. And, as stated above, if you are reporting outpatient clinic facility charges on an 837I those services must be reported to WHAIC as outpatient services.

PBL data is provided in the public datasets and includes the site number, which allows data users to distinguish between patients seen at the hospital or at a PBL.

To add or update a PBC/PBL Hospitals must email WHAIC with the following information:

> Facility ID and Name of Hospital
> PBL Name (what do you want it called in your reports or what did you call it in the PECOS system)
> PBL Address (try to use the one used in the PECOS system)
> Date PBL opened or became a PBL.

3. WIPOP ACCESS AND DATA SUBMISSION

This section covers access to WIpop (pronounced WHY-POP). All users must register to the secure portal site in order to submit or correct data. Once registered and approved a confirmation email is sent to both the user and primary contact(s).

All hospitals and ASCs are required to have at least one Primary Contact to oversee the quarterly discharge data process, receive notification of newly registered WIpop users, and access quarterly reports. More *than one primary contact encouraged*.

All registered users agree that use of the WIpop and Secure Portal system without authority, is prohibited. Sharing of passwords is not permitted.

Effective 11/1/2023 WHAIC moved to a multi-factor or single sign-on system access. Whereby users are no longer required to maintain a separate username or password, rather they will use their own facility login credentials. In addition, this process will initiate an Account Verification Code in the user email account that will be required in order to access the system. This process will occur every 30 days.

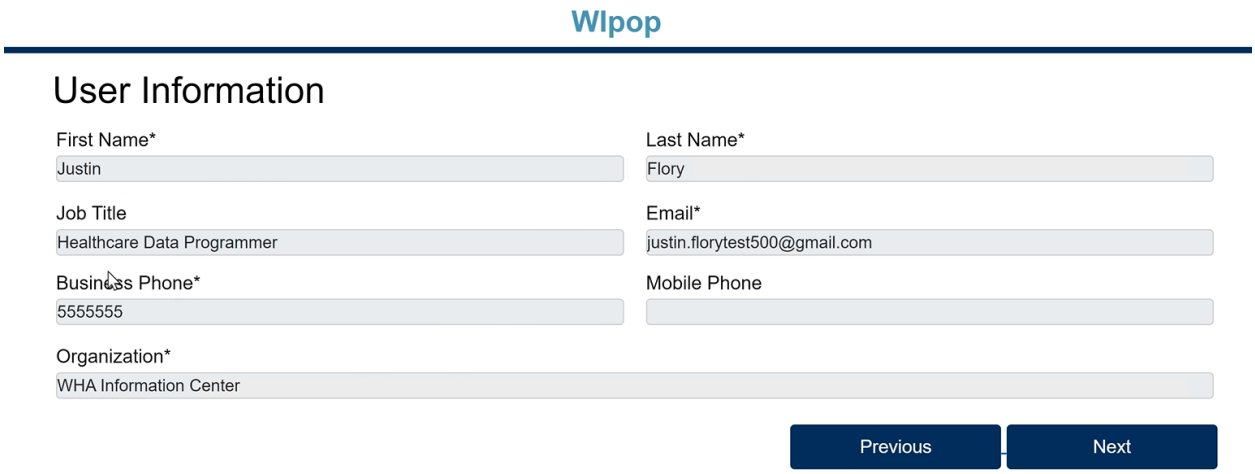
3.1 Access to WIpop

All data submitters, editors and other WIpop users are required to register for access to WIpop through the secure Portal. **WIpop is a role-based system in which** designations are assigned and decided by the facility.

WHAIC does not add users to WIpop. All users must register through the secure WIpop portal site.

To register, open site https://portal.whainfocenter.com in your web browser and enter your email address to see if an account already exists and click submit. If an account exists, the user's information will populate in a form for the user to either update the account information or click "Next" to receive the account information code in order to log in.

- If no email is registered, user will be required to register as a WIpop User and select a role based on primary or secondary contact (see WIpop Roles), as it relates to WHAIC Data Submissions.

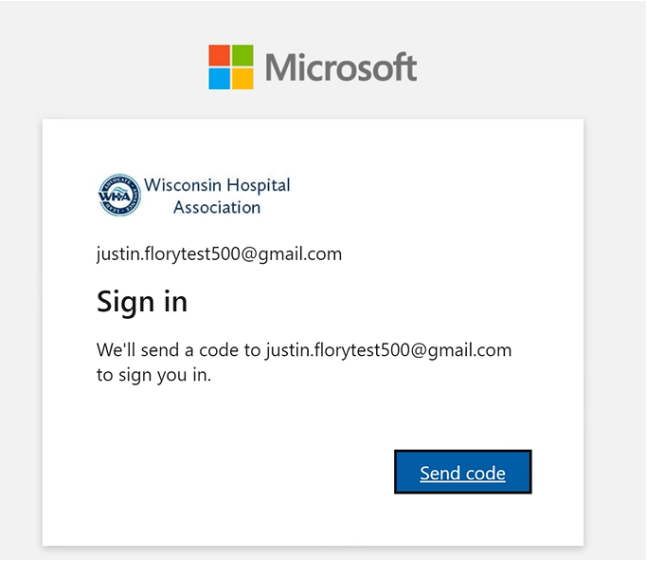


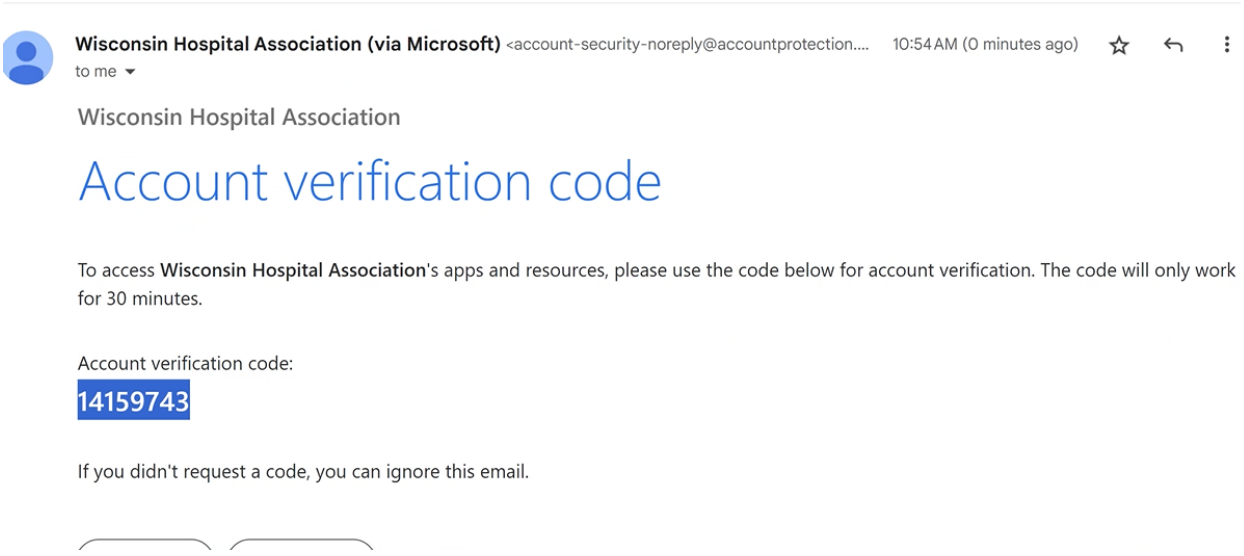
- If the user is not registered, he/she will be required to complete the new user registration page and check all facility(s) for which you submit or correct data for and click Next.

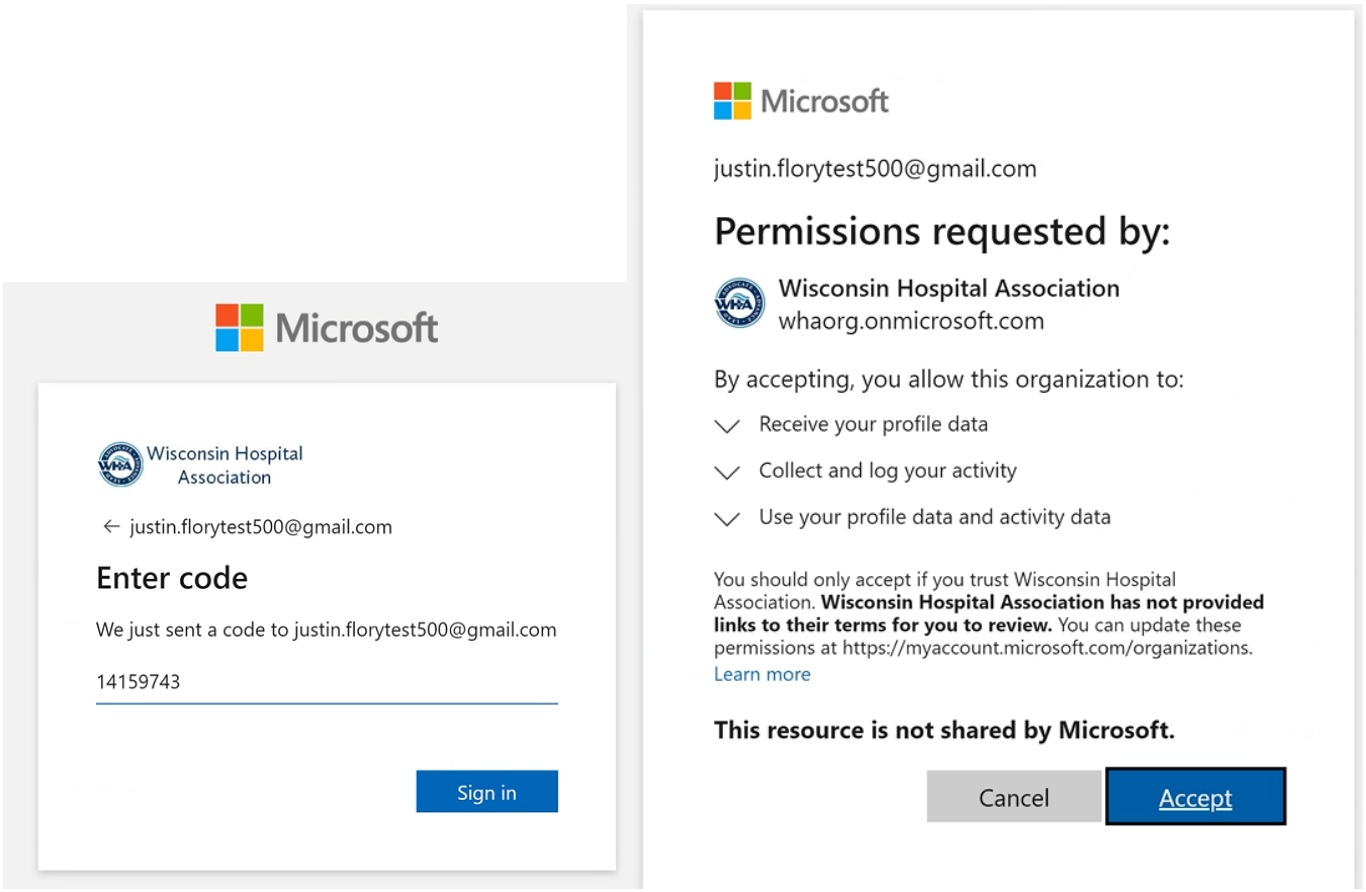
  *In general, the only hospitals that will populate will be the ones associated with the email address. For example, if you are with Aurora, only the Aurora sites will populate. Please choose all sites or use the "select all" feature to allow us to assign your account correctly.

  NOTE: If you are with a vendor or coding company like Optum or R1R1 we will need to add that to the hospital's domain in order for you to gain access to that particular hospital(s).

- Once all the Registration Details are complete and an account is created the user will be required to sign in using their hospital or ASC credentials. Following this, an email is sent with an Account verification code the user must copy and paste into Microsoft Authenticator.







Users will be required to copy and paste the code accordingly. This process will occur every 30 days!

Questions about the registration process should be directed to the WHAIC Staff at whainfocenter@wha.org.

User will no longer be required to create or enter a password, rather they will receive an Account Verification Code in their email that will be required in order to access the system.

3.2 Inactive Account Policy

WHAIC makes every effort to create and maintain security efficiencies in the systems we operate. Please notify us of any system users no longer with the organization or in a position in which access to our systems is necessary.

In the event we are not made aware of user status, we have an automatic deactivation procedure that has been put in place to enhance portal security and data access. If an account has not been used for an extended period of time, it is more likely to be compromised. All Users with Data Deliverables (Primary, Secondary, Sales, etc.) – deactivated after 15 months.

If an account was deactivated but access is still needed, notify WHAIC at whainfocenter@wha.org to reactivate the account.

3.3 Security of Data Submission

The WHAIC WIpop system is a Web based application. The Data Submission Process ensures a secure application by:

- User authentication is required to verify the identity of users and determine access rights.
- Secure Sockets Layer (SSL) certificate for establishing an encrypted link between the WIpop application and browser clients.
- Database server encryption; and
- Files are uploaded to an isolated "edge" server, and only the necessary data is extracted to WIpop.

3.4 Testing HIPAA Compliant 837 File

All new facilities submitting discharge date for the first time are encouraged to test their files with WHAIC prior to submitting files to the production environment.

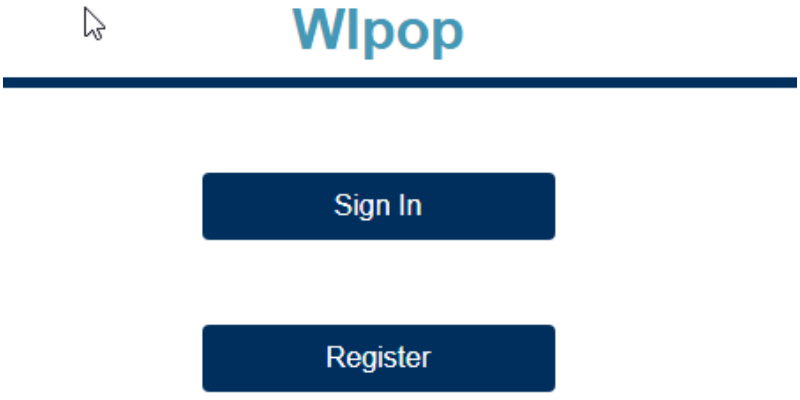
Most facilities require resources from their vendor or IT department to create the modified 837 claims file. Testing the file allows WHAIC and the facility to evaluate specifics of the file set up that include the facility ID, specific mapping requirements, and validate if it adheres to the technical specifications contained in this Manual and Technical *Guide*. **It may take 3-6 months to develop and test a file.**

All submitted files receive an email response of either a batch process or batch failure/invalid batch.

When testing with WHAIC, do not include patient PHI such as names or SSN. Be sure the file is structurally correct and includes the fields outlined in section 5. If specific fields are missing on too many records, the file will automatically be rejected.

3.5 How to Submit Data in WIpop

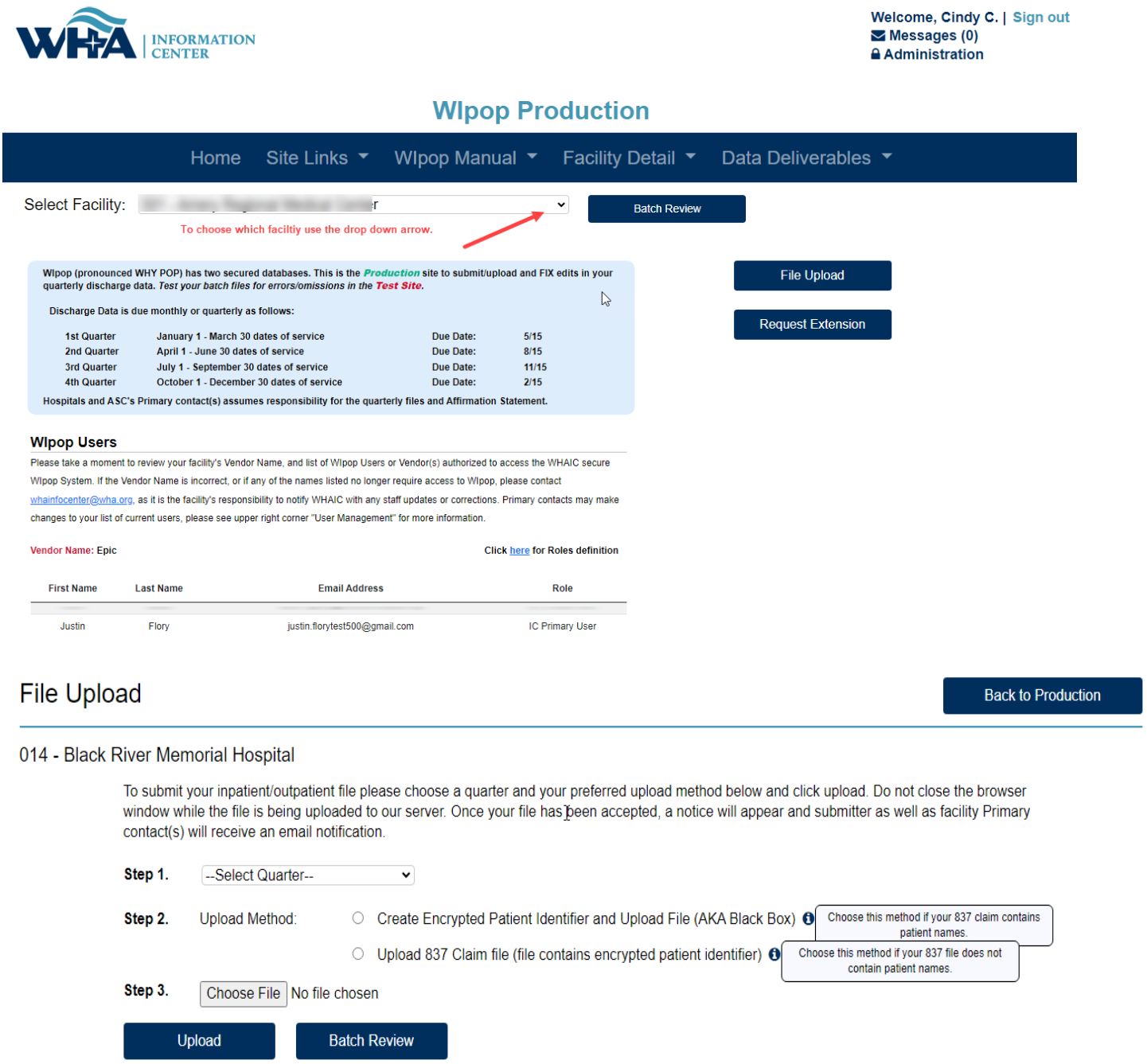
Registration to the WIpop Secure Portal site is required to submit data. The use of the facility 3-digit ID must be used to submit the file. Any WIpop user may submit data through the portal and run detailed reports.



Choose Sign in to get to the main WIpop page. Once there you will see this:

1. To submit a file, click on "**WIpop Production or WIpop Test**" to get to the "**File Upload**" Screen and then choose the quarter the data is for, using your internal browser locate your file. **Do not close the browser while the file is being uploaded to our server. After clicking 'Upload,' a status bar will appear with the progress of the batch file upload.

2. If you manage multiple facilities, be sure to select the facility you are intending to upload data for.

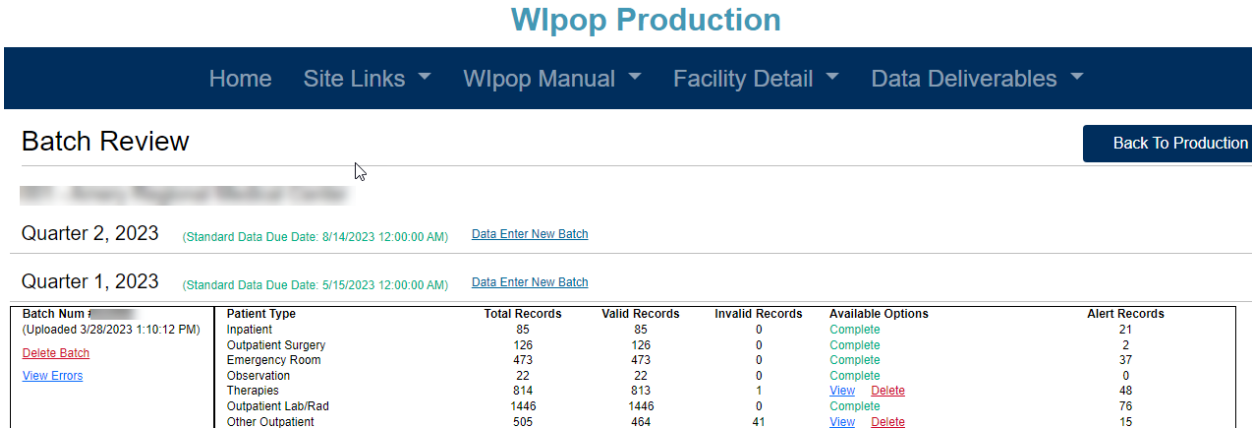


Two main upload options and the 837 File Handler:

- The **first method** allows user to submit file with the patient name and WHAIC will replace name with the 64-character UCID.
- The **second method** allows user to upload the output file directly to WIpop, assuming the name has already been replaced with the UCID.

Tips:

1. Do not close browser while the file is being uploaded.
2. A status bar will appear with the progress of the batch file upload.
3. An acknowledgment email will be sent once batch is processed.
4. Please wait for your file to process before uploading a second, third, etc.



- Distinct batch numbers are assigned to each batch file.
- Edits may be worked once the file is uploaded.
- Mark Data Complete once all edits are worked.
- Users may reopen or delete an entire batch using the keys under the Batch Number.

When a file is processing, as of now the system can only process 500 records at a time so our system doesn't lock up given we have over 200 facilities that could submit at any given time. Batch processing isn't instant and can take upwards of 20-30 minutes to process a file depending on file size. So, to avoid the files getting kicked out for duplicate records, please be patient and allow your files to process before submitting multiple times.

WHAIC is working on the timing to process the file as we know this could potentially be an issue with systems and submitters who manage multiple facilities. To avoid submitting duplicate files, we created a return message as provided below.

File Name:	Name of Facility_00000_000_Q323_Exclude_Duplicates.cli
Submitted By:	email name
For Facility:	000- Bellin Hospital
For Quarter:	1 2024

Transaction	Claim	Error
0	0	A file with this name is currently being processed. Please wait until the first file is finished before attempting to upload it again.

Please correct these issues and resubmit the data.

The file submitter will receive this message, with applicable patient control numbers added, in his/her WHAIC User messages at https://wipopicd10.whainfocenter.com

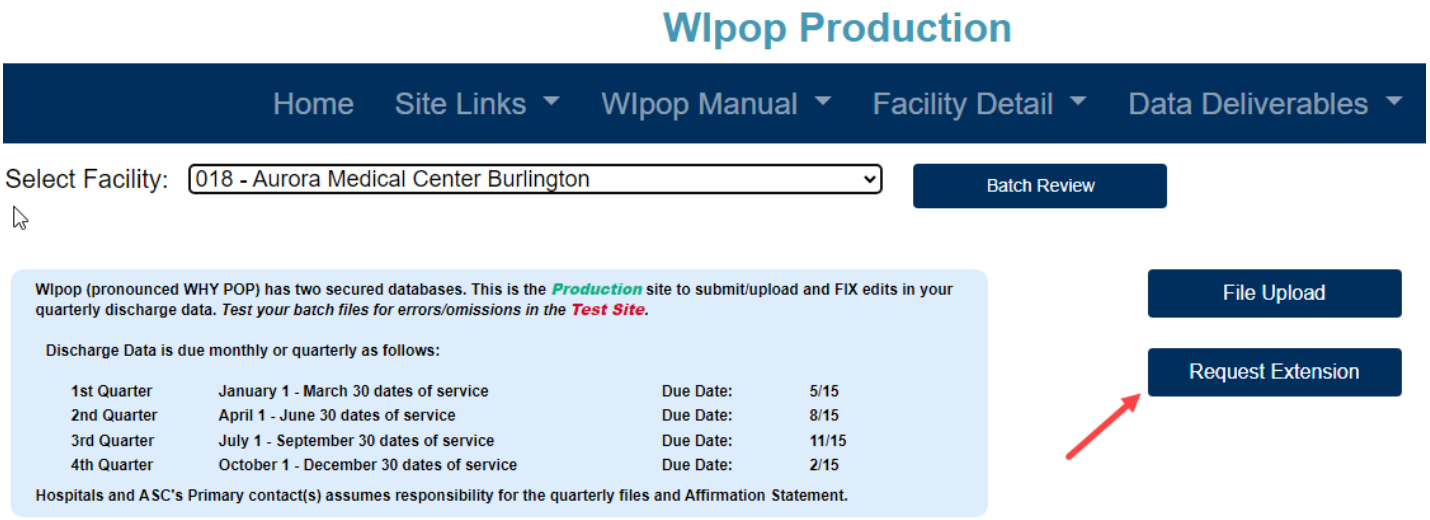
If you need further assistance, please contact us at whainfocenter@wha.org

3.6 Request an Extension

Extension requests may be submitted under specific circumstances such as vendor changes and catastrophic situations (fire, tornado, or flood) that prevent the facility from submitting timely data.

Extension requests must be filed 10 days before the data is due. Data is due 45 days after the close of the quarter. To file for an extension, log into WIpop secured portal and to the right of the Select a Facility, click on the "Request Extension" to begin the process. Once the extension is filed, you will have an extra 20 days to submit the data.

Although a facility may file for an extension, WHAIC may continue to contact the facility to better gauge and understand the situation and when the data will be submitted.



4. SPECIFIC BUSINESS RULES, MAPPING AND LIMITATIONS

General Business Rules for 837 Processes that all facilities are required to follow. These guidelines are intended to facilitate the processing of the file and minimize the number of edits.

The intent of using an 837 claims file is to receive as much detail that goes out on the claim as possible without much mapping intervention from the facility technical side.

> If your vendor or file developer asks what the file type should be, we say the file should look like a claim file format. The file must be structurally correct with loops and segments to meet the 837 standards, meaning our parser will not work if it does not meet the ASC X12 Implementation Guide. We do not have or require file extensions like.txt.

4.1 Unique (Encrypted) Case Identifier (UCID)

As per state statute, WHAIC cannot accept patient names or social security in the data. Facilities must include a 64-character Unique Case Identifier **(UCID)** in their 837 claims file. Its primary purpose is to securely deidentify patients and assist facilities in identifying when a readmission occurs at a different facility than where the original admission or ambulatory surgery occurred. ***Batch Files will be rejected if a patient's name is detected*.**

4.2 Race and Ethnicity

Collection of race and ethnicity is **a state mandate** and required for all data types. WHAIC follows the guidance provided by the OMB and collect based on the minimum requirements. https://wonder.cdc.gov/wonder/help/populations/bridged-race/Directive15.html

In May 1995, the Bureau of Labor Statistics (BLS) sponsored a Supplement on Race and Ethnicity to the Current Population Survey (CPS). The findings were made available in a 1996 report.

We encourage collection and reporting of more than one race as applicable. See **Appendix 7.2** for detailed mapping tables.

4.3 Expected Source of Payment/Payer Mapping

WHAIC requires payer name, claim filing indicator, and Payer ID # if reported on the claim. Details for required payer mapping are located in Appendix 7.3 For example, a commercial payer format is **A##-## – (**SOPID is characters 1-3-SOPTYPE is characters 5-6).

Expected Source of Payment ID (SOPID): The first three characters from the primary payer code (expected to pay the greater share) from the claim file. For example, Wisconsin Medical Assistance (Medicaid) is coded as "T19," and commercial or private insurance payers are a 3-digit alpha number code A## for example A15 = Cigna Insurance.

Expected Source of Payment Type (SOPTYPE): The fourth and fifth characters of the payer code. This field identifies the payer type, for example, HMO/PPO, Workers Compensation = (OTH -41), Self-pay (OTH-61), etc.

Payer ID is expected for Medicare, Medicare Advantage, Medicaid, BadgerCare and Commercial Payers

4.4 Type of Bill (TOB)

WHAIC is statutorily limited by the types of bills (TOB) we can collect and supply in the data sets. The TOBs in the table below **are not to be included in the data**, if provided, an edit will occur. These types of facilities as defined by the State of Wisconsin do not meet the criteria of a "hospital" or "Surgery Center" and must be excluded.

Type of Bill Codes are Required in WIpop. Type of bill (TOB) codes are published in the UB-04 National Uniform Billing Committee guidelines (NUBC). As with most fields on the 837 claims file format, these codes should come directly from the claim that is sent to the payer.

TOB is a four-digit field on the institutional paper claim and in WIpop, but a three-digit field on the EDI 837 Claims File. WHAIC requires a leading zero but will accept the 3-digit code as provided on the 837 claims file format and assign a leading zero in WIpop.

The TOB gives three specific pieces of information after a leading zero. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit indicates the sequence of the bill in any episode of care. It is referred to as a "frequency" code.

Edits applicable to TOB:

1160	Type of Bill is a required field.
3180	Type of Bill does not correspond to accepted values.
3181	Type of Bill 0999 is not allowed for hospitals
3185	Zero charge records require Nonpayment/Zero charge Bill Type
3186	Type of bill must match the record type. Edit 3186 will apply when either of these is true: • The record is inpatient and the type of bill is NOT in the 110-121 range • The record is outpatient and the type of bill is in the 110-121 range

This table displays the TOB codes that **WHAIC cannot statutorily collect** as they are y not allowed in the data.

14X – Hospital – Lab services provided to non-patients. Example – worksite drug testing, contracted lab work.	21X – 23X – Skilled Nursing Inpatient and Outpatient facility. Example, long term care in a nursing home 28X – Skilled Nursing swing bed (ICF and SNF)	34X – Home Health Services NOT under a Plan of Treatment
41X – 43X – Religious Institutions (e.g. Catholic charities)	65X – 66X – Intermediate Care Level I & Level II: Institutional Long Term Care (LTC) for intellectual disability, residential facility services support and specialized training.	71X – Clinic – Rural Health – A certified facility located in a rural medically underserved area that provides primary medical care.
73X – Clinic Freestanding NOT associated with a Hospital as a PBC	77X – Clinic – Federally Qualified Health Center	79X – Clinic – Other
76X – Clinic – Community Mental Health Center	81X – Hospice (non-hospital based) 82X – Hospice (hospital based)	86X – Residential facility – non-hospital based providing therapy for substance abuse, mental or behavioral health illness
089X – Specialty Facility – Other		

4.5 Revenue Codes

Most revenue codes are accepted. WHAIC assigns a Place of Service (POS) to each record based off the revenue codes in the line item claims detail and our own POS Hierarchy. Certain revenue codes such as supplies, patient convenience items, ambulance transports, or other services that do not generate a face-to-face encounter should not be submitted as a stand-alone record. Other records that represent data from facilities that are not considered, by definition, a hospital such as hospice records or straight

nursing home records should be excluded too. The table below represents revenue codes that **are not accepted** when submitted alone (such as the ambulance or supply codes) or in combination with other records such as hospice or professional fees.

054X – Ambulance as a stand-alone record	065X – Hospice records when submitted with a TOB 81X or 82X	096X – 098X Professional Fees when submitted on any record

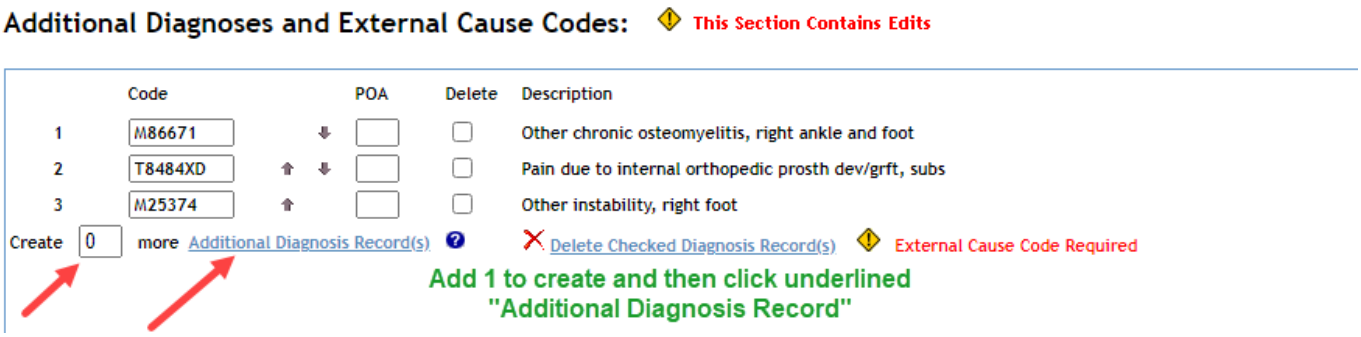
4.6 External Cause of Injury (ECI) Codes

Diagnosis codes in the "S" Injury section and a few of the "T" range of the ICD-10-CM require an external cause diagnosis code in the V through Y range. At least one external cause of injury (ECI) code must be specified when a diagnosis exists as defined in table below.

State Statute dictates the use of external cause codes on inpatient, emergency room, observation, and outpatient surgery records, including FASC. External Cause Codes in the V00-Y99 permits the classification of environmental events and circumstances as the cause of injury, and other adverse effects.

External cause code is required with a diagnosis code in this range:
S00 – S99: Injury, Poisoning, & Certain Other Consequences of External Causes
T07 – Injuries involving multiple body regions.
T20 – T25 Burns and corrosions of external body surface, specified by site.
T26 – T28 – Burns & corrosions confined to eye/internal organs.
T30 – T32 – Burns and corrosions of multiple and unspecified body regions.
T33 – T34 – Frostbite
T69 - Other effects of reduced temperature
To get a code added or removed from the edit list or to fix an edit, contact ccase@wha.org

How to add an additional diagnosis code:



4.7 Language

The primary language of the patient, if collected, should be submitted in the file. Collection of language is useful to data users, policy makers and market researchers to allow analysis of neighborhoods and impact of other social determinants in receiving health care. Much like all other data elements we collect and use, language is another valuable tool data users have asked us to continue to improve upon in the datasets. Just as hospitals and ASCs report race and ethnicity out of the EMR, please be sure to include language in the file as well. See Appendix 7.2.1 for proper file mapping.

- Data Element 837 Field: Loop 2010BA / 2010CA, DMG10 = ZZ (Mutually Defined), DMG11 = Language Code
- Situational field – if collected, report the code. Map according to Language table in WHAIC Manual

ABRV	Language
AFR	African Language(s)
ALB	Albanian
ARA	Arabic
ASI	Asia (Other Asia)
ASL	American Sign Language
BEN	India-Bangladesh
BOS	Bosnian
BUR	Burmese
CHI	Chinese
ENG	English
FRC	French-Creole
FRE	French
GER	German/Deutsch
GRE	Greek
GUJ	India (Gujarati)
HAI	Haitian Creole
HEB	Hebrew
HIN	Hindi
HMO	Hmong
ICE	Icelandic
IND	Indonesian
ITA	Italian
JPN	Japanese
KOR	Korean
LAO	Laos / Laotian
MAN	Mandarin
MON	Mongolian
NA	Unknown or Unavailable
NAV	Navajo
OIE	Other Indo-European
ONA	Other Native - North American
OPI	Other Pacific Island
OTH	Other
OWG	Other West Germanic
PER	Persian
PHI	Philippine
POL	Polish
POR	Portuguese
PUN	Punjabi
ROM	Romanian
RUS	Russian
SCA	Scandanavian
SCC	Serbo-Croatian (Cyrillic)
SER	Serbian
SIG	Sign Language
SPA	Spanish
SWE	Sweedish
TAG	Tagalog
THA	Thai
UNK	Unknown or Unavailable
URD	Urdo (Pakistan & India)
VIE	Vietnamese
YAO	Yao (Hmong-Mien)

5. 837 DATA SUBMISSION AND TECHNICAL REQUIREMENTS

This section provides additional detail about the file submission and specific characteristics about the file and file expectations. Review of this section will help the technical advisor, vendor or developer create the custom 837 claim file and format it according to WHAIC specifications. If you follow these guidelines, the file will process accurately, efficiently and with minimal edits.

> Common question: If your vendor or file developer asks what the file type should be, we say the file should look like a claim file format. The file must be structurally correct with loops and segments to meet the 837 standards, meaning our parser will not work if it does not meet the ASC X12 Implementation Guide. We do not have or require file extensions like.txt.

Specifications of the following HIPAA 5010 inbound transactions:

837I sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837I_Sample-File.pdf

837P sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837P_SampleFile.pdf

837R sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837R-Sample-File.pdf

The 837 WIpop claims file **DO NOT have** file extension requirements.

5.1 Interchange Control Header (ISA06)

WHAIC manages two data submission environments - one for test and one for production, therefore the data submitter is choosing the environment; the use of the ISA15 segment is not necessary or required.

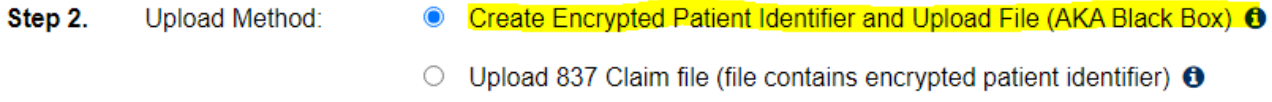
An uploaded 837 file must contain data for only one facility. *The facility number in ISA06, GS02, and NM109 in loop 1000A* must all match the facility number specified when the file is uploaded. In other words, if the user specifies that the uploaded file is for facility 043 (Aurora - Hartford) but the file contains data and field identifiers for facility 124 (Aurora - Sheboygan), the file will be rejected.

5.2 WHAIC 837 File Handler and De-Identification Program

WHAIC does not allow patient names. Users can upload through the WIpop File Handler system. WIpop submitters can upload the file(s) with patient names directly through the WIpop application system. The functionality is embedded in the system to replace and discard the patient's name to create the UCID. This program executes a Windows console program which resides behind the scenes to remove names. Alternatively, facilities may create their own program to replace patients' names with a 64-character Unique Case Identifier (**UCID**) in their 837 claims file using a custom methodology. The UCID employs a name standardization algorithm (New York State Identification and Intelligence System) and then hashes the result to produce a 64-character ID – please contact WHAIC if this is the chosen method

The primary purpose of the UCID is to assist facilities in identifying when a readmission occurs at a different facility from where the original admission or ambulatory surgery occurred. In addition, to preserve historical trends, Batch Files will be rejected if a patient name is detected.

In order to create the 64-character UCID and scrub the patient names from the file, the user must select the first option in the WIpop File Upload page: This option first creates the UCID and scrubs the names, then uploads the file to our system



5.3 Delimiters in the Segment of the file

A delimiter is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data. Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered implementation compliant with this guide to be a 105 byte fixed length record, followed by a segment terminator.

- the data element separator is byte number 4;
- the repetition separator is byte number 83;
- the component element separator is byte number 105; and,
- the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown below in Delimiters Table, in all examples of the EDI transmissions.

File Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

5.4 Special Characters in the Claims Data

The use of the following special characters should be used within the claim data as defined below.

Period	Dash	Colon
.	-	:
Ex: Charges 111.11	**Ex:** source of payment, ex. AAA-01 Ex: Element format is **UCID** UCID is characters 1 – 64	Ex: Race:Ethnicity DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3

5.5 Mapping Rules and 837 File Specifications

This section addresses a variety of issues that will facilitate the 837 Claims Submission Process. Only the sections and segments that are required or situational **and apply** to the WHAIC data collection requirements, or that are different from the ANSI 837 Guide sections are written in this manual.

The file must be structurally correct with loops and segments to meet the 837 standards, meaning our parser will not work if it does not meet the ASC X12 Implementation Guide.

Fields marked Situational **does not** mean optional. For example, Attending NPI is required on inpatient records, but the field says situational because it is not required on outpatient records.

- Only loops, segments, and data elements valid for the HIPAA 837I (005010X223A2), 837P (005010X222A1) and 837R (005010X225A2) will be translated. Deviating from the Technical Report Guidelines and submitting invalid data will cause the file/batch to reject.
- Uploaded files are not limited in total size, but a single transaction (ST – SE envelope) can have no more than 5,000 CLM segments or 10 million characters. Files exceeding either limit will be rejected.
- WIpop max upload size is 100 megabytes. Files larger than 100 megabytes need to split it.

When a HIPAA compliant ANSI 837 Institutional or Reporting formatted file with the additional required fields, including all mapped fields listed below, is submitted the data file should pass the WIpop Edits. Data elements listed as "Situational" or "Not Used" in the ANSI 837 Institutional Guide but REQUIRED by WHAIC are listed below.

WHAIC file and technical support is available Monday through Friday, 8:00 a.m. to 4:00 p.m. The system is available to collect and accept data from submitters seven (7) days a week, twenty-four (24) hours a day. The secure electronic system for notification is available seven (7) days a week, twenty-four (24) hours a day to the Submitter for retrieval of information.

If you cannot find the answers to your questions within this manual, FAQ, or other available resources, please use the contact information below. All file issues will be addressed during normal business hours within 24-48 hours.

Cindy Case Director, Data Management & Integrity ccase@wha.org whainfocenter@wha.org All things WIpop or file submission related.	Justin Flory Health Care Data Programmer 837 Technical and File related. jflory@wha.org whainfocenter@wha.org	Heather Scambler Program Specialist hscambler@wha.org whainfocenter@wha.org General WIpop or redirected questions.

5.6 **837I** (Hospital) Institutional Claims Data Specifications

837I Crosswalk and WIpop Map - Summary Table of required elements

Uploaded files are not limited in total size, but a single transaction (ST – SE envelope) can have no more than 5,000 CLM segments or 10 million characters. Files exceeding either limit will be rejected.

This document notes only the loops and elements relevant to WHAIC data collection specifications as defined by the State Statute. It is not intended to serve as a complete 837 reference, and not all requirements for a valid 837 file are specified. Elements not mentioned in this document will be discarded by WHAIC prior to the file processing in WIpop, if supplied.

Fields defined, created, or updated in WIpop by WHAIC from the 837 claims file.

Patient Type (`1' Inpatient & `2' outpatient)	Place of Service (Blank if INP)	Principal Procedure on OP Records
Principal Procedure Date	Additional Procedures	
Principal Procedure Modifier(s)	Additional Procedure Modifier(s)	Leave of Absence Days

Legend

Name	Data Edit/ Name	Description
R	Required	Data Element Must be Submitted for the data type and must not be blank
S	Situational	Required based upon values in the claim/EMR or other elements
O	Optional	This element is not required and may be left blank, however, if submitted, it will be edited.

Gray shade	WIpop Field Notes	Data is not stored, but may be sent, and may or may not be used to route data in WIpop.

837I sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837I_Sample-File.pdf

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
0000	ISA06	Interchange Sender ID (3 digit)	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Facility ID - Appendix 7.1 Facility List	Must match GS02 & 1000A/NM109
	ISA08	Receiver ID	O	Submitter choice: leave blank or use WHAIC837	Optional field
	GS02	Application Sender's Code	O	Use 3-digit Facility ID assigned by WHAIC. See Appendix 7.1 Facility List Example: Osceola Medical Center is '102' WHAIC Facility ID	ISA06, GS02 and 1000A/NM109 must match.
	GS03	Application Receiver's Code	O	Submitter choice: leave blank or use WHAIC837	Optional field
0000	ST03	Implementation Guide Version	R	005010X223A2	Required but not stored
LOOP ID 1000A/B and 2010AA Submitter and Billing (HOSPITAL / ASC) Detail **LOOP 1000A: SUBMITTER NAME** **NM1*41*2*SAMPLE HOSPITAL*****46*333~** **PER*IC*SUBMITTER NAME*TE*6142222222~** **LOOP 1000B: RECEIVER NAME** **NM1*40*2*WHAIC*****46*WHAIC 837~**					
1000A	NM101	Entity ID code	O	41 = Submitter	
1000A	NM102	Entity Type Qualifier	R	"2" – non-person entity	
1000A	NM103	Organization Name	O	Vendor name, Hospital or ASC name	
1000A	NM108	Identification Code Qualifier	R	46	

1000A	NM109	Identification Code of Submitter	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Facility ID - Appendix 7.1 Facility List	ISA06, GS02 and 1000A/NM109 must match.
1000B	NM101	Entity ID code	O	40 = Receiver	
1000B	NM103	Receiver Name – WHAIC	O	**Use WHAIC** – This identifies WHAIC as receiver	
1000B	NM109	Receiver (WHAIC) Primary Identifier	O	WHAIC 837	
2010AA	NM101	Billing/Service Provider Identifier code	R	85 = Billing Provider	
2010AA	NM108	Billing Entity ID Qualifier	R	"XX"	
2010AA	NM109	Billing Entity ID Code	R	Use Facility NPI Number (Billing Provider NPI) WHAIC has on File.	**To avoid edits, notify WHAIC of all subpart NPI's to update our tables.**
Patient and/or Subscriber Detail: **Patient Detail Required when the patient *is different* from the Subscriber.** **If not required by this Implementation Guide, do not send.** **DO NOT SEND 2010CA *IF* PATIENT IS SUBSCRIBER**					
Patient / Subscriber details cannot be determined until processing of UCID occurs – Use of Windows Program may be required					
Required v. Situational *depends on* if the patient is the subscriber. **LOOP 2000B: SUBSCRIBER HIERARCHICAL LEVEL** **HL*2*1*22*1~** **SBR*P**CERTNUM2222SJ~** **LOOP 2010BA: SUBSCRIBER NAME** **NM1*IL*1*NULL*****MI*3CFD1B33ACBD5475CE36D8C439FEC42475B9ADBEC7B91A6926DACF0F45BE269F-S530J~** **N3*236 N MAIN ST~** **N4*MADISON*WI*53717~** **DMG*D8*19830501*F*M*5:2~** **DO NOT SEND 2010CA *IF* PATIENT IS SUBSCRIBER**					
2000B	SBR03	Policy Number – Insurance SBR03 is Policy, Group Number, Member ID, Certificate Number.	R/S	Send "NULL" if Self-pay The term policy number or group number is synonymous with insurance ID, member ID, insurance code, Plan number, etc. *any number on the card or in the file that identifies the patient to the carrier.* *SEE FAQ – for more info	Self-pay is required. Do not default to all zeroes. NULL is necessary because that element is required in the 837 spec, and we are trying to conform to the

					rules as much as we can.
2000B	SBR09	Claim Filing Indicator Code	S	Code identifying type of claim.	See Appendix 7.3.1 for codes
2010BA	NM103	Subscriber Last Name	R/S	Subscriber names are not accepted. Send "NULL." NM104 – NM107 must be blank.	Patient Detail Required when the patient *is different* from the Subscriber.
2010CA	NM103	Patient Last Name	R/S	Patient names are not accepted. Send "NULL." NM104 – NM107 must be blank.	Send "NULL." NM104 – NM107 must be blank.
2010BA	NM109	Subscriber UCID	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Element format is **UCID** UCID is characters 1 – 64	This field is to encrypt the patient and/or subscriber name. Provide Patient UCID if different from subscriber.
2010CA	NM109	Patient UCID	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 UCID is characters 1 – 64	This field is to be used for encrypting the patient and/or subscriber name. Provide Patient UCID if different from subscriber.
2010BA	N301	Subscriber Address 1	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Address, City, State and Zip will be used to find the patient's census block group. The block group, but not the address, will be saved in WIpop. Physical address discarded.	Census Block Group - the block group number processes on the edge server over a period of 12-24 hours before available in WIpop. Files rejected if >10% missing address.
2010CA	N301	Patient Address 1	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 Address, City, State and Zip will be used to find the patient's census block group. The block group, but not the address, will be saved in WIpop.	Census Block Group - the block group number processes on the edge server over a period of 12-24 hours before available in WIpop. Files

				Physical address is discarded.	rejected if >10% missing address.
2010BA	N302	Subscriber Address Line 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N302	Patient Address Line 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N401	Subscriber City	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	*File rejected if > 10% of records missing address
2010CA	N401	Patient City	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	*File rejected if > 10% of records missing address
2010BA	N402	Subscriber State	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N402	Patient State	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N403	Subscriber Zip code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Zip Code Stored in WIpop
2010CA	N403	Patient Zip Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Zip Code stored in WIpop
2010BA	DMG02	Subscriber Birth Date	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Birth Date
2010CA	DMG02	Patient Birth Date	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Birth Date
2010BA	DMG03	Subscriber Gender / Sex Code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	F, M, U (U or O requires Cond Code 45)
2010CA	DMG03	Patient Gender / Sex Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	F, M, U (U or O requires Cond Code 45)
2010BA	DMG04	Marital Status Code	O	Loop 2010BA, NM101 = IL	Marital Status optional field,

				Loop 2010BA, NM102 = 1	supply if collected.
2010CA	DMG04	Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Marital Status optional - supply if collected.
2010BA	DMG05-1	Subscriber Race Code1 See Appendix 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 For each entry: DMG05-1: Leave empty DMG05-2: Value is RET (race or ethnicity) DMG05-3: Two-character value. The first character is either R (race) or E (ethnicity). The second character is the race or ethnicity code. DMG*D8*19830501*F*M*:RET:R3^:RET:E1~	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2. The first entry for ethnicity will be used for field ETHN.
2010CA	DMG05-1	Patient Race Code1 See Appendix 2 10/1/2024 – file has been updated to accept the additional main and subcategory codes. Example:	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 For each entry: DMG05-1: Leave empty DMG05-2: Value is RET (race or ethnicity) DMG05-3: Two-character value. The first character is either R (race) or E (ethnicity). The second character is the race or ethnicity code. DMG*D8*19830501*F*M*:RET:R3^:RET:E1~	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2. The first entry for ethnicity will be used for field ETHN.
2010BA	DMG05-2	Subscriber Ethnicity Code See Appendix 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 (Valid through 12/31/25)	File rejected if >25% of records = declined/unkwn
2010CA	DMG05-2	Patient Ethnicity Code See Appendix 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	File rejected if >25% of records = declined/unkwn

2010BA	DMG05-3	Subscriber Race 2	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Report only if more than one race is collected.
2010CA	DMG05-3	Patient Race 2	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Report only if more than one race is collected.
2010BA	DMG10	Subscriber Language Qualifier	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 ZZ – Mutually Defined DMG 10 = ZZ	Primary Language collected from patient. New field Q32019
2010CA	DMG10	Patient Language Qualifier	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 ZZ = Mutually Defined DMG 10 = ZZ	Primary language collected from patient. New field Q32019
2010BA	DMG11	Subscriber Language Code	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	New Field Q319 See Appendix 7.3.1 for Code List Mapping
2010CA	DMG11	Patient Language Code	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	New Field Q319 See Appendix 7.3.1 for Code List Mapping.
LOOP ID - 2010BB Payer Detail **LOOP 2010BB: PAYER NAME** **NM1*PR*1*Aetna*****PI*A10-09~** **REF*NF*60054**					
2010BB	NM101	Payer Entity ID Code	R	PR = Payer	
2010BB	NM102	Entity Type Qualifier	O	1 = Non-Person Entity *NM102 qualifies NM103	Discarded
2010BB	NM103	Payer Name	R/S	Name of Payer Organization as provided on the claim.	
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code	R	WHAIC Values in Appendix 7.3 Element format is **AAA-99;** Example A21-09	SOPID is characters 1-3 -

		*Self-pay requires OTH-61		Primary Source of Payment ID	SOPTYPE is characters 5-6 The dash is preferred, but not required
2010BB	REF01	REF ID Qualifier for Payer/NAIC#	S	NF	Payer Identifier in the EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer ID	S	Enter the Value of the Payer ID. This value is found on the patient's insurance ID card. This value directs the claim to the correct payer or plan type (commercial, Medicare, ACA plan, etc.)	Refer to Appendix 7.3.2 for additional info.
LOOP 2300: CLAIM INFORMATION **CLM*PCTRL535*2500.50***11:A:1**A*Y*Y~** **DTP*096*DT*201702032359~** **DTP*434*RD8*20170202-20170203~** **DTP*435*DT*201702022359~** **CL1*2*1*20~** **REF*LU*MN~** **REF*EA*MRN123~** **HI*ABK:G9782::::::Y~** **HI*ABJ:G9389~** **HI*APR:G9389*APR:N179~** **HI*ABF:A4152::::::::N*ABF:G918::::::::Y*ABF:N179::::::::Y*ABF:B370::::::::N~**					
2300	CLM01	Patient Control Number	R	Use Patient Control Number *File rejected for Duplicate Patient control numbers. IF response email indicates duplicates are found, resubmit file with this phrase anywhere in the file name: exclude_duplicates	PCONTROL or PCTRL Do not use special characters <>
2300	CLM02	Total Claim Charge	R	Total Charges in SV2 must match this number. The total amount of all submitted charges of service for this claim. ****Exclude Professional fees****	Total charges from revenue line-item details must match claim detail in WIpop
2300	CLM05-1	Type of Bill – Facility Type Code	R	WHAIC mapping required: Appendix 7.4 TOB Exclusions and special mapping apply.	Leading zero not required in 837 claims file.
2300	CLM05-02	Facility Code Qualifier	O	A – Uniform Billing Claim Form Bill Type	Ignored in the WIpop data

2300	CLM05-3	Type of Bill – Claim Frequency Code	R	WHAIC Exclusions Apply: Appendix 7.4 TOB Do not send values from 5-9 or alpha characters "1" – Admit through Discharge claim includes bills representing total confinement or course of tx. "2" - indicates Interim – first claim "3" – indicates interim – continuing claim "4" – indicates interim – Last Claim – used for the last of a series of bills, for the same confinement or course of treatment. Claim Frequency Code '0' must be used on non-payment zero charge claims.	Ex: 131 1 (hospital) 3 (outpatient) 1 (admit/discharge claim) Claim Frequency Code '0' must be used on non-payment zero charge claims.
2300	DTP01	Discharge Date Qualifier	S	096	
2300	DTP02	Discharge Date Format Qualifier	S	DT	
2300	DTP03	Discharge Date/ Time	S	CCYYMMDDHHMM DDAT is first 8 characters DTIME is last 4 characters Required on INP and ED records only *Cannot provide Admission date w/o discharge date.	Discharge Date required for INP & ED. Discharge Time required for INP May be provided on other record types.
2300	DTP01	Statement Dates Qualifier	R	434	
2300	DTP02	Statement Date / Time Format Qualifier	R	RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Use RD8 (range of dates) to indicate the "from and through (To)" date of the statement. When the statement is for a single date of service, the 'from and through' date are the same.	Required on Outpatient Records / Encounters. Edits will occur if discharge dates are different than Revenue DOS.
2300	DTP03	Statement From and Through (To) Dates	S	CCYYMMDD–CCYYMMDD STPERODF is first 8 characters STPERODT is last 8 characters	**Required** = **Outpatient** (observation, lab/rad therapies, etc.)

2300	DTP01	Admission Date / Time Qualifier	S	435 Required on Inpatient and Emergency Dept. Only	May be provided on other record types. Cannot provide Admission date w/o discharge date.
2300	DTP02	Admission Time Period	S	DT Required on Inpatient	ER records can use 12:00 if not collected
2300	DTP03	Admission Date and Hour	S	CCYYMMDDHHMM ADAT is first 8 characters ADMTIME is last 4 characters Admission Date Required on Inpatient and ER/ED claims.	WIpop: Admission Date/Time **Admission Time** – Req on INP but would like on ER/ED too.
2300	CL101	Priority (Type) of Admission or Visit / Admission Type Code	R	National Uniform Billing Codes *Required - Inpatient and Outpatient (ED, OBS, OPS)	WIpop: Admit Type *New Edit Q22020
2300	CL102	Point of Origin for Admission or Visit	R	NUBC Codes – Required on all Bill Types except 014X See Appendix 7.7	WIpop: Point of Origin See Appendix 7.7
2300	CL103	Discharge (Patient) Status	R	Per NUBC: Required on all institutional claims.	WIpop: Discharge Status See Appendix 7.8
2300	REF01	Auto Accident State Qualifier	S	LU = Location Number	
2300	REF02	Auto Accident State	S	Use valid 2- digit U.S. State code	Accident State – where the accident occurred.
2300	REF01	Ref ID qualifier for MRN	O	EA	
2300	REF02	Medical Record Number	R	MRN Number	WIpop: MRN (WHAIC cannot locate record using MRN)
2300	HI01-1	Principal Diagnosis Qualifier	R	ABK	

2300	HI01-2	Principal ICD-10 Diagnosis Code	R	ICD-10 Code Do not use the decimal point	Follow correct coding guidelines.
2300	HI01-9	Present on Admission (POA)	S	Y, N, U, W – **INP ONLY** Leave blank for exempt – per CMS.	WIpop: Principal Diagnosis POA. For a list of exempt codes: CDC.gov
2300	HI01-1	Admitting Diagnosis *Qualifier*	S	ABJ	
2300	HI01-2	Admitting Diagnosis ICD-10 Code	R/S	ICD-10 Code R= Inpatient ONLY	WIpop: Admitting Diagnosis
2300	HI01-1	Reason for Visit *Qualifier*	R/S	APR R = Outpatient Only	
2300	HI01-2	Reason for Visit ICD-10	R/S	ICD diagnosis codes, describing the patient's stated reason for visit at the time of outpatient registration. R = Outpatient Required on TOB 013X, 078X, and 085X when: type of admission or visit codes 1, 2 or 5 are reported; and Rev codes 045X, 0516, 0526 or 0762 are reported.	At least one Reason for Visit Diagnosis code is required on OP records R = Outpatient Only
2300	HI02-1	Reason for Visit Qualifier	S	APR	
2300	HI02-2	Reason for Visit ICD-10	S	ICD-10 Code R = Outpatient if applicable and coded.	Reason for Visit Diagnosis 2 – required on OP records if documented.
2300	HI03-1	Reason for Visit Qualifier	S	APR	
2300	HI03-2	Reason for Visit ICD-10	S	ICD-10 Code R = Outpatient if applicable and coded.	Reason for Visit Diagnosis 3 – required if coded.
2300	HI0X-1	Other Diagnosis Code Qualifier	S	ABF	
2300	HI0X-2	Other Diagnosis Codes – ICD-10	S	ICD-10 Codes *Additional Diagnosis in WIpop	Additional DIAGNOSIS and External Cause Codes
2300	HI0X-9	Other Diagnosis - Present on Admission Indicator	S	Y, N, U, W – INP only	Additional Diagnosis and

				Leave blank for exempt – per CMS	External Cause Codes
2300	HI0X-1	External Cause of Injury Qualifier	S	ABN	
2300	HI0X-2	External Cause of Injury ICD-10 Codes	S	***Required on ICD-10 Codes in the S range*** and some in the T range – See 5.1.6 for more information. Applies only to INP, ED, OPS and OBS records.	Additional Diagnosis and External Cause Codes
2300	HI0X-9	External Cause Present on Admission	S	Y, N, U, W – INP only	Additional Diagnosis and External Cause Codes
2300	HI01-1	Principal Procedure Qualifier	S	BBR for ICD-10 Procedure Codes	
2300	HI01-2	Principal Procedure Code	S	**ICD-10 Procedure codes for inpatient stays.** No decimal point. ***Do Not Hard Code CPT/HCPCS into this field.***	WHAIC populates Principal procedure code based on Rev. Code line-item detail & coding guidelines.
2300	HI01-3	Principal procedure Date qualifier	S	D8	
2300	HI01-4	Principal procedure Date	S	CCYYMMDD – Required when a Principal Procedure is provided on INP records.	WHAIC populates Principal Procedure Date.
2300	HI0**X**-1	Additional / Other Procedure Code Qualifier	S	BBQ – ICD-10 Procedure codes verify with addenda	
2300	HI0**X**-2	Additional Procedure Codes	S	ICD-10 Procedure codes for inpatient stays **Facility File will only have INP procedure codes** per NUBC – UB-04 Official Coding Guidelines	WHAIC populates fields for additional procedures as applicable from CPT/HCPCS in revenue section.
2300	HI0**X**-3	Additional/Other Procedure Dates	S	D8	
2300	HI0**X**-4	Additional/Other Procedure Date	S	CCYYMMDD Facility File will only have INP procedure dates.	For Outpatient, additional procedure DATE – populated by WHAIC.

2300	HI0X-1	Occurrence Span Qualifier	S	BI	
2300	HI0X-2	Occurrence Span Code	S	Occurrence Code 1-4: NUBC Billing Codes	WHAIC will record the first 4 occurrence codes, others will be discarded.
2300	HI0X-3	Occurrence Span Code Date Qualifier	S	RD8	
2300	HI0X-4	Occurrence Span Code Range of Dates	S	CCYYMMDD-CCYYMMDD OCCSTART is first 8 characters OCCEND is last 8 characters	Occurrence Code 1 Start / End. Follow 837 file layout
2300	HI0X-1	Occurrence Code Qualifier	S	BH	
2300	HI0X-2	Occurrence Code – Industry Standard	S	NUBC Uniform Billing Codes UB-04	
2300	HI0X-3	Occurrence Code Date Qualifier	S	D8 (meaning one date)	
2300	HI0X-4	Occurrence Code Date	S	CCYYMMDD OCCSTART and OCCEND set to same value	WHAIC will record the first 4 occurrence codes/dates, others will be discarded.
2300	HI0X-1	Value Code Qualifier	S	BE	
2300	HI0X-2	Value Code – Industry Standard	S	NUBC Uniform Billing Codes UB-04 The first 4 value codes will be saved in WIpop	WHAIC will record the first 4 Value Codes, others will be discarded.
2300	HI0X-5	Value Code Amount	S	No decimals Value Code Amounts 1 thru 4 recorded.	WHAIC will record the first 4 Value code amounts, others will be discarded.
2300	HI0**X**-1	Condition Code Qualifier	S	BG	
2300	HI0X-2	Condition Code	S	NUBC Billing Codes The first 4 condition codes will be saved in WIpop	WHAIC will record the first 4 Condition Codes.

LOOP ID 2310 (A – F) PROVIDER Information LOOP 2310A: ATTENDING PHYSICIAN NAME NM1*71*1*ATTENDING*****XX*9876543210~ LOOP 2310B: OPERATING PHYSICIAN NAME NM1*72*1*OPERATING*****XX*9876543211~					
2310A	NM101	Attending ID Code	S	71 = Attending Physician/Provider	
2310A	NM108	Attending Provider ID Qualifier	S	XX = NPI	
2310A	NM109	Attending Provider ID NPI	S	Use Attending Provider NPI Number Provider = Any Qualified Health Care Provider NPI –	WIpop: Attending NPI Required on INP and ED – edits will occur if provided on other data.
2310B	NM101	Operating Entity ID Code	S	72 = Operating Provider	
2310B	NM108	Operating ID Code Qualifier	S	XX = NPI	
2310B	NM109	Operating Provider NPI Number	S	Use Operating Provider NPI Number Required on Outpatient Surgery (OPS)	WIpop: Operating NPI *ASCs that only populate rendering NPI will auto copy to Operating NPI
2310C	NM101	Other Operating Code Qualifier	S	ZZ = Other Operating Provider	
2310C	NM108	Other Operating ID Qualifier	S	XX = NPI	
2310C	NM109	Other Operating Provider NPI	S	Use Other Operating provider NPI Number	WIpop: Other Operating NPI – secondary provider.
2310D	NM101	Rendering ID code	S	82 = Rendering Provider	
2310D	NM108	Rendering ID Code Qualifier	S	XX = NPI	
2310D	NM109	Rendering Provider NPI number	S	Use Rendering Provider NPI number	Often used on the 837P
2310E	NM101	Service Facility Location Identifier	S	77 = Service Facility Location	Off-campus hospitals & facilities that

				*** applies to Hospitals that have off-campus hospitals and outpatient facilities that share the same Medicare number as the main hospital***	share the same Medicare # must report ALL services with Location ID.
2310E	NM108	Service Facility Location Qualifier	S	PI = Provider ID	
2310E	NM109	Service Facility Location Value	S	Service Facility/Provider Based Location (PBL) ID value as provided by WHAIC. Also referred to as provider-based clinic.	Service Facility Location ID / PBL ID assigned by WHA.
2310F	NM101	Referring Provider Qualifier	S	DN = Referring Provider	
2310F	NM108	Referring Provider ID Code Qualifier	S	XX = NPI	
2310F	NM109	Referring Provider NPI	S	Use Referring Provider NPI ***This is not the billing provider – sometimes PCP***	The individual who directed the patient for care to the provider that rendered the services.
LOOP ID – 2320 / 2330B OTHER SUBSCRIBER INFORMATION FOR SECONDARY PAYER Required if applicable					
2320	SBR01	Payer Responsibility Sequence Code	R/S	S = Secondary Include only if secondary payer applies	
2330B	NM101	Entity ID code	R/S	PR = Payer	
2330B	NM108	Payer Identifier Qualifier	S	PI = Payer ID	
2330B	NM109	Payer Identifier Code	S	Mapping required: Secondary Source of Payment ID: Format is **A##-99** SOPID2 is characters 1-3 - SOPTYPE2 is characters 5-6	Source of payment requires mapping. WHAIC Values in Appendix 7.3
LOOP ID – 2400 SERVICE LINE DETAIL **LOOP 2400: SERVICE LINE NUMBER** **LX*1~** **SV2*0119**2000*DA*2~**					

DTP*472*D8*20170202~					
2400	SV201	Revenue Code	R	NUBC Billing Codes Some reporting exclusions apply .	Revenue CODE
2400	SV202-1	CPT/HCPCS Qualifier	R	HC (HCPCS) or HP (HIPPS)	
2400	SV202-2	CPT / HCPCS Procedure Code codes	R	CPT Codes (AMA) or HCPCS (CMS) required on OP claims if required by uniform billing standards.	CPT/HCPCS code *NO limit in WIpop.
2400	SV202-3	Procedure Modifier 1	S	Modifier 1 CPT/HCPCS	CPT/HCPCS
2400	SV202-4	Procedure Modifier 2	S	Modifier 2 CPT/HCPCS	CPT/HCPCS
2400	SV202-5	Procedure Modifier 3	S	Modifier 3 CPT/HCPCS	CPT/HCPCS
2400	SV202-6	Procedure Modifier 4	S	Modifier 4 CPT/HCPCS	CPT/HCPCS
2400	SV203	Monetary amount - Revenue Code Charge – Line-Item Charge Amount	R	Line-Item Charge Amount – Zero 0$ is a valid amount	Charge
2400	SV204	Unit or Basis for Measurement Code	R	DA = Days UN = Units	
2400	SV205	Service Unit Count	R	Quantity – positive whole numbers	UNITS
2400	DTP01	Service Date Qualifier	S	472	
2400	DTP02	Service Date Qualifier	S	D8 – one date is acceptable	
2400	DTP03	Service Date on Revenue Line Item	S	CCYYMMDD	SERVICE DATE

5.7 837P (ASC) Professional Claim Submissions - Freestanding ASC (FASC)

This section provides additional detail about the file submission and specific characteristics about the file and file expectations. Review of this section will help the technical advisor, vendor or developer create the custom 837 claim file and format it according to WHAIC specifications. If you follow these guidelines, the file will process accurately, efficiently and with minimal edits.

Although this manual is intended to serve ASCs, some ASCs prefer to program the file using the 837I or 837R format, see the full hospital manual for those details. This document references the 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1)

837P sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837P_SampleFile.pdf

The 837 WIpop claims file **does NOT have** file extension requirements.

○ INTERCHANGE CONTROL HEADER (ISA06)

WHAIC manages two data submission environments - one for test and one for production, therefore the data submitter is choosing the environment; the use of the ISA15 segment is not necessary or required.

An uploaded 837 file must contain data for only one facility. The facility number in ISA06, GS02, and NM109 in loop 1000A must all match the facility number specified when the file is uploaded. In other words, if the user specifies that the uploaded file is for facility 043 (Aurora - Hartford) but the file contains data and field identifiers for facility 124 (Aurora - Sheboygan), the file will be rejected.

○ DELIMITERS IN THE SEGMENT OF THE FILE

A delimiter is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data. Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered implementation compliant with this guide to be a 105-byte fixed length record, followed by a segment terminator.

- the data element separator is byte number 4;
- the repetition separator is byte number 83;
- the component element separator is byte number 105; and,
- the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown below in Delimiters Table, in all examples of the EDI transmissions.

File Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

The use of the following special characters should be used within the claim data as defined below.

Period	Dash	Colon
.	-	:
Ex: Charges 111.11	**Ex:** source of payment, ex. AAA-01	Ex: Race:Ethnicity DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3

○ 837P (ASC) PROFESSIONAL CLAIM SUBMISSIONS - ASCS

This section applies to freestanding ambulatory surgery centers (FASC/ASCs), with a three-digit ID in the range of 200 or 400 Appendix 7.1. FASCs are required to submit selected items or aggregation of items on all ambulatory surgeries, **including records of self-pay patients.** Most of these items are located on the National Uniform Claims Committee (NUCC) or CMS-1500 claim form.

This document notes the loops and elements relevant to WHAIC Data Collection. It is not intended to serve as a complete 837 reference, not all requirements for a valid 837 file are specified. *See the main 837 Companion Guide and Tech Specifications Manual (Hospital Manual) for the 837I and 837R specs.*

Fields defined, created, or added by WHAIC from the 837 claims file

Patient Type (outpatient surgery)	Type of Encounter (Outpatient = 2)	Place of Service = 1
Principal Procedure on OP Records	Principal Procedure Date	Additional Procedures on OPS records
Principal Procedure Modifier(s)	Additional Procedure Modifier(s)	

Legend

Name	Field	Description
R	Required	Data Element Must be Submitted for the data type and must not be blank.
S	Situational	Required based upon values in the claim/EMR or other elements.
O	Optional	This element is not required and may be left blank, however, if submitted, it will be edited.
Gray shade	Blank	data is not stored, but may be sent, and may or may not be used to route data in WIpop

837P Crosswalk and WIpop Map - Summary Table of required elements

Additional Elements supplied and not mentioned in this document will be discarded by WHAIC prior to processing.

837 Professional Health Care Claim – ASC X12N 837 (005010X222A1) | Download Sample 837 P File

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
0000	ISA06	Interchange Sender ID (3 digit)	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match GS02 & 1000A/NM109
	ISA08	Receiver ID	O	Submitter choice: leave blank or use WHAIC837	
	GS02	Application Sender's Code	O	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match ISA06 & 1000A/NM109
	GS03	Application Receiver's Code	O	Submitter choice: leave blank or use WHAIC837	
0000	ST03	Implementation Guide Version	R	005010X222A1	Req but not stored.
LOOP ID 1000A/B and 2010AA Submitter and Billing (HOSPITAL / ASC) Detail LOOP 2010AA: BILLING PROVIDER NAME NM1*85*2*SAMPLE HOSPITAL PROVID*11****XX*9876543210~ N3*236 N MAIN ST~ N4*MADISON*WI*53717~ REF*EI*11-12345678~					
1000A	NM101	Entity ID code	O	41 = Submitter	
1000A	NM102	Entity Type Qualifier	R	"2" – non-person entity	
1000A	NM103	Organization Name	O	ASC name	
1000A	NM108	Identification Code Qualifier	R	46	
1000A	NM109	Identification Code of Submitter	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match ISA06 & GS02

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
1000B	NM101	Entity ID code	O	40 = Receiver	
1000B	NM103	Receiver Name – WHAIC	O	Use WHAIC – identifies WHAIC as receiver	
1000B	NM109	Receiver (WHAIC) Primary Identifier	O	WHAIC 837	
2010AA	NM101	Billing/Service Provider Identifier code	R	85 = Billing Provider	
2010AA	NM108	Billing Entity ID Qualifier	R	"XX"	
2010AA	NM109	Billing Entity ID Code	R	Use Facility Billing NPI Number	Facility NPI number used to bill claims.
Patient/Subscriber Detail: Patient Detail Required when the patient is different from the Subscriber. ***If not required by this Implementation Guide, do not send.***					
Patient / Subscriber details cannot be determined until processing of UCID occurs – prior to submission					
LOOP 2000B: SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*1~ SBR*P**CERTNUM2222SJ~ LOOP 2010BA: SUBSCRIBER NAME NM1*IL*1*NULL*****MI*3CFD1B33ACBD5475CE36D8C439FEC42475B9ADBEC7B91A6926DACF0F45BE269F-S530J~ N3*123 OAK ST~ N4*MADISON*WI*53719~ DMG*D8*19830501*F*M*5:2~				**DO NOT SEND 2010CA IF PATIENT IS SUBSCRIBER**	
2000B	SBR03	Policy Number – Insurance SBR03 is Policy or Group Number	R	Send "NULL" if Self-pay Other terms: Policy #, Member ID, Insurance Card #, Group Number, certificate number.	Insurance Cert # - can only be NULL or blank for self-pay
2000B	SBR09	Claim Filing Indicator Code	S	Code identifying type of claim.	See Appendix 7.3.1 for list of codes associated with primary payer.
2010BA	NM103	Subscriber Last Name	R	Subscriber names are not accepted. Send "NULL." NM104 – NM107 must be blank.	Patient Detail Required when the patient *is different* from the Subscriber
2010CA	NM103	Patient Last Name	R	Patient names are not accepted. Send "NULL." NM104 – NM107 must be blank.	Send "NULL." NM104 – NM107 must be blank.
2010BA	NM109	Subscriber UCID	R	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Element format is **UCID** UCID is characters 1 – 64	This field is used for encrypting the patient and/or subscriber name. Provide Patient UCID if different from subscriber.
2010CA	NM109	Patient UCID	R	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 Element format is **UCID** UCID is characters 1 – 64	This field is used for encrypting the patient and/or subscriber name. Provide Patient UCID if different from subscriber.

2010BA	N301	Subscriber Address 1	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Address, City, State and Zip will be used to find the patient's census block group. **The block group**, but **not the address, will be saved** in WIpop. *File rejected if more than 10% of records missing address	Census Block Group -Typically, the block group number populates in WIpop during overnight processing. Files rejected if >10% missing address.
2010CA	N301	Patient Address 1	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 *File rejected if more than 10% of records missing address	Census Block Group -Typically, the block group number populates in WIpop during overnight processing. Files rejected if >10% missing address.
2010BA	N302	Subscriber Address Line 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N302	Patient Address Line 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N401	Subscriber City	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	***File rejected if > 10% of records missing address**
2010CA	N401	Patient City	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	***File rejected if > 10% of records missing address**
2010BA	N402	Subscriber State	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N402	Patient State	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N403	Subscriber Zip code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Zip Code Stored in WIpop
2010CA	N403	Patient Zip Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Zip Code stored in WIpop
2010BA	DMG02	Subscriber Birth Date	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Birth Date
2010CA	DMG02	Patient Birth Date	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Birth Date
2010BA	DMG03	Subscriber Gender Code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 F, M, X, U or O	F, M, X, U, O (U or O requires Cond Code 45) 10/2024 NEW: X = Nonbinary Gender
2010CA	DMG03	Patient Gender Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 F, M, X, U or O	F, M, U, O (U or O requires Cond Code 45) 10/2024 NEW: X = Nonbinary Gender
2010BA	DMG04	Subscriber Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status optional field, supply if collected.

2010CA	DMG04	Patient Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status optional field, supply if collected.
2010BA	DMG05 -1	Subscriber Race Code1 See Appendix 7.2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 DMG*D8*19830501*F*M*5:2	DMG05 is a composite element, which repeats up to ten (10) times. The first two entries for the race will be used for WIpop fields RACE and RACE2. File rejected if > 25% of records = declined or unavailable.
2010CA	DMG05 -1	Patient Race Code1 See Appendix 7.2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 DMG*D8*19830501*F*M*5:2	DMG05 is a composite element, which repeats up to ten (10) times. The first two entries for the race will be used for WIpop fields RACE and RACE2. File rejected if > 25% of records coded as declined or unavailable.
2010BA	DMG05 -2	Subscriber Ethnicity Code See Appendix 7.2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 File rejected if > 25% of records = declined or unavailable.	The first entry for ethnicity will be used for field ETHN.
2010CA	DMG05 -2	Patient Ethnicity Code See Appendix 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	The first entry for ethnicity will be used for field ETHN.
2010BA	DMG05 -3	Subscriber Race 2	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Do not repeat race codes.
2010CA	DMG05 -3	Patient Race 2	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Do not repeat race codes.
2010BA	DMG10	Subscriber Language Qualifier	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 ZZ – Mutually Defined	DMG10 = ZZ
2010CA	DMG10	Patient Language Qualifier	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 ZZ = Mutually Defined	DMG10 = ZZ
2010BA	DMG11	Subscriber Language Code	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	New Field Q319 See Appendix 7.3.1 for Code List Mapping
2010CA	DMG11	Patient Language Code	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	New Field Q319 See Appendix 7.3.1 for Code List
LOOP ID - 2010BB Payer Detail LOOP 2010BB: PAYER NAME NM1*PR*2*PRIMARY PAYER*****PI*A21-09~					
2010BB	NM101	Payer Entity ID Code	R	PR = Payer	
2010BB	NM102	Entity Type Qualifier	O	1 = Non-Person Entity *NM102 qualifies NM103	Discarded

2010BB	NM103	Payer Name	S	Name of Payer Organization	New Q32019: Stored on the database and used in the Unknown Payer Report to help data submitters correct data.
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code	R	Map Payer's to WHAIC Values in Appendix 7.3. Element format is **AAA-99** Example A21-09 AKA: Primary Source of Payment ID Pay ID characters 1-3 – Pay TYPE is characters 5-6 The dash is preferred, but not required.	Expected Source of Payment ID/ Type: characters 1-3 – Pay Type is characters 5-6 The dash is preferred, but not required *Self-pay requires OTH-61
2010BB	REF01	REF ID Qualifier for Payer ID Number	S	NF = Payer ID	New Field Q32019: Payer Identifier in the EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer ID Number	S	Enter the Value of the Payer ID	
LOOP ID – 2300 CLAIM INFORMATION (If Loop and Element are not included, do not send) LOOP 2300: CLAIM INFORMATION CLM*PCTRL535*2740.00***11:B:1*Y*A*Y*Y~ REF*EA*MRN123~ HI*ABK:Z85030*ABF:Z86010~					
2300	CLM01	Patient Control Number	R	ASCs often refer to this as Patient's Account No. or HAR. Do not use special characters <> *File rejected for Duplicate Patient control numbers.	Use Patient Control Number (PCONTROL or PCTRL) **IF duplicates are found, resubmit file with this phrase anywhere in the file name: exclude_duplicates Ex: 400_ASCname_exclude_duplicates
2300	CLM02	Total Claim Charge	R	Total Charges in SV1 must match this number. The total amount of all submitted charges of service for this claim.	Total Charges must match the services rendered. Do not submit PROFEE
2300	CLM05-1	Type of Bill – Facility Type Code	R	83:B:1 (alternative 99:B:9)	ASCs can use 0831, 0999 – leading zero optional to use.
2300	CLM05 – 2	Facility Code Qualifier	O	B – Place of Service Codes for Professional or Dental	Ignored if supplied – WHAIC populates
2300	CLM05-3	Type of Bill – Claim Frequency Code	R	Titled Claim Frequency Code in the 837P.	Type of Bill - ASCs may refer to this as resubmission and/or orig. ref number
2300	REF01	Ref ID qualifier for MRN	O	EA	
2300	REF02	Medical Record Number	R	MRN Number	Medical Record Number
2300	HI01-1	Principal Diagnosis Qualifier	R	ABK	
2300	HI01-2	Principal ICD-10 Diagnosis Code	R	ICD-10 Code – do not include decimal points.	Principal/Primary diagnosis code or nature of illness or injury.

				Claim Field may be repeated up to twelve times. HI01-2, HI02-2, HI03-2, HI04-2, etc.	WHAIC can take as many diagnosis codes as collected.
2300	HI0X-1	Other Diagnosis Code Qualifier	S	ABF	
2300	HI0X-2	Other Diagnosis Codes – ICD-10	S	ICD-10 CM Codes ***External Cause Code Required per State Statute on records with ICD-10 diagnosis Codes in S injury range***.	Diagnosis Codes only and no decimals.
2300	HI0X-1	Condition Code Qualifier	S	BG	
2300	HI0X – 2	Condition Code	S	Condition Code 45 is required when the Sex/Gender of the patients is either Unknown "U" or Other "O".	Condition Code 45 required with Unknown sex/gender.
LOOP ID 2310 (A – B) PROVIDER INFORMATION LOOP 2310A: REFERRING PROVIDER NAME NM1*DN*1*REFERRING*****XX*9876543214~ LOOP 2310B: RENDERING PROVIDER NAME NM1*82*1*RENDERING*****XX*9876543213~					
2310A	NM101	Referring Provider Qualifier	S	DN = Referring Provider	
2310A	NM108	Referring Provider ID Code Qualifier	S	XX = NPI	
2310A	NM109	Referring Provider NPI	S	Use Referring Provider NPI if available	Referring NPI – e.g., PCP NPI or "Other" specialist.
2310B	NM101	Rendering/Operating ID	R	82 = Rendering Provider	
2310B	NM108	Rendering/Operating Qualifier	R	XX = NPI	837P References Rendering not Operating
2310B	NM109	Rendering/Operating Provider NPI	R	Rendering means the same thing as Operating Provider NPI number.	Rendering NPI will equate to Operating NPI in WIpop and map accordingly.
LOOP ID – 2320 / 2330B OTHER SUBSCRIBER INFORMATION FOR SECONDARY PAYER Required if on claim LOOP 2330B: OTHER PAYER NAME NM1*PR*2*SECONDARY PAYER*****PI*A21-09~					
2320	SBR01	Payer Responsibility Sequence Code	S	S = Secondary	Include only if secondary payer applies.
2330B	NM101	Entity ID code	R/S	PR = Payer	
2330B	NM108	Payer Identifier Qualifier	R/S	PI = Payer ID	This field is for mapping of Secondary Source of payment codes. See segment Loop 2010BB / REF01 (NF (PayerID Code), REF02 = Value
2330B	NM109	Payer Identifier Code	R/S	Secondary Source of Payment ID Element format is **AAA-99** PayID is characters 1-3 – Pay TYPE is characters 5-6	Expected Source of Payment ID and Type. Two fields in WIpop. Appendix 7.3
LOOP ID – 2400 SERVICE LINE DETAIL (*REVENUE LINE-ITEM DETAIL) LOOP 2400: SERVICE LINE NUMBER LX*1~					

837P does not have a field for Revenue Code and ASCs typically do not report them. If ASC wants to report one, many revenue codes are accepted.

SV1*HC:45380*2700.00*UN*1***1~ DTP*472*D8*20170202~					
2400	SV101-1	CPT / HCPCS Qualifier	R	HC (HCPCS)	
2400	SV101-2	CPT/HCPCS Codes	R	Procedures, Services or Supplies	*CPT or HCPCS codes required
2400	SV101-3	Procedure Modifier 1	S	Modifier 1 CPT/HCPCS	Do not duplicate modifiers
2400	SV101-4	Procedure Modifier 2	S	Modifier 2 CPT/HCPCS	
2400	SV101-5	Procedure Modifier 3	S	Modifier 3 CPT/HCPCS	
2400	SV101-6	Procedure Modifier 4	S	Modifier 4 CPT/HCPCS	
2400	SV102	Line-Item Charge Amount	R	Line-Item Charge Amount – Zero is a valid amount.	Facility charge amount in this field. Charge for service, supply, or drug.
2400	SV103	Unit	R	UN = Units	
2400	SV104	Service Unit Count	R	Quantity = positive numbers only	Field required. Value must be 1 or >
2400	SV105	Place of Service Code	R	*WHAIC maps to POS 1 for OPS**	Place of Service “1” assigned by WHAIC
2400	DTP01	Service Date Qualifier	R	472	
2400	DTP02	Service Date Qualifier	R	D8	
2400	DTP03	Service Date on Revenue Line Item	R	CCYYMMDD (example: 20180103)	Service Date

5.8 837R (Hospital) Reporting Claim Submissions

Uploaded files are not limited in total size, but a single transaction (ST – SE envelope) can have no more than 5,000 CLM segments or 10 million characters. Files exceeding either limit will be rejected.

This document notes only the loops and elements relevant to WHAIC data collection specifications as defined by the State Statute. It is not intended to serve as a complete 837 reference, and not all requirements for a valid 837 file are specified. Elements not mentioned in this document will be discarded by WHAIC prior to the file processing in WIpop, if supplied.

Fields defined, created, or added by WHAIC from the 837 claims file

Patient Type (Inpatient, outpatient surgery)	Type of Encounter (INP =1) (OutPt = 2)	Place of Service
Principal Procedure on OP Records	Principal Procedure Date	Additional Procedures on OPS records
Principal Procedure Modifier(s)	Additional Procedure Modifier(s)	Leave of Absence Days

Legend

Name	Data Edit/ Name	Description
R	Required	Data Element Must be Submitted for the data type and must not be blank
S	Situational	Required based upon values in the claim/EMR or other elements
O	Optional	Element not required and may be left blank, however, if submitted, it will be edited.
Gray shade	WIpop Name / Field #	Data is not stored, but may be sent, and may be used to route data in WIpop

837R sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837R-Sample-File.pdf

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
0000	ISA06	Interchange Sender ID (3 digit)	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match GS02 & 1000A/NM109
	ISA08	Receiver ID	O	Submitter choice: leave blank or use WHAIC837	Optional field
	GS02	Application Sender's Code	O	Use 3-digit Facility ID assigned by WHAIC. See Appendix 7.1 Facility List Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID	ISA06, GS02 and 1000A/NM109 must match.
	GS03	Application Receiver's Code	O	Submitter choice: leave blank or use WHAIC837	Optional field
0000	ST03	Implementation Guide Version	R	005010X223A2	Required but not stored
LOOP ID 1000A/B and 2010AA Submitter and Billing (HOSPITAL / ASC) Detail **LOOP 1000A: SUBMITTER NAME** **NM1*41*2*SAMPLE HOSPITAL*****46*333~**					

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
PER*IC*SUBMITTER NAME*TE*6142222222~ **LOOP 1000B: RECEIVER NAME** **NM1*40*2*WHAIC*****46*WHAIC 837~**					
1000A	NM101	Entity ID code	O	41 = Submitter	
1000A	NM102	Entity Type Qualifier	R	"2" – non-person entity	
1000A	NM103	Organization Name	O	Vendor name, Hospital or ASC name	
1000A	NM108	Identification Code Qualifier	R	46	
1000A	NM109	Identification Code of Submitter	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Facility ID - Appendix 7.1 Facility List	ISA06, GS02 and 1000A/NM109 must match.
1000B	NM101	Entity ID code	O	40 = Receiver	
1000B	NM103	Receiver Name – WHAIC	O	**Use WHAIC** – This identifies WHAIC as receiver	
1000B	NM109	Receiver (WHAIC) Primary Identifier	O	WHAIC 837	
2010AA	NM101	Billing/Service Provider Identifier code	R	85 = Billing Provider	(837R – uses SJ = Service Provider)
2010AA	NM108	Billing Entity ID Qualifier	R	"XX"	
2010AA	NM109	Billing Entity ID Code	R	Use Facility NPI Number (Billing Provider NPI) WHAIC has on File.	**Notify WHAIC of all subpart NPI's to allow us time to update our tables.**
Patient and/or Subscriber Detail: **Patient Detail Required when the patient *is different* from the Subscriber. If not required by this Implementation Guide, do not send.** **DO NOT SEND 2010CA *IF* PATIENT IS SUBSCRIBER**					
Patient / Subscriber details cannot be determined until processing of UCID					
Required v. Situational *depends on* if the patient is the subscriber. LOOP 2000B: SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*1~ SBR*P**CERTNUM2222SJ~ LOOP 2010BA: SUBSCRIBER NAME NM1*IL*1*NULL*****MI*3CFD1B33ACBD5475CE36D8C439FEC42475B9ADBEC7B91A6926DACF0F45BE269F-S530J~ N3*236 N MAIN ST~ N4*MADISON*WI*53717~ DMG*D8*19830501*F*M*5:2~					
2000B	SBR03	Policy Number – Insurance	R/S	Send "NULL" if Self-pay	Do not default to all zeroes.

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
		SBR03 is Policy, Group Number, Member ID, Certificate Number.		The term policy number or group number is synonymous with insurance ID, member ID, insurance code, Plan number, etc. *any number on the card or in the file that identifies the patient to the carrier.* *SEE FAQ – for more info 837R Users – SB03 may require a Form Override to send Subscriber ID / Policy or Group number that would otherwise be sent in NM109.	NULL is necessary because that element is required in the 837 spec, and we are trying to conform to the rules as much as we can.
2000B	SBR09	Claim Filing Indicator Code	S	Code identifying type of claim Appendix 7.3.1 – list of codes	New Field Q12020: See Appendix 7.3.1 for codes
2010BA	NM103	Subscriber Last Name	R/S	Subscriber names are not accepted. Send "NULL." NM104 – NM107 must be blank.	Patient Detail Required when the patient *is different* from the Subscriber
2010CA	NM103	Patient Last Name	R/S	Patient names are not accepted. Send "NULL." NM104 – NM107 must be blank.	Send "NULL." NM104 – NM107 must be blank.
2010BA	NM109	Subscriber UCID	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Element format is **UCID** UCID is characters 1 – 64	This field is to be used for encrypting the patient and/or subscriber name.
2010CA	NM109	Patient UCID	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 UCID is characters 1 – 64	This field is to be used for encrypting the patient and/or subscriber name.
2010BA	N301	Subscriber Address 1	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Address, City, State and Zip will be used to find the patient's census block group. The block group, but not the address, will be saved in WIpop. Physical address discarded.	Census Block Group - Typically, the block group number populate in WIpop during overnight processing. Files rejected if >10% missing address.
2010CA	N301	Patient Address 1	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 Address, City, State and Zip will be used to find the patient's census block group. The block group, but not the address, will be saved in WIpop.	Census Block Group - Typically, the block group number populate in WIpop during overnight processing. Files rejected if >10% missing address.
2010BA	N302	Subscriber Address Line 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N302	Patient Address Line 2	R/S	Loop 2010CA, NM101 = QC	Value not stored

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
				Loop 2010CA, NM102 = 1	
2010BA	N401	Subscriber City	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	*File rejected if more than 10% of records missing address
2010CA	N401	Patient City	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	*File rejected if more than 10% of records missing address
2010BA	N402	Subscriber State	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N402	Patient State	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N403	Subscriber Zip code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Zip Code Stored in WIpop
2010CA	N403	Patient Zip Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Zip Code stored in WIpop
2010BA	DMG02	Subscriber Birth Date	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Birth Date
2010CA	DMG02	Patient Birth Date	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Birth Date
2010BA	DMG03	Subscriber Gender / Sex Code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	F, M, U (U or O requires Cond Code 45)
2010CA	DMG03	Patient Gender / Sex Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	F, M, U (U or O requires Cond Code 45)
2010BA	DMG04	Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 See Appendix 7.14 for Marital Status Codes	Marital Status optional field, supply if collected.
2010CA	DMG04	Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 See Appendix 7.14 for Marital Status Codes	Marital Status optional field, supply if collected.
2010BA	DMG05-1	Subscriber Race Code1 See Appendix 7.2	RS	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 For each entry: DMG05-1: Leave empty DMG05-2: Value is RET (race or ethnicity) DMG05-3: Two-character value. The first character is either R (race) or E (ethnicity).	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2.

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
				Second character is the race or ethnicity code. DMG*D. 9830501*F*M*:RET:R3^:RET:E1~	The first entry for ethnicity will be used for field ETHN. File rejected if >25% of records are declined/unknown
2010CA	DMG05-1	Patient Race Code1 See Appendix 7.2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 For each entry: DMG05-1: Leave empty DMG05-2: Value is RET (race or ethnicity) DMG05-3: Two-character value. First character is either R (race) or E (ethnicity). Second character is the race or ethnicity code. DMG*D8*19830501*F*M*:RET:R3^:RET:E1~	DMG05 is a composite element, repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2. The first entry for ethnicity will be used for field ETHN. File rejected if >25% of records are declined/unknown
2010BA	DMG05-2	Subscriber Ethnicity Code See Appendix 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	File rejected if >25% of records are declined/unknown
2010CA	DMG05-2	Patient Ethnicity Code See Appendix 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	File rejected if >25% of records are declined/unknown
2010BA	DMG05-3	Subscriber Race 2	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Report only if more than one race is collected.
2010CA	DMG05-3	Patient Race 2	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Report only if more than one race is collected.
2010BA	DMG10	Subscriber Language Qualifier	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 ZZ – Mutually Defined	DMG10 = ZZ
2010CA	DMG10	Patient Language Qualifier	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 ZZ = Mutually Defined	DMG10 = ZZ
2010BA	DMG11	Subscriber Language Code	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	See Appendix 7.3.1 for Code List Mapping
2010CA	DMG11	Patient Language Code	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	See Appendix 7.3.1 for Code List Mapping
LOOP ID - 2010BB Payer Detail LOOP 2010BB: PAYER NAME					

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
NM1*PR*1*PRIMARY PAYER NAME*****PI*A21-09~					
2010BB	NM101	Payer Entity ID Code	R	PR = Payer	
2010BB	NM102	Entity Type Qualifier	O	1 = Non-Person Entity *NM102 qualifies NM103	Discarded
2010BB	NM103	Payer Name	S	Name of Payer Organization as provided on the claim.	.
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code *Self-pay requires OTH-61	R	WHAIC Values in Appendix 7.3 Element format is **AAA-99** Example A21-09 Primary Source of Payment ID	SOPID is characters 1-3 - SOPTYPE is characters 5-6 The dash is preferred, but not required
2010BB	REF01	REF ID Qualifier for Payer ID#	S	NF = Payer ID number See Appendix 7.3.2 for more information.	New Q32019: Payer Identifier on EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer ID #	S	Enter the Value of the Payer ID# See Appendix 7.3.2 for more information.	Refer to Appendix 7.3.2 for additional info.
LOOP ID – 2300 CLAIM INFORMATION LOOP 2300: CLAIM INFORMATION CLM*PCTRL535*2500.50***11:A:1**A*Y*Y~ DTP*096*DT*201702032359~ DTP*434*RD8*20170202-20170203~ DTP*435*DT*201702022359~ CL1*2*1*20~ REF*LU*MN~ REF*EA*MRN123~ HI*ABK:G9782:::::::Y~ HI*ABJ:G9389~ HI*APR:G9389*APR:N179~ HI*ABF:A4152:::::::N*ABF:G918:::::::Y*ABF:N179:::::::Y*ABF:B370:::::::N~					
2300	CLM01	Patient Control Number	R	Use Patient Control Number *File rejected for Duplicate Patient control numbers. IF duplicates are found, resubmit file with this phrase anywhere in the file name: Exclude_duplicates Ex: Q322hospitalname exclude_duplicates	PCONTROL or PCTRL Do not use special characters <> IF duplicates are found, resubmit file and add exclude_duplicates anywhere in file name.

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
2300	CLM02	Total Claim Charge	R	Total Charges in SV2 must match this number. The total amount of all submitted charges of service for this claim. ****Exclude Professional fees****	Total charges from revenue line-item details must match claim detail in WIpop
2300	CLM05-1	Type of Bill – Facility Type Code	R	WHAIC mapping required: Appendix 7.4 TOB Exclusions and special mapping apply.	Leading zero not required in 837 claims file.
2300	CLM05-02	Facility Code Qualifier	O	A – Uniform Billing Claim Form Bill Type	Ignored in the WIpop data
2300	CLM05-3	Type of Bill – Claim Frequency Code	R	WHAIC Exclusions Apply: Appendix 7.4 TOB Do not send values from 5-9 or alpha characters "1" – Admit through Discharge claim includes bills representing total confinement or course of tx. "2" - indicates Interim – first claim "3" – indicates interim – continuing claim "4" – indicates interim – Last Claim – used for the last of a series of bills, for the same confinement or course of treatment. Claim Frequency Code '0' must be used on non-payment zero charge claims.	Ex: 131 1 (hospital) 3 (outpatient) 1 (admit/discharge claim) Claim Frequency Code '0' must be used on non-payment zero charge claims.
2300	DTP01	Discharge Date Qualifier	S	096	
2300	DTP02	Discharge Date Format Qualifier	S	DT	
2300	DTP03	Discharge Date/ Time	S	CCYYMMDDHHMM DDAT is first 8 characters DTIME is last 4 characters Required on INP and ED records only	Discharge Date required for INP & ED. Discharge Time required for INP May be provided on other record types. Cannot provide Admission date w/o discharge date.
2300	DTP01	Statement Dates Qualifier	R	434	
2300	DTP02	Statement Date / Time Format Qualifier	R	RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Use RD8 (range of dates) to indicate the "from and through (To)" date of the statement. When the statement is for a single date of service, the 'from and through' date are the same.	Required on Outpatient Records / Encounters
2300	DTP03	Statement From and Through (To) Dates	S	CCYYMMDD–CCYYMMDD STPERODF is first 8 characters STPERODT is last 8 characters	Required = Outpatient (observation, lab/rad therapies, etc.)

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop Field Name/ Field Notes
2300	DTP01	Admission Date / Time Qualifier	S	435 Required on Inpatient and Emergency Dept. Only	May be provided on other record types. Cannot provide Admission date w/o discharge date.
2300	DTP02	Admission Time Period	S	DT Required on Inpatient	ER records can use 12:00 if not collected
2300	DTP03	Admission Date and Hour	S	CCYYMMDDHHMM ADAT is first 8 characters ADMTIME is last 4 characters Admission Date Required on Inpatient and ER/ED claims.	WIpop: Admission Date/Time Admission Time – Req on INP
2300	CL101	Priority (Type) of Admission or visit / Admission Type Code	R	National Uniform Billing Codes *Appendix is included, see 7.7.1 for code list.	WIpop: Admit Type
2300	CL102	Point of Origin for Admission or Visit	R	NUBC Codes – Required on all Bill Types except 014X See Appendix 7.7	WIpop: Point of Origin See Appendix 7.7
2300	CL103	Discharge (Patient) Status	R	Per NUBC: Required on all institutional claims.	WIpop: Discharge Status See Appendix 7.8
2300	REF01	Auto Accident State Qualifier	S	LU = Location Number	
2300	REF02	Auto Accident State	S	Use valid 2- digit U.S. State code	Accident State – where the accident occurred
Service Facility and Provider-base Location (PBL) Details: ****Note – In the 837R:** Segment NTE may be used as alternate means to supply the service facility/provider-based location (PBL) ID. **Use only if your vendor software will not allow you to send loop 2310E**. If both are supplied, the value in 2310E will be used. PBL NOTE: The 837R "Reporting" specification does not include the 2310E Loop. Developers programming the Provider Based Location (PBL) detail must use the NTE segment and send PBL ID in Loop 2300 - NTE02, as noted below. *At the time of this release: The 2310E section is grayed out for the 837R, but users are not discouraged from usage in loop 2310E if available in program*.					
2300	NTE01	Service Facility Location Identifier	S	UPI = Service Facility Location Identifier *** Send only if this visit applies to a PBL*** See NTE segment above if not using this to report PBL	*Epic use NTE segment.
2300	NTE02	Service Facility Location Value	S	Set to PBL ID Number Provider Based Location ID Leading zero will be discarded.	Set to PBL ID Off-campus hospitals & facilities that share the same Medicare # must report ALL

					services with Location ID.
2300	REF01	Ref ID qualifier for MRN	O	EA	
2300	REF02	Medical Record Number	R	MRN Number	WIpop: MRN (WHAIC does not locate record using MRN)
2300	HI01-1	Principal Diagnosis Qualifier	R	ABK	
2300	HI01-2	Principal ICD-10 Diagnosis Code	R	ICD-10 Code Do not use the decimal point	Principal Diagnosis – follow correct coding guidelines.
2300	HI01-9	Present on Admission (POA)	S	Y, N, U, W – **INP ONLY** Leave blank for exempt – per CMS.	WIpop: Principal Diagnosis POA. For a list of exempt codes: see CDC.gov
2300	HI01-1	Admitting Diagnosis Qualifier	S	ABJ	
2300	HI01-2	Admitting Diagnosis ICD-10 Code	R/S	ICD-10 Code – Decimals not allowed R= Inpatient ONLY	WIpop: Admitting Diagnosis required on INP only.
2300	HI01-1	Reason for Visit Qualifier	R/S	APR R = Outpatient Only	
2300	HI01-2	Reason for Visit ICD-10	S	ICD diagnosis codes describes patient's stated reason for visit at the time of outpatient registration. R = Outpatient Required on TOB 013X, 078X, and 085X when: type of admission or visit codes 1, 2 or 5 are reported; and Rev codes 045X, 0516, 0526 or 0762 reported.	Reason for Visit Diagnosis 1 – required on OP records
2300	HI02-1	Reason for Visit Qualifier	S	APR	
2300	HI02-2	Reason for Visit ICD-10	S	ICD-10 Code R = Outpatient if applicable and coded	Reason for Visit Diagnosis 2 – required on OP records if documented
2300	HI03-1	Reason for Visit Qualifier	S	APR	
2300	HI03-2	Reason for Visit ICD-10	S	ICD-10 Code R = Outpatient if applicable and coded	Reason for Visit Diagnosis 3 – required if coded
2300	HI0X-1	Other Diagnosis Code Qualifier	S	ABF	
2300	HI0X-2	Other Diagnosis Codes – ICD-10	S	ICD-10 Codes *Additional Diagnosis in WIpop	Additional DIAGNOSIS and External Cause Codes

2300	HI0X-9	Other Diagnosis - Present on Admission Indicator	S	Y, N, U, W – INP only Leave blank for exempt – per CMS	Additional Diagnosis and External Cause Codes
2300	HI0X-1	External Cause of Injury Qualifier	S	ABN	
2300	HI0X-2	External Cause of Injury ICD-10 Codes	S	***Required on ICD-10 Codes in the S range*** and some in the T range –Applies only to INP, ED, OPS and OBS records.	Additional Diagnosis and External Cause Codes
2300	HI0X-9	External Cause Present on Admission	S	Y, N, U, W – INP only	Additional Diagnosis and External Cause Codes
2300	HI01-1	Principal Procedure Qualifier	S	BBR for ICD-10 Procedure Codes	
2300	HI01-2	Principal Procedure Code	S	**Hospital supplies ICD-10 Procedure codes for inpatient stays.** No decimal point. Do Not Hard Code CPT/HCPCS into this field.	WHAIC populates OP Procedure codes based on Revenue Code detail
2300	HI01-3	Principal procedure Date qualifier	S	D8	
2300	HI01-4	Principal procedure Date	S	CCYYMMDD – Required when a Principal Procedure is provided on INP records	Principal Procedure Date WHAIC will populate Outpatient Records based on revenue line-item details
2300	HI0**X**-1	Additional / Other Procedure Code Qualifier	S	BBQ – ICD-10 Procedure codes verify with addenda	
2300	HI0**X**-2	Additional Procedure Codes	S	ICD-10 Procedure codes for inpatient stays.	Additional Procedures are populated by WHAIC from revenue codes in rev line item
2300	HI0**X**-3	Additional/Other Procedure Dates	S	D8	
2300	HI0**X**-4	Additional/Other Procedure Date	S	CCYYMMDD Facility File will only have INP procedure dates.	Additional / Other Procedure DATE WHAIC populates
2300	HI0X-1	Occurrence Span Qualifier	S	BI	
2300	HI0X-2	Occurrence Span Code	S	Occurrence Code 1-4: NUBC Billing Codes	WHAIC will record the first 4 occurrence codes, others will be discarded.
2300	HI0X-3	Occurrence Span Code Date Qualifier	S	RD8	
2300	HI0X-4	Occurrence Span Code Range of Dates	S	CCYYMMDD-CCYYMMDD OCCSTART is first 8 characters OCCEND is last 8 characters	Occurrence Code 1 Start / End. Follow 837 file layout

2300	HI0X-1	Occurrence Code Qualifier	S	BH	
2300	HI0X-2	Occurrence Code – Industry Standard	S	NUBC Uniform Billing Codes UB-04	
2300	HI0X-3	Occurrence Code Date Qualifier	S	D8 (meaning one date)	
2300	HI0X-4	Occurrence Code Date	S	CCYYMMDD OCCSTART and OCCEND set to same value	WHAIC will record the first 4 occurrence codes/dates.
2300	HI0X-1	Value Code Qualifier	S	BE	
2300	HI0X-2	Value Code – Industry Standard	S	NUBC Uniform Billing Codes UB-04 The first 4 value codes will be saved in WIpop	WHAIC will record the first 4 Value Codes, others will be discarded.
2300	HI0X-5	Value Code Amount	S	No decimals Value Code Amounts 1 thru 4 recorded.	WHAIC will record the first 4 Value code amounts.
2300	HI0**X**-1	Condition Code Qualifier	S	BG	
2300	HI0X-2	Condition Code	S	NUBC Billing Codes The first 4 condition codes will be saved in WIpop	WHAIC stores the first 4 Condition Codes.
LOOP ID 2310 (A – F) PROVIDER Information **LOOP 2310A: ATTENDING PHYSICIAN NAME** **NM1*71*1*ATTENDING*****XX*9876543210~** **LOOP 2310B: OPERATING PHYSICIAN NAME** **NM1*72*1*OPERATING*****XX*9876543211~**					
2310A	NM101	Attending ID Code	S	71 = Attending Physician/Provider	
2310A	NM108	Attending Provider ID Qualifier	S	XX = NPI	
2310A	NM109	Attending Provider ID NPI	S	Use Attending Provider NPI Number Provider = Any Qualified Health Care Provider NPI –	WIpop: Attending NPI Required INP and ED
2310B	NM101	Operating Entity ID Code	S	72 = Operating Provider	
2310B	NM108	Operating ID Code Qualifier	S	XX = NPI	
2310B	NM109	Operating Provider NPI Number	S	Use Operating Provider NPI Number Required on Outpatient Surgery (OPS)	WIpop: Operating NPI
2310C	NM101	Other Operating Code Qualifier	S	ZZ = Other Operating Provider	
2310C	NM108	Other Operating ID Qualifier	S	XX = NPI	
2310C	NM109	Other Operating Provider NPI	S	Use Other Operating provider NPI Number	WIpop: Other Operating NPI
2310D	NM101	Rendering ID code	S	82 = Rendering Provider	
2310D	NM108	Rendering ID Code Qualifier	S	XX = NPI	
2310D	NM109	Rendering Provider NPI number	S	Use Rendering Provider NPI number	Most often used on the 837P

2310E	NM101	Service Facility Location Identifier	S	77 = Service Facility Location *** applies to Hospitals that have off-campus hospitals and outpatient facilities **that share the same Medicare number as the main hospital***	837R – see the 2300 / NTE segment above.
2310E	NM108	Service Facility Location Qualifier	S	PI = Provider ID	
2310E	NM109	Service Facility Location Value	S	Service Facility / Provider Based Location (PBL) ID A leading zero is not necessary and will be discarded.	Service/Provider-Based Location ID is assigned by WHAIC.
2310F	NM101	Referring Provider Qualifier	S	DN = Referring Provider	
2310F	NM108	Referring Provider ID Code Qualifier	S	XX = NPI	
2310F	NM109	Referring Provider NPI	S	Use Referring Provider NPI ***This is not the billing provider – sometimes PCP***	The individual who directed the patient for care to the provider that rendered the services.
LOOP ID – 2320 / 2330B OTHER SUBSCRIBER INFORMATION FOR SECONDARY PAYER Required if applicable					
2320	SBR01	Payer Responsibility Sequence Code	R/S	S = Secondary Include only if secondary payer applies	
2330B	NM101	Entity ID code	R/S	PR = Payer	
2330B	NM108	Payer Identifier Qualifier	S	PI = Payer ID	
2330B	NM109	Payer Identifier Code	S	Mapping required: Secondary Source of Payment ID: Format is **A##-09 Expected Source of Payment ID** is characters 1-3 – Pay TYPE is characters 5-6	Source of payment requires mapping to WHAIC Values in Appendix 7.3
LOOP ID – 2400 SERVICE LINE DETAIL LOOP 2400: SERVICE LINE NUMBER LX*1~ SV2*0119**2000*DA*2~ DTP*472*D8*20170202~					
2400	SV201	Revenue Codes	R	NUBC Billing Codes – leading zero required when applicable. Some exclusions for reporting apply - see 5.1.5	Revenue codes identify specific accommodation, or service
2400	SV202-1	CPT/HCPCS Qualifier	R	HC (HCPCS) or HP (HIPPS)	
2400	SV202-2	CPT / HCPCS Procedure Code codes Or HIPPS Code for INP	R	CPT Codes (AMA) or HCPCS (CMS) required on OP claims if required by uniform billing standards. HIPPS rate appropriate for INP claims if available.	HIPPS rate for INP CPT/HCPCS code for OP

2400	SV202-3	Procedure Modifier 1	S	Modifier 1 CPT/HCPCS	CPT/HCPCS
2400	SV202-4	Procedure Modifier 2	S	Modifier 2 CPT/HCPCS	CPT/HCPCS
2400	SV202-5	Procedure Modifier 3	S	Modifier 3 CPT/HCPCS	CPT/HCPCS
2400	SV202-6	Procedure Modifier 4	S	Modifier 4 CPT/HCPCS	CPT/HCPCS
2400	SV203	Monetary amount - Revenue Code Charge – Line-Item Charge Amount	R	Line-Item Charge Amount – Zero 0$ is a valid amount	Charge
2400	SV204	Unit or Basis for Measurement Code	R	DA = Days UN = Units	
2400	SV205	Service Unit Count	R	Quantity – positive whole numbers	Units value must be 1 or >
2400	DTP01	Service Date Qualifier	S	472	
2400	DTP02	Service Date Qualifier	S	D8 – one date is acceptable	
2400	DTP03	Service Date on Revenue Line Item	S	CCYYMMDD	SERVICE DATE

837R– Click here for **Sample File**

6. BATCH DETAILS, VALIDATION AND AFFIRMATION PROCESS

To maintain our contractual agreement with the State of Wisconsin and continue to provide exceptional data in a timely fashion, facilities must comply with the data submission requirements and timelines as defined by the Wisconsin Statute and WHAIC calendar.

WHAIC staff make every effort to ensure accurate data through internal validation, reports, and historical trending.

- If a month(s) of data is missing, we contact the facility and inform them of the missing month(s) and provide a snapshot of the report.
- When data is under-reported, we notify the facility and provide snapshots from the previous quarter / year's submission.
- When there are unusual changes in data from one quarter/year to the next, we look to the primary contact at the facility to provide explanations in and/or clarification.
- If there are inconsistencies with historic trends, we reexamine individual cases until either the reported data is validated, or we identify a specific problem and rectify it or write a caveat to explain it.

According to the Wisconsin Statutes, failure to comply with the data submission deadlines may result in or be subject to non-compliance issues. WHAIC staff may write a letter of non-compliance to the CEO/Administrator or send a letter to the DHS.

Examples of non-compliance issues include, but are not limited to:

- Failure to notify WHAIC of third- party data submission vendor. *Hospitals and freestanding ambulatory surgery centers are accountable for their qualified vendor's failure to submit data in the formats required.
- Failure to submit patient data electronically with physical specifications, format, and record layout in accordance with the technical components as provided in the data submission manual.
- Failure to meet data submission deadlines or correcting edits timely as outlined in the WHAIC data submission calendar.
- Failure to respond to inquiries on data validation issues.
- Failure to submit Electronic Affirmation Statement timely.

6.1 File (Batch) Failures

Initial validation is conducted at a batch level. If the batch file is not syntactically valid, the submitter will need to resubmit the corrected batch in its entirety. In other words, the file must be formatted correctly to process throughout the WHAIC Database system.

Reasons for batch failures

1) The file is not structurally correct.
2) Patient / Subscriber Name or Subscriber Social Security Number is detected in the file.
3) More than 10% of addresses are missing from the file.
4) More than 25% of records are submitted with an unknown or declined race or ethnicity.
5) File submitted with claims from multiple hospitals or ASC sites – i.e., no grouping facility data. An uploaded 837 file must contain data for only one facility. In addition, the facility number in ISA06, GS02, and NM109 in loop 1000A must all match the facility number specified when the file is uploaded. In other words, if the user specifies that the uploaded file is for facility 043 (Aurora - Hartford) but the file contains data for facility 124 (Aurora - Sheboygan), the file will be rejected
6) Uploaded files are not limited in total size to 20 million characters, but a single transaction (ST – SE envelope) can have no more than 5,000 CLM segments or 10 million characters. Files exceeding either limit will be rejected.
7) Duplicate Patient Control Numbers will result in a file failure. WHAIC cannot accept replacement/void or other adjusted type of bill. Effective with Q318 New Process to remove duplicate patient control numbers:

REMOVING DUPLICATES FROM FILE SUBMISSION

There are two types of batch file rejects as it relates to duplicate records that apply to this process.

1. **Duplicates within same file - two records with the same patient control number:**

    a. **Resubmit the batch with the phrase "exclude_duplicates" somewhere within the file name.**

        i. Example file name: Q220_WHAIC_ facilityname_exclude_duplicates.txt

    b. We will keep the original encounter/record if it has a valid bill type.

    c. The batch file email response will include the number of records submitted and number of duplicates removed.

2. Duplicate patient control number of a record/encounter that already exists in WIpop:

- If the WIpop file contains a duplicate patient control number for an encounter that was previously uploaded, rerun the batch file with the phrase "**exclude_duplicates" (see example above) to remove the duplicate record(s) in the new file.** We will not replace original file records/encounters because there are too many variables such as trying to locate a duplicate record that is in a batch marked complete, and/or edits have already been worked, or the record is from a previous quarter.

6.2 Batch File Edits

Only loops, segments, and data elements valid for the HIPAA 837 Implementation Guides will be translated. Submitting data not based on the Implementation Guide will either be ignored or cause the file to be rejected.

WHAIC validates the NPI numbers against the NPPES table. It is rare, but sometimes, the data comes in before the NPPES table is updated.

All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective quarter. For more information on edits see Appendix 7.10.

Custom bypass edits

Bypass edits to accommodate facility and WHAIC place of service mappings, submission shortcomings, or standard claims requirements:

1. WHAIC set up the parser code to pull **statement from and through dates** from the earliest and latest revenue line service dates if the DTP*434 loop is not sent in the file.
2. Hospitals that use the emergency room (ER/ED) and an ER revenue code of 045X while also providing recurring specialty type services such as infusions, chemo or dialysis will be allowed to keep the record in the outpatient hospital data if the encounters contain *multiple revenue line items for outpatient lab/radiology or other outpatient services.*

The rule states that if statement thru minus statement from is more than seven days, the record WILL NOT be assigned to ER POS. WHAIC will ignore the 045X revenue code and assign POS based on the remaining rev codes.

Revenue:

09162019	0260	96372					1			IV Therapy - General Classification
09162019	0305	85025					1			Laboratory - Hematology
09162019	0450	99283					1			Emergency Room - General Classification
09162019	0636	J0881	EC				60	60		Pharmacy - Drugs Requiring Detailed Coding
09232019	0260	96372					1			IV Therapy - General Classification
09232019	0636	J0881	EC				60	60		Pharmacy - Drugs Requiring Detailed Coding
09302019	0260	96372					1			IV Therapy - General Classification
09302019	0305	85025					1			Laboratory - Hematology

For outpatient surgery (OPS) records:

3. To reduce the number of edits for services or encounters on records for claims that occur within the 90-day global surgical period (such as cataract surgeries that are often performed on both eyes within the 90-day global surgery period), we have made an exception.
4. If there is an LT or RT modifier on any revenue line, then all revenue lines can have a service date up to 90 days after the principal procedure date. The program will look for the highest charge first to account for the initial service data. If two or more revenue line items have the same (highest) charge, the earliest service date will be marked as the principal procedure.

For more information on edits, corrections and explanations, review Appendix 7.9 Edit Codes and Descriptions.

6.3 Correcting Edits

WHAIC has statutory guidelines to follow for release of the data, therefore we ask all WIpop users to follow the WHAIC Calendar timelines for clearing edits and marking batch(s) complete. For more information on specific edits, see Appendix 7.10. To clear an edit:

1. Choose the facility in which the edit applies (for those that manage multiple facilities.)
2. Click on Batch Review to see the data that was submitted and the number of invalid records that have edits and **click 'View.'**
3. On the Batch Detail Screen use the drop-down menus to work all edits in the batch or work edits based on a data type. The drop-down arrow in the (All Errors) box provides details specific edits in the records.
4. Click edit to get to the Edit Record Screen. Click on the TRIANGLE to see the edit language and work the edit accordingly.
5. Once the edit is fixed, **click 'Update'** to clear the record and move to the next edit.
6. After all the edits are worked **mark the batch complete**.
7. Once the data is submitted, WIpop users have the option to run real-time reports from WIpop to validate their data.
    a. On the 'Batch Review' screen, on the tool bar, click on Data Detail and click on 'Create Report.'
    b. The Summary Profile Report takes several minutes to run due to the significant amount of data that must be processed.
    c. Census Block group takes up to 24 hours to populate in WIpop.

6.4 Data Validation (Obtaining and viewing reports)

Primary contacts and signors are tasked with following the statutory requirements for validating the data at the close of the quarter. However, data can and should be reviewed and validated in real-time in WIpop.

Approximately 6 weeks after the quarter closes, users will receive an email notifying them to log into WIpop Data Deliverables Tab to obtain the Validation Reports and Affirmation Statement. **Posted files remain online in the WHAIC Portal for 30 days.** Users are encouraged to download the reports and save them to their internal file locations for a rolling five (5) quarters of data to accurately validate and trend the history of reporting..

The data should be compared to internal census reports, audit reports, department reports, etc. We rely on hospitals to implement their own best practices and follow HIPAA and other Security Standards to download and save the packaged data for review and distribution.

Importance of Summary Report and Validation

The WIpop data submission system is role based. Each facility assigns a primary contact as the main point of contact directly responsible for quarterly discharge data. This person is the lead contact for making sure the data is submitted, correct, validated, and represents an accurate number of patient encounters. He or she completes the affirmation statement and/or provides commentary, corrections, or caveats to thoroughly explain significant shifts in the data.

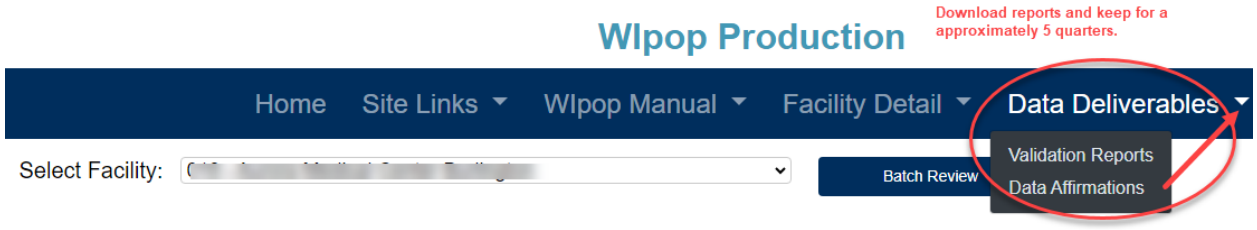
Directions:

1. Carefully review each page of the **Summary Profile Report**. This report provides a high-level summary of the data using graphs, charts, and tables, including 12-month rolling totals for each data type submitted.
2. Validate the data using internal census or abstract reports from internal systems to compare data submitted. *Most data is consistent month to month.
3. Review previous quarters reports against the current quarter's volumes, monthly patient and records/encounters and document reason for any significant variance immediately.

To obtain facility VALIDATION and PROFILE reports:

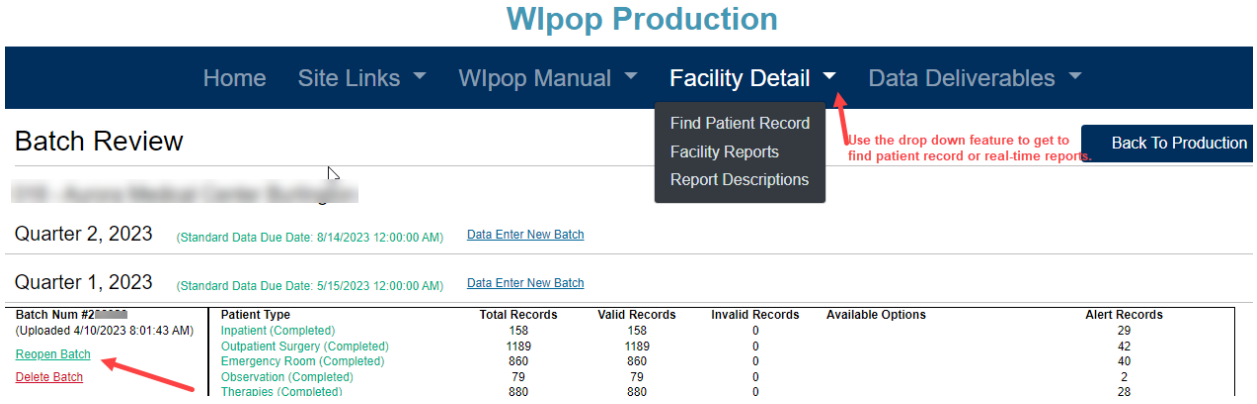
Download and save each report before you get started. Save at least 5 rolling quarters of data for historical trending and analysis. This **is your opportunity to fix or update data inconsistencies found on the validation reports.*

To get to Reports and Affirmation Statement: Log into WIpop and go to the site you are working on (if user manages multiple sites) otherwise simply login and to Data Deliverables tab.



Directions to find patient records/encounters and or obtain your real-time reports:

1. **Open** all the Batch files in the correct quarter to make corrections to the data by clicking on **Reopen Batch**.
2. Go to Facility Detail in the Tool Bar of the Batch Review screen and click on 'find patient record.'
3. Enter patient control number from the validation report and click enter or find.
4. Make necessary corrections – for example update a payer, and then **click 'Update'** to accept the changes.
5. Mark batch complete once all validation reports are reviewed and corrections finalized.
6. If shifts in the data signal it is under-reported or you recognize an entire month(s) is missing from the quarter, this should take priority over all other data reporting issues. Submit and correct any missing data immediately.



NOTE: Reports are automatically rerun and reposted (including the Affirmation Statement) once the quarter is reopened. If the Affirmation Statement is signed, before the quarter is validated, a new affirmation will be required.

WHAIC processes over 3 million records per quarter and evaluates data for over 250 hospitals and ASCs across the state. Our role is not to find data submission errors, our role is to help identify, guide, and address key issues in the data through internal reports with a variance of ± 20% change in the data. Once the data is released there is no fixing it, replacing it or submitting additional records. We do not give extensions for signing off and/or submitting the affirmation statements.

6.5 Affirmation Statement

The Affirmation Statement is in the Portal, in Data Deliverables, Data Affirmation. Do not sign until validation is complete, or a new one will need to be submitted if quarter is reopened.

The designated primary contacts and/or the person(s) responsible for affirming the correctness of the data acting in his or her capacity as a designated representative of an organization may sign off on the Electronic Data Affirmation Statement (EDAS). **To complete and submit an affirmation statement the primary contact must use the "Data Affirmations" tab via the data deliverables site in the portal.**

Although the EDAS is available immediately, the facility is responsible for validating the data in the reports confirming its accuracy before electronically signing.

Affirmation Statement: The number of records submitted each month are included on the affirmation statement as well as the summary profile report. Users are encouraged to run a similar report, the '**Data Integrity Report'** out of WIpop to review the data in real-time prior to the close of the quarter. The number of patients seen each month is relatively consistent. Any significant shifts in the data or inconsistencies should be investigated and data validated through census or audit reports or other revenue cycle/analytical reporting available at the facility.

An explanation of findings indicating and confirming a formal review took place will be required in the comment field for any deviations of records that have a ± 20% variance from quarter to quarter.

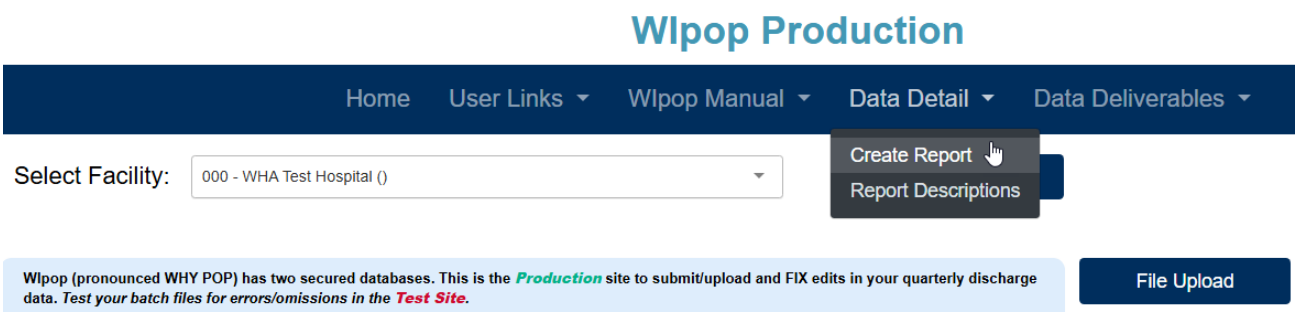
The login credentials of the person signing off on the EDAS will be recorded in the database, a date stamp recording the time of the affirmation and any comments. It is the facility's responsibility to manage internal processes for storage (i.e., save a copy), electronic or printing, of the approved affirmation statement(s). **Wisconsin Administrative Code DHS 120: http://docs.legis.wisconsin.gov/code/admin_code/dhs/110/120**

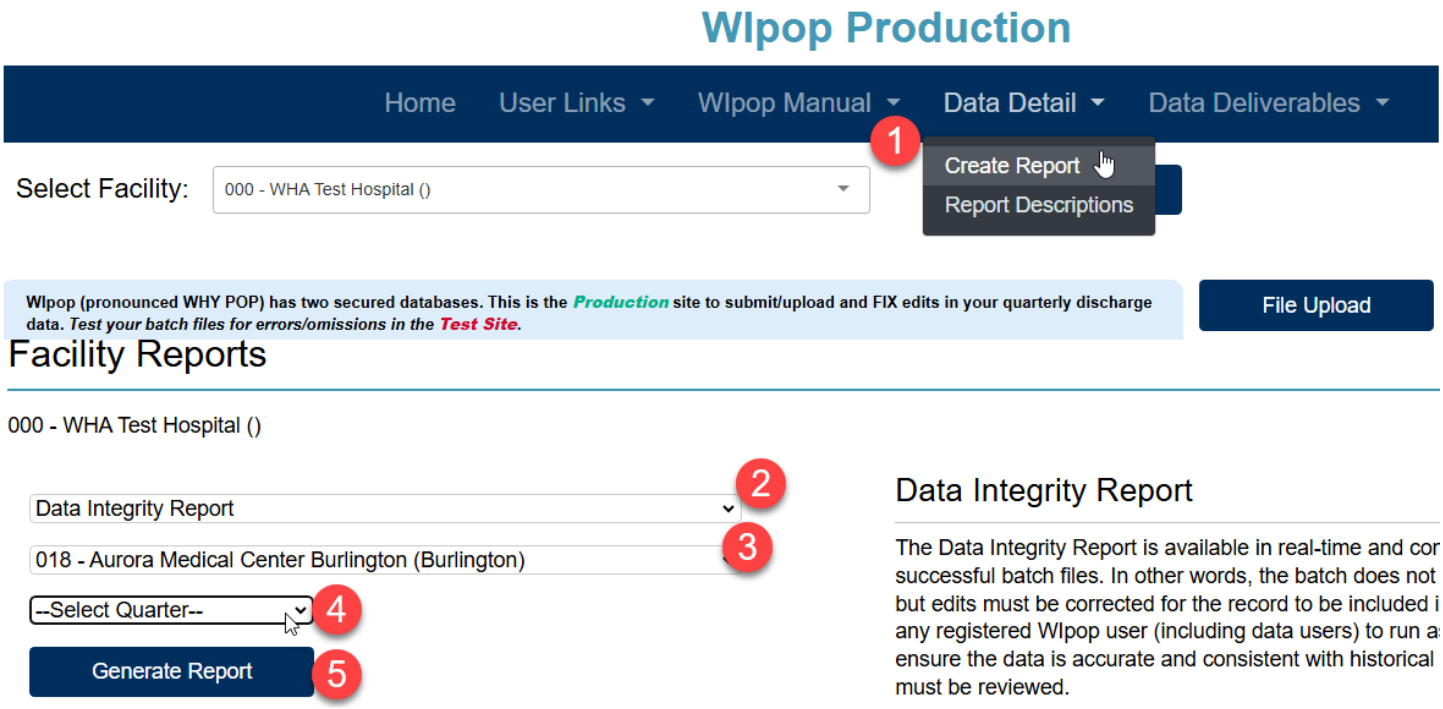
Please note, we discourage facilities to sign the Affirmation Statement before reviewing the data because any changes or updates (including opening the batch files) made will reset. Once the reports and affirmation statement is posted to the porta any changes to the datal will automatically prompt the entire quarter of reports, including the Affirmation Statement, to rerun. Any signed affirmation statements will need to be resubmitted.

6.6 How to Create/Run a Report

Online reports are available in WIpop soon after the data is submitted.

1. First login to WIpop and choose the Data Detail Tab.
2. Click on the Create Report or if you are unsure, choose Report Descriptions to better understand your options.
3. Next pick the report you are seeking, which facility and then the quarter.
4. **Some reports may take longer than others depending on the size of the facility and number of records in the report.**
5. Contact the whainfocenter@wha.org to request a special report or offer a suggestion.



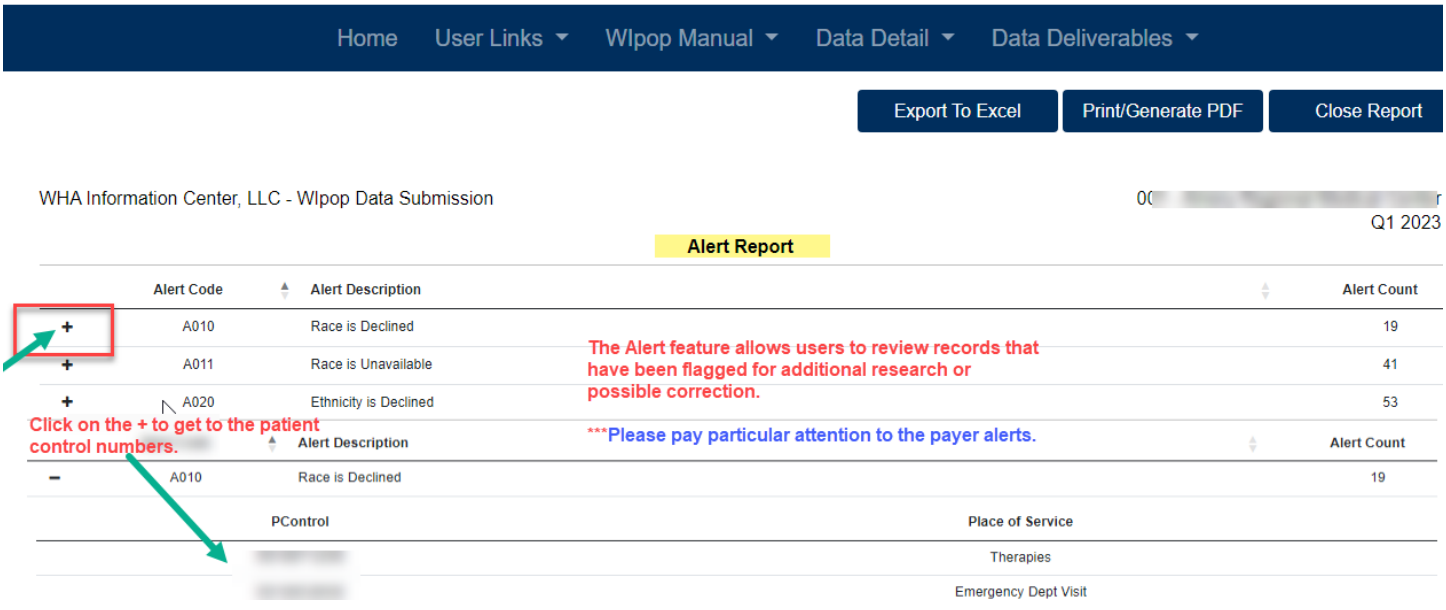


6.7 Batch File Alerts

Alerts are not Edits or Errors. Alerts are an opportunity to review the data more closely and timely and allow ample time to make necessary changes before the end of the year. Submitters and editors are not required to work all Alerts.

* The **Alert bell** may draw your attention to specific areas of race, ethnicity, payer and inpatient and observation stays. *Examples might include patients over 65 reported as non-Medicare, other/unknown payer, race declined/unavailable, OBS over 5 days, IP under 2 days, unknown payer, etc.*

Reports are available in WIpop: Go to Data Detail, Create Report and choose the parameters.



WIpop Batch files contain an Alert Records section for each Patient Type on the far right of the screen. Alerts are based on commentary from data users, the existing real-time and end-of-quarter validation reports, and internal audits of the data. WIpop reports have been updated to compliment the alerts and isolate areas of concern.

Please share any comments, questions, suggestions, and concerns with us at whainfocenter@wha.org

Alert Codes – WIpop Edit Screen	Alert Defined	Alert reconciliation how to handle
A010	Race is Declined	Review EMR and update patient account if race is in the EMR.
A011	Race is Unavailable	Review EMR and update patient account. *Continue to encourage and remind registration of the importance of asking the question even with telehealth, COVID testing, and vaccination encounters.
A020	Ethnicity is Declined	Review EMR and update patient account.
A021	Ethnicity is Unavailable	Review EMR and update patient account. *Continue to encourage and remind registration of the importance of asking the question even with telehealth, COVID testing, and vaccination encounters.
A025	Language is not identified	*New Q22023 – Language is a required field if collected
A026	Payer ID is required AXX, MED, MPC, T19, BGR	*NEW Q12023 – Payer ID is required according to UB-04 and 5010 Standards *Effective Q32024 – an edit will be put in place that will be required to fix
A030	Observation over 5 days	Review EMR and Claim – verify correct use of rev code 0762, and make sure the correct number of days in the hospital is accurate. Adjust record if needed.
A060	Unknown or Other Primary Payer	Verify payor assignment.
A065	Primary Payer code will be expiring 12/31/2021. Edits may occur in Q1 2022. Please see Appendix 7.3 for correct mapping.	To make it easier on the submitter, we are trying to reduce redundancy in payer mapping and code usage. Comments and suggestions are welcome. We may reconsider the requirement to combine all codes into pay type – 09.
A067	Primary and Secondary Payors are the same.	Please verify payer. It is common to list two (2) Medicare payers if the patient has a dual Medicare plan.
A070	*Unknown or Other Secondary Payer*	*This alert has been disabled temporarily. We will reevaluate over the next year.*
A075	Secondary Payer Code will be Invalid after Q12021.	To make it easier on the submitter, we are trying to reduce redundancy in payer mapping and code usage. Comments and suggestions are welcome. We may reconsider the requirement to combine all codes into pay type – 09.
A080	Over 65 non-Medicare Payer	This is not an edit, if the patient is still working and does not have Medicare, leave as is. However, most 65 and older patients have Medicare as a primary payer. Commercial plans offering Medicare Advantage = MPC – 09.
A090	Inpatient stay under 2 days	This alert is based on the CMS' Hospital Inpatient Admission Order and Certification requirements. Inpatient stays that are less than 2 days (excluding discharge status codes: 02, 05, 07, 20 and 66) will trigger alerts.

7. APPENDICES

7.1 Facility List (Hospital and ASCs)

Facility ID: WHAIC assigns a unique 3-digit facility identification number to each facility. This number must be used in the 837 files to upload your data and when corresponding through email or other communications.

if you become aware of a new facility being added or joining your system, please complete the New Facility Form located on our website at:

http://www.whainfocenter.com/Data-Submitters/WiPop/New-Facility-Services

Facility Number	Facility Name	Facility City
001	Amery Regional Medical Center	Amery
002	Aspirus Langlade Hospital	Antigo
003	ThedaCare Regional Medical Center – Appleton, Inc.	Appleton
004	Ascension NE Wisconsin - St Elizabeth Campus (NC Q118)	Appleton
006	Tamarack Health Ashland Medical Center (NC Q42023)	Ashland
007	Western Wisconsin Health (NC: Q316)	Baldwin
008	SSM Health St Clare Hospital - Baraboo	Baraboo
009	Mayo Clinic Health System – Northland in Barron	Barron
010	Marshfield Medical Center - Beaver Dam (Name Change Q42020)	Beaver Dam
011	Beloit Health System	Beloit
013	ThedaCare Medical Center – Berlin, Inc.	Berlin
014	Black River Memorial Hospital	Black River Falls
015	Mayo Clinic Health System – Chippewa Valley in Bloomer	Bloomer
016	Gundersen Boscobel Area Hospital and Clinics	Boscobel
017	Ascension SE Wisconsin - Elmbrook Campus (NC: Q118)	Brookfield
018	Aurora Medical Center - Burlington	Burlington
019	Ascension Calumet Hospital (NC:Q118)	Chilton
~~020~~	~~St Joseph's Hospital~~ (Closed Q124)	Chippewa Falls
022	Prairie Ridge Health (NC Q42019 from Columbus Community Hospital)	Columbus
024	Cumberland Healthcare (NC 0413)	Cumberland
025	Memorial Hospital of Lafayette Co.	Darlington
026	Upland Hills Health Inc.	Dodgeville
027	AdventHealth Durand	Durand
028	Aspirus Eagle River Hospital (NC from Ascension)	Eagle River
029	Mayo Clinic Health System - Eau Claire	Eau Claire
~~030~~	~~Sacred Heart Hospital~~ (closed Q124)	Eau Claire
031	Edgerton Hospital and Health Services	Edgerton
032	Aurora Lakeland Medical Center in Elkhorn	Elkhorn
033	Fond du Lac County Health Care Center	Fond du Lac

034	SSM Health St. Agnes Hospital – Fond du Lac (NC 09/2021)	Fond du Lac
035	Fort HealthCare	Fort Atkinson
037	Gundersen Moundview Hospital & Clinics (NC 10/2017)	Friendship
038	Burnett Medical Center	Grantsburg
039	Bellin Hospital	Green Bay
040	Brown County Community Treatment Center	Green Bay
041	St Mary's Hospital Medical Center	Green Bay
042	St Vincent Hospital	Green Bay
043	Aurora Medical Center in Hartford	Hartford
044	Tamarack Health Hayward Medical Center (NC Q423)	Hayward
045	Gundersen St Joseph's Hospital and Clinics	Hillsboro
046	Hudson Hospital & Clinics	Hudson
048	Mercy Health Hospital and Trauma Center – Janesville (NC 1/18/17)	Janesville
056	Gundersen Lutheran Medical Center	La Crosse
057	Mayo Clinic Health System – La Crosse (NC Q22021)	La Crosse
058	Marshfield Medical Center - Ladysmith (NC Q318)	Ladysmith
059	Grant Regional Health Center	Lancaster
060	Mendota Mental Health Institute	Madison
061	UnityPoint Health - Meriter (NC 1/16)	Madison
063	SSM Health St Mary's Hospital	Madison
064	UW Hospital and Clinics Authority (NC 10/17)	Madison
067	Aurora Medical Center - Bay Area	Marinette
068	Norwood Health Center	Marshfield
069	Marshfield Medical Center (NC 07/17)	Marshfield
070	Mile Bluff Medical Center	Mauston
071	Aspirus Medford Hospital and Clinics, Inc.	Medford
072	Froedtert Menomonee Falls Hospital	Menomonee Falls
073	Mayo Clinic Health System – Red Cedar in Menomonie	Menomonie
074	Aspirus Merrill Hospital (NC from Ascension Good Samaritan Hospital 11/2021)	Merrill
075	Children's Wisconsin Hospital - Milwaukee Hospital (NC 12/19)	Milwaukee
079	Froedtert Hospital	Milwaukee
082	Ascension Sacred Heart Rehabilitation Hospital	Milwaukee
085	Ascension St. Francis Hospital	Milwaukee
086	Ascension SE Wisconsin Hospital - St. Joseph Campus	Milwaukee
087	Aurora St Luke's Medical Center	Milwaukee
091	SSM Health Monroe Hospital (SSM Health: Q118) (NC 09/2021)	Monroe
092	ThedaCare Regional Medical Center - Neenah	Neenah
093	Marshfield Medical Center - Neillsville	Neillsville
094	ThedaCare Medical Center - New London	New London

095	Westfields Hospital & Clinics	New Richmond
098	ProHealth Oconomowoc Memorial Hospital	Oconomowoc
099	Rogers Memorial Hospital Inc.	Oconomowoc
101	St. Clare Memorial Hospital	Oconto Falls
102	Osceola Medical Center	Osceola
103	Ascension NE Wisconsin - Mercy Campus (NC: Q118)	Oshkosh
104	Mayo Clinic Health System – Oakridge in Osseo	Osseo
106	Marshfield Medical Center - Park Falls (NC Q12021)	Park Falls
108	Southwest Health	Platteville
110	Ascension Columbia St Mary's Hospital Ozaukee	Mequon
111	Aspirus Divine Savior Hospital and Clinics (NC 10/1/2020)	Portage
112	Crossing Rivers Health	Prairie du Chien
113	Sauk Prairie Healthcare	Prairie du Sac
117	Reedsburg Area Medical Center	Reedsburg
118	Aspirus Rhinelander Hospital (NC Q421)	Rhinelander
119	Marshfield Medical Center - Rice Lake (NC: Q318)	Rice Lake
120	The Richland Hospital, Inc.	Richland Center
121	SSM Health Ripon Community Hospital (NC Q32021)	Ripon
122	River Falls Area Hospital	River Falls
123	ThedaCare Medical Center - Shawano	Shawano
124	Aurora Sheboygan Memorial Medical Center	Sheboygan
125	St Nicholas Hospital	Sheboygan
127	Mayo Clinic Health System – Sparta (NC Q12021)	Sparta
128	Spooner Health	Spooner
129	St. Croix Regional Medical Center	St Croix Falls
130	Aspirus Stanley Hospital (NC Q4/21)	Stanley
131	Aspirus Steven's Point Hospital (NC Q421)	Stevens Point
132	Stoughton Health (NC 3/2020)	Stoughton
133	Door County Medical Center (NC 11/16)	Sturgeon Bay
134	St Mary's Hospital of Superior	Superior
135	Tomah Health (NC 10/19)	Tomah
136	Aspirus Tomahawk Hospital (NC Q421)	Tomahawk
137	Aurora Medical Center of Manitowoc County	Two Rivers
138	Vernon Memorial Healthcare	Viroqua
139	Watertown Regional Medical Center	Watertown
140	Waukesha County Mental Health Center	Waukesha
141	ProHealth Waukesha Memorial Hospital (Q218)	Waukesha
142	ThedaCare Medical Center – Waupaca	Waupaca
143	SSM Health Waupun Memorial Hospital (NC Q321)	Waupun

144	North Central Health Care	Wausau
145	Aspirus Wausau Hospital	Wausau
~~147~~	~~Milwaukee County Behavioral Health Complex~~ (Closed Q322)	Milwaukee
149	Aurora Psychiatric Hospital	Wauwatosa
150	Aurora West Allis Medical Center	West Allis
151	Froedtert West Bend Hospital	West Bend
152	Gundersen Tri-County Hospital and Clinics	Whitehall
153	ThedaCare Medical Center - Wild Rose	Wild Rose
154	Winnebago Mental Health Institute	Winnebago
155	Aspirus Riverview Hospital and Clinics, Inc.	Wisconsin Rapids
156	Howard Young Medical Center	Woodruff
168	Aurora Sinai Medical Center	Milwaukee
170	Libertas Center (OP Data Only)	Green Bay
172	Bellin Psychiatric Center	Green Bay
178	Froedtert Holy Family Memorial, Inc.	Manitowoc
179	Indianhead Medical Center / Shell Lake	Shell Lake
~~181~~	~~Post-Acute Medical Specialty Hospital of Milwaukee~~ Closed Q219	~~Greenfield~~
182	Aurora St Luke's Medical Center – South Shore	Cudahy
184	Lakeview Specialty Hospital & Rehab	Waterford
189	Aurora Medical Center in Kenosha	Kenosha
190	Select Specialty Hospital – Milwaukee	West Allis
192	Rogers Memorial Hospital – Milwaukee	West Allis
194	Children's Wisconsin – Fox Valley Hospital (NC 12/19)	Neenah
195	Orthopaedic Hospital of Wisconsin	Glendale
~~196~~	~~Columbia Center Birth Hospital~~ (Closed 7/1/2018)	~~Mequon~~
197	Aurora BayCare Medical Center in Green Bay	Green Bay
198	Oakleaf Surgical Hospital	Eau Claire
~~203~~	~~SurgiCenter of Racine Ltd~~ (Facility closed Q418)	~~Racine~~
~~207~~	~~Marshfield Clinic ASC~~ (Termed Q418 - Reporting as PBL under 069)	~~Marshfield~~
~~208~~	~~North Shore Surgical Center~~ (closed Q32020)	~~Milwaukee~~
209	SSM Health Surgery and Care Center	Madison
210	Wauwatosa Surgery Center	Wauwatosa
211	SSM Health Davis Duehr Surgery Center	Madison
212	SurgiCenter of Greater Milwaukee	Milwaukee
218	Northwest Surgery Center	Milwaukee
220	Wausau Surgery Center	Wausau
222	Menomonee Falls ASC	Menomonee Falls
225	Center for Digestive Health	Milwaukee
229	Niagara Health Center	Niagara

231	Madison Surgery Center, Inc.	Madison
233	West Bend Surgery Center	West Bend
234	Ambulatory Surgery Center LLC	Oshkosh
~~235~~	~~Marshfield Clinic – Minocqua ASC~~ (reporting as PBL 01/2021)	~~Minocqua~~
240	Wisconsin Laser and Surgery Center, LLC	Milwaukee
241	Woodland Surgery Center	Appleton
~~242~~	~~Marshfield Clinic – Eau Claire ASC~~ (Reporting as PBL Q12021)	~~Eau Claire~~
243	Arthroscopic Surgery Center LLC	Appleton
246	Center for Aesthetic and Plastic Surgery	Neenah
249	Marshfield Clinic – Wausau Center ASC	Wausau
250	Mayfair Digestive Health Center LLC	Wauwatosa
~~251~~	~~Wisconsin Health Center ASC~~ (APM site closed Q22020)	~~Greenfield~~
253	East Mequon Surgery Center LLC	Mequon
254	PMTC Surgery Center Inc.	Milwaukee
255	Bluemound Surgery Center	Waukesha
257	NovaMed Surgery Center of Madison LLP	Madison
258	Froedtert Surgery Center LLC	Milwaukee
259	Wisconsin Surgery Center LLC	Milwaukee
260	Pinnacle Cataract & Laser Institute LLC	Appleton
~~261~~	~~SurgiCenter of Greater Madison~~ (APM facility closed Q22020)	~~Middleton~~
262	Surgery Center of Wisconsin Rapids	Wisconsin Rapids
~~263~~	~~Sheboygan Medical Center LLC~~ (APM facility closed Q22020)	~~Sheboygan~~
264	Ambulatory Surgical Center of Stevens Point	Stevens Point
266	Orthopedic & Sports Surgery Center	Appleton
~~269~~	~~Aspirus Stevens Point Surgery Center~~	~~Stevens Point~~
270	Transformations Surgery Center, Inc. (Has not reported since Q22020)	Middleton
272	The Orthopaedic Surgery Center LLC	Pewaukee
~~273~~	~~Access Medical Center LLC~~ (APM site closed Q22020)	~~Racine~~
~~274~~	~~United Medical Center~~ (APM site closed Q22020)	~~Milwaukee~~
276	Lake Country Endoscopy Center LLC	Oconomowoc
277	GastroIntestinal Associates Endoscopy Center, LLC	Wausau
278	Northwoods Surgery Center	Woodruff
279	BJOSC, LLC	Wausau
280	The Surgery Center, LLC	Franklin
281	ProHealth Care Moreland Surgery Center	Waukesha
283	Metropolitan Medical Center	Shorewood
~~285~~	~~Pain Centers of Wisconsin – Green Bay, LLC~~	~~Green Bay~~
~~286~~	~~Pain Centers of Wisconsin – Franklin, LLC~~	~~Franklin~~
287	Pine Ridge Surgery Center	Wausau

288	Orthopedic Surgery Center of Green Bay (Q22021 No longer affiliated with Bellin)	Green Bay
289	Alexander Eye Surgery Center, LLC	Appleton
290	GI Specialists, LLC d/b/a Moreland Endoscopy Center	Waukesha
~~291~~	~~Southeast Wisconsin Ambulatory Surgical Center~~ Closed February 2019	~~Kenosha~~
~~293~~	~~Pain Centers of Wisconsin-Fox Point~~	~~Fox Point~~
294	Independent Surgery Center, LLC	Chippewa Falls
~~295~~	~~Pain Centers of Wisconsin - Kenosha~~	~~Pleasant Prairie~~
296	Pain Centers of Wisconsin – Fort Atkinson (reopened - new arrangement with Fort)	Fort Atkinson
297	EC Laser and Surgery Institute of WI, LLC	Wausau
298	Vascare Mayfair, LLC	Wauwatosa
299	Tower Clock Surgery Center	Green Bay
300	Select Specialty Hospital – Milwaukee – St. Francis (NC 04/18)	Milwaukee
302	Ascension All Saints, Inc. (NC: Q118)	Racine
303	Aurora Medical Center in Oshkosh	Oshkosh
305	Froedtert South (NC: from UHS 10/1/17)	Kenosha
306	Bellin Health Oconto Hospital	Oconto
~~307~~	~~LIFECARE Hospitals of Milwaukee~~ (closed June 2019)	~~Milwaukee~~
308	Marshfield Medical Center - Weston (NC 1/8/2020)	Weston
309	Mercyhealth Hospital & Medical Center – Walworth (NC 1/18/17)	Lake Geneva
310	Select Specialty Hospital - Madison	Madison
311	Ascension SE Wisconsin Hospital – Franklin (NC: Q118)	Franklin
312	ProHealth Rehabilitation Hospital of Wisconsin (NC Q218)	Waukesha
313	Midwest Orthopedic Specialty Hospital	Franklin
314	Aurora Medical Center in Summit	Summit
315	Aurora Medical Center in Grafton	Grafton
316	Columbia St. Mary's Hospital Milwaukee	Milwaukee
317	St. Mary's Janesville Hospital	Janesville
319	Rogers Memorial Hospital	Brown Deer
320	UW Health Rehabilitation Hospital	Madison
321	Willow Creek Behavioral Health (New 01/2017)	Green Bay
322	Marshfield Medical Center - Eau Claire (New Q318)	Eau Claire
323	Marshfield Medical Center-Minocqua (New Q32020)	Minocqua
324	Aspirus Plover Hospital (NC from Stevens Point Hospital 11/2021)	Steven's Point
325	Froedtert Community Hospital - New Berlin (New Q4 2020)	New Berlin
326	Froedtert Community Hospital - Pewaukee (New Q42020)	Pewaukee
327	Miramont Behavioral Health (New Q12022)	Madison
328	Ascension Wisconsin Hospital - Menomonee Falls - Micro Hospital (New Q12022)	Menomonee Falls
329	Ascension Wisconsin Hospital - Greenfield - Micro Hospital (New Q12022)	Greenfield
330	Ascension Wisconsin Hospital - Waukesha - Micro Hospital (New Q12022)	Waukesha

331	Aurora Medical Center Mount Pleasant	Mount Pleasant
332	Froedtert Community Hospital - Oak Creek	Oak Creek
333	Froedtert Community Hospital - Mequon	Mequon
334	ProHealth Care Waukesha Memorial Hospital - Muckwonago	Muckwonago
335	Marshfield Medical Center - River Region at Steven's Point	Steven's Point
336	Granite Hills Hospital	West Allis
337	Milwaukee Rehabilitation Hospital	Milwaukee
338	ThedaCare Medical Center Orthopedics - Spine and Pain	Appleton
339	Froedtert Bluemound Rehabilitation Hospital	Wauwatosa
340	Mental Health Emergency Center (New Q123)	Milwaukee
341	Encompass Health Rehabilitation Hospital of Fitchburg (New Q124)	Fitchburg
342	ClearSky Rehabilitation Hospital of Kenosha	Kenosha
343	Green Bay Rehabilitation Hospital	Green Bay
344	Green Bay ER & Hospital	Bellvue
345	Aurora Medical Center - Fond du Lac	Fond du Lac
346	PAM Health Rehabilitation of Wausau	Wausau
~~400~~	~~Pain Center of Wisconsin – Wausau~~	~~Wausau~~
~~401~~	~~Pain Center of Wisconsin - Wauwatosa~~	~~Wauwatosa~~
~~402~~	~~Pain Center of Wisconsin – Beaver Dam~~	~~Beaver Dam~~
~~403~~	~~Pain Center of Wisconsin – West Bend~~	~~West Bend~~
~~404~~	~~Pain Center of Wisconsin – Appleton~~	~~Appleton~~
405	~~Pain Center of Wisconsin – Stevens Point~~ (Closed Q1 2020)	Stevens Point
~~406~~	~~Waukesha Pain Center, LLC~~	~~Waukesha~~
407	Wisconsin Digestive Health Center	West Allis
408	Wisconsin Specialty Surgery Center	Kenosha
409	Heart and Vascular Institute, LLC	Pewaukee
~~410~~	~~Pain Center of Wisconsin – Sauk Prairie~~	~~Prairie du Sac~~
~~411~~	~~Pain Center of Wisconsin – Oconto Falls~~	~~Oconto Falls~~
412	GLSD Medical LLC	Franklin
413	BJOSC at Plover (New Q319)	Plover
414	Aurora Surgery Center, LLC - Germantown	Germantown
~~415~~	~~Lake Country Surgery Center~~ (Closed Q418)	~~Pewaukee~~
416	Bellin Health Marinette Surgery Center (New Q118)	Marinette
417	Geneva Surgical Suites, LLC (New Q318)	Genoa City
418	Milwaukee Surgical Suites, LLC	Franklin
419	Midwest Nephrology Associates Surgery Center	Milwaukee
420	Wisconsin Institute of Surgical Excellence, LLC (New Q418)	Neenah
421	New Berlin Medical Services (New Q418)	New Berlin

422	Southern Lakes Endoscopy LLC (New Q119)	Mukwonago
423	Drexel Town Square Surgery Center (New Q119)	Oak Creek
424	Aurora Surgery Center - Greenfield (New Q32019)	Greenfield
425	Advanced Spine Center of Wisconsin, LLC	Neenah
426	Ascension Wisconsin Surgery Center - Mount Pleasant LLC (New Q22020)	Mount Pleasant
427	BayCare Aurora Kaukauna Surgery Center (New Q4 2020)	Kaukauna
428	Aurora Pleasant Prairie Ambulatory Surgery Center (New Q4 2020)	Pleasant Prairie
429	Kenosha Digestive Health Center (New Q12021)	Kenosha
430	Orthopedic Surgery Center of the Fox Valley (New Q22021)	Neenah
431	North Shore Surgical Suites (New Q32021)	Pleasant Prairie
432	Racine Digestive health Center (New Q32021)	Sturtevant
433	Eye Surgery Center of Wisconsin	Oak Creek
434	Spine Solutions of Green Bay	Green Bay
435	Spine Solutions of Sheboygan	Sheboygan
436	Spine Solutions of West Bend	West Bend
437	BJOSC LLC Westwood	Wausau
438	Gastrointestinal Associates Endoscopy Center LLC	Steven's Point
439	Neurospine and Endovascular Center LLC	Franklin
440	Valley Surgery Center (New Q423)	Hudson
441	Pharos Enterprises of Wisconsin (New Q423)	West Allis
442	Prevea Health Ambulatory Center (New Q423)	Green Bay
443	OrthoMidwest Surgery Center	Beloit
444	Waukesha SurgiCenter LLC	Waukesha
445	Milwaukee SurgiCenter LLC	Franklin
446	Madison SurgiCenter LLC	Madison
447	Kenosha SurgiCenter LLC	Kenosha
448	Fresenius Access Care Physicians of Madison ASC	Madison
449	Advanced Surgical and Restorative Care, LLC	Altoona
450	Spine and Neuro Health and wellness Center	Lake Geneva
451	Tower Clock Surgery Center Appleton	Appleton

7.2 Race and Ethnicity Codes

The State of Wisconsin requires collection and reporting of race data. Batch files will be **rejected if more than 25% of race and ethnicity codes are missing.**

Effective with Q42024 WHAIC is implementing the two (2) new OMB Race categories and codes and asks that you update your data collection efforts. This change will require facilities to update the patient registration questions or mapping to the updated list of race options. In addition, we also encourage facilities to collect and report a more detailed sub-category of race. Meaning, we are expanding the race field to allow for the collection of the main category as well as allowing patients to self-identify in reporting (more than one) sub-category in the discharge data if collected.

WHAIC Implementation of New OMB Guidelines

Implementation Timeline: Effective Date: Q4 2024 New Race Data Collection Updated and Available.

Requirement: By Q1 2026 - All facilities are required to submit data according to the new guidelines and codes.

Interim: For the next year, during the transition period, WHAIC will allow for both types of submission of race and ethnicity while working with facilities to update their extracts.

Key Changes:

- Single Question Format: There is no longer a separate category for ethnicity. The new format combines race and ethnicity into a single question.
- Reasoning: The OMB's research indicates that a single question format reduces confusion and more accurately reflects how people view their identity.
- Action Items for Data Collection Entities:
- Update Data Collection Systems: Ensure all verbal, written, EMR/EHR and collection systems and processes are updated to reflect the new combined race and ethnicity categories. We encourage hospitals and ASCs to collect data at the detailed level.
- Update the 837 File Loop 2010BA/2010CA and Element DMG05-1. DMG is a composite element, which repeats up to 10 times. RET
- Resources: Addressing Health Care Disparities through Race, Ethnicity and Language (REaL) Data | IFDHE
- ifdhe_real_data_resource.pdf

Main Code	Main Category	Subcategory Code	Subcategory Code	Subcategory	Subcategory	Subcategory	Subcategory
1	American Indian or Alaskan Native	101 - Aztec	102 - Cherokee	103 - Eskimo	104 - Iroquois	105 -Maya	106 -Navajo
2	Asian, Asian American, Asian Indian	201 - Chinese	202 - Filipino	203 - Hmong	204-Japanese	205 - Korean	206 - Laotian or Vietnamese
3	Black or African American	301 - African	302 - Jamaican	303 - Ethiopian	304 - Haitian	305 -Nigerian	306 - Somali
4	Native Hawaiian or Pacific Islander	401 -Chamorro	402 -Guamanian	403 - Fijian	404-Marshallese	405 - Tongan	406 - Samoan
5	White / Caucasian	501 - English	502 - German	503 - Irish	504 - Italian	505 - Polish	506 - Scottish

6	NEW: Arab, Middle Easter or North African	601 - Egyptian	602 - Iraqi	603 - Lebanese	604 - Pakistani	605 - Syrian	606- Moroccan
8	NEW: Hispanic or Latino	801 - Cuban	802 - Dominican	803 - Guatemalan	804 - Mexican	805 - Puerto Rican	806 - Salvadoran
7	Declined						
9	Unavailable						

Simplified Listing of Main Categories

WHAIC Code	Main Category	Description
1	American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
2	Asian	A person having origins in any of the original peoples of East Asia, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
3	Black or African American	A person having origins in any of the Black racial groups of Africa.
4	Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5	White	A person having origins in any of the peoples of North America, Europe, North Africa, or the Middle East.
6	NEW: Arab, Middle Eastern or North African	MENA Americans can trace their origins to more than a dozen countries, including Egypt, Morocco, Iran, Turkey and Yemen. People from there can be white, brown or Black, as well as identify with an ethnic group, like Arab, Amazigh, Kurdish, Chaldean and more.
8	NEW: Hispanic or Latino	A person of Mexican, Puerto Rican, Cuban, Central or South American, or Spanish culture or origin, regardless of race.
7	Declined	A person who refuses to answer this question.
9	Unavailable	A person unable to answer this question, or no available family member or caregiver to respond for the patient. May also be used by patients if their race is unknown.

Ethnicity Valid Until 12/31/2025

1	Hispanic or Latino	A person of Mexican, Puerto Rican, Cuban, Central or South American, or Spanish culture or origin, regardless of race.
2	Non-Hispanic or Latino	Person not of Hispanic or Latino ethnicity.
7	Declined	A person who refuses to answer this question or cannot identify him/herself ethnicity.
9	Unavailable/Unknown	A person unable to answer the question, or ethnicity is unknown to the patient.

WHAIC Race Collections Update Effective 10/1/2024

According to the OMB **SPD 15 is revised to** and details contained in the Federal Register, patients (to the degree possible) should self-report race and/or ethnicity *at the detailed subcategory levels*. If this is not feasible, data must be collected and reported at the Minimum Category. OMB "Standards set forth minimum categories. The standards should set forth minimum categories; additional categories should be encouraged, provided they can be aggregated to the minimum categories. The number of minimum categories should be kept to a manageable size, as determined by statistical concerns and data needs." The updated SPD 15 is effective immediately. Patients may choose all the subcategories that apply. WHAIC will record the categories as supplied in the file in WIpop.

Additional Information:

In 2022, the Office of Management and Budget (OMB) initiated a review of the 25-year-old race and ethnicity standards. The update aims to produce more accurate and useful race and ethnicity data across all data collection agencies.

Facilities may need to work with their EMR/EHR or claims vendor to make sure they have the capability to collect and report more than one race. Collecting Subcategories: If a facility collects patient race data at the detailed/sub-category level, prior to release of data, WHAIC will map those back to the main collection category until we have enough data to support adding the subcategories to WIpop. For example, if a patient chooses German, WHAIC will map that patient to the WHITE Category 5.

Update the 837 File Loop 2010BA/2010CA and Element DMG05-1. DMG is a composite element, which repeats up to 10 times.

Questions you may have for WIpop data collection system

Q1. Can the facility send main or subcategory or both?

A. Yes, the file may contain both main and subcategory.

Q2. If a facility has different categories in the patient registry such as Chinese American – but it's not on the WHAIC list as a viable category, should the facility roll that up to the proper Asian category for WHAIC?

A. Yes, the facility may choose to map to the main category code 2 or subcategory 201.

Q3. Can you provide an example of what the new codes would look like in the file?

A. DMG*D8*19960913*M*S*RET:R5^RET:E2^RET:R502^RET:R503****ZZ*ENG

- When translated in the file it looks like this:
  DMG*D8*19960913*M*S*5:2:502:503****ZZ*ENG
  Race 1 = 5
  Ethnicity = 2
  Race 2 = 502
  Race 3 = 503

Q4. For reporting of ethnicity in the hospitals 837 claim file – In 2026, can hospitals still submit the ethnicity segment, but WHAIC ignores that in the file/parser.

A. Once WHAIC transitions to the new collection requirement, users do not have to update their files to remove the ethnicity. Facilities may still submit how they do now, meaning the Ethnicity field will be ignored effective 1/1/2026. We feel this is likely to be the easiest and most cost-effective way for facilities to do this.

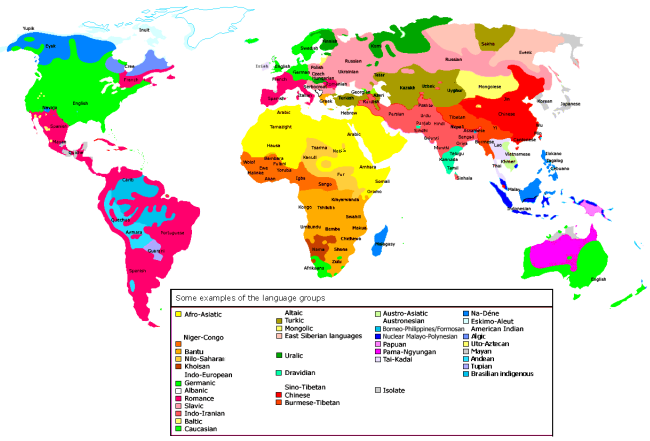
7.3 Language Codes

Language is not on the claim form, but available in the EMR – much like Race/Ethnicity

- Language: Loop 2010BA / 2010CA, DMG10 = ZZ (Mutually Defined), DMG11 = Language Code
- If the language name (comes through on the file, it will be cut off after three characters) In other words, we will take a full language name as most of them are the first three characters and disregard the rest.
    - https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf

WHAIC Language Codes	
Abrv	Primary Language
AFR	African Language(s)
ALB	Albanian
ARA	Arabic
ASL	American Sign Language
CHI	Chinese
ENG	English
FRC	French-Creole
FRE	French
GER	German/Deutsch
GRE	Greek
HAI	Haitian Creole
HEB	Hebrew
HIN	Hindi
HMO	Hmong-Mien
ICE	Icelandic
IND	Indonesia
ITA	Italian
JPN	Japanese
KOR	Korean
LAO	Laos / Laotian
MAN	Mandarin
MON	Mongolian
NAV	Navajo
OIE	Other Indo European
ONA	Other Native - North American
OPI	Other Pacific Island
OTH	Other

OWG	Other West Germanic
PER	Persian
PHI	Philippine
POL	Polish
POR	Portuguese
PUN	Punjabi
ROM	Romanian
RUS	Russian
SCA	Scandinavian
SCC	Serbo-Croatian (Cyrillic)
SER	Serbian
SPA	Spanish
SWE	Swedish
TAG	Tagalog
THA	Thai
VIE	Vietnamese
YAO	Yao (Hmong-Mien)



7.4 Expected Source of Payment and 837 Payer Mapping

Definition: *The source of payment that is expected to pay the greatest share of the encounter or claim should be listed as the primary payer.*

Types of Health Insurance Coverage - Most consumers have health insurance coverage from one of three sources:

https://oci.wi.gov/Documents/Consumers/PI-225.pdf

- An individual health insurance policy
- A group health insurance policy (employer-sponsored coverage) or self-insured plans such as TPA/BPA
- A government-sponsored program (includes BadgerCare Plus, Medicaid, and Medicare).

See Section 5.5 to reference the Mapping rules and Spec's to include the Payer ID off the claim in loop 2010BB REF02

Payer Table Mapping Details

11/2024 Updated Table - removed plans that are no longer available or serving WI residents.

Payer ID	Pay Type	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website & comments Medicare Advantage plans = MPC 09
A10	09	Aetna (Aetna Healthcare Assurance Programs of Wisconsin, Inc.)	https://www.aetna.com/
A11	09	Ambetter (Managed Health Services Insurance Corp.)	Marketplace: https://www.ambetterhealth.com
A12	09	Blue Cross Blue Shield (aka Anthem, Anthem Blue, etc.)	www.anthem.com
A15	09	Cigna Health and Life Insurance Company	Multiple plan types: https://www.cigna.com/
A16	09	Common Ground Healthcare Cooperative (Brookfield)	https://www.commongroundhealthcare.org/our-plans/individuals-families/
A17	09	Dean Health Plan, Inc. (Madison)	www.deancare.com
A18	09	Group Health Cooperative of South-Central Wisconsin (Madison)	ghcscw.com
A20	09	HealthPartners Insurance Company	https://www.healthpartners.com/hp/insurance/ domicile state MN
A22	09	Humana Insurance Company, Humana Wisconsin Health Ins. Corp.	www.humana.com
A24	09	Medica Community Health Plan Insurance Company	www.medica.com
A25	09	MercyCare HMO, Inc. - and MercyCare Insurance Company	www.mercycarehealthplans.com
A26	09	Molina Healthcare of Wisconsin, Inc.	https://www.molinahealthcare.com/
A27	09	Network Health Plan	https://networkhealth.com/
A29	09	Security Health Plan of Wisconsin, Inc. (Marshfield)	www.securityhealth.org
A30	09	UnitedHealthcare Insurance Company	www.uhc.com
A31	09	Quartz (Formerly Unity Health Plans Insurance Corporation) "Quartz Health Solutions, Inc. is co-owned by UW Health, Gundersen Health System and UnityPoint Health – Meriter.	Users can use this code or A43-09 01/2023 left in the table for 2023 reporting year.
A32	09	WPS Wisconsin Physicians Service Insurance Corp. (Madison, WI)	www.wpshealth.com
A33	09	Managed Health Services Insurance Corp.	https://www.mhswi.com/get-insured.html
A34	09	Aspirus Health Plan of Wisconsin	https://www.aspirus.org/aspirus-health-plan
A35	09	ARM Health EOS / HealthEOS / MultiPlan	
A36	09	Chorus Community Health Plan (Formerly Children's Community Health Plan, Inc. 9/2022)	http://TogetherCCHP.org
A39	09	Group Health Cooperative of Eau Claire (Eau Claire)	www.group-health.com
A40	09	The Medical Associates Clinic Health Plan of Wisconsin	www.mahealthcare.com

Payer ID	Pay Type	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website & comments Medicare Advantage plans = MPC 09
A43	09	Quartz Health Benefit Plans Corporation (Sauk City, WI) GHP, Unity and PPIC:	https://quartzbenefits.com
A44	09	Choice Plus UHC / UMR (University Health Care)	
A47	09	US Health and Life Insurance Company	www.ushealthandlife.com
A48	09	All Savers Insurance Company	www.myallsavers.com
A49	09	Care Improvement Plus Wisconsin Insurance Company	Parent company is UnitedHealth Group Inc.
A51	09	New 2023: Robin with HealthPartners	https://www.healthpartners.com/insurance/robin/
A99	09	Other Commercial or nationwide out of state (not listed here) carriers. (Golden Rule Insurance, American National Life Insurance Co. of Texas)	
		NON-COMMERCIAL PLANS	
MED	09	Medicare Medicare is **federal health insurance for people 65 or older**, some younger people with disabilities, and people with End-Stage Renal Disease. Medicare Supplement policy is an extension of Medicare. A Medigap policy is a supplement to Original Medicare. https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance What is Medicare? *https://www.medicare.gov/Pubs/pdf/11306-Medicare-Medicaid.pdf*	Effective Q12021: To simplify mapping, we removed the requirement to identify PayType 01 & 02 - these paytypes are still available, but users may now report w/Paytype 09. This is intended to simply the processes of the hospital and ASC staff. Some patients >65 may carry employer sponsored health coverage. An alert will show.
MPC	09	NEW Q422: Medicare Advantage Plans (Part C) *Medicare Advantage plans are offered by private companies approved by Medicare.* Medicare Advantage HMO/PPO (E.g., Medicare Advantage Plans) AARP, Senior insurance carriers, etc. all go in this bucket. If the patient has dual Medicare plans, list both primary and secondary using the correct codes. This bucket can also include Medicare Supplemental / Medigap plans.	Usually provided by a commercial plan. Typical Plans: Aetna Allwell Anthem Blue Cross/Blue Shield Humana Medica Molina Quartz Benefits United Healthcare WellCare (Centene)
T19	09	Medicaid, Fee for Service: Wisconsin Medical Assistance (Medicaid). According to DHS: Medicaid serves the elderly, blind and disabled = T19/09 Facilities may verify eligibility through the ForwardHealth Portal. Medicaid, HMO/PPO: Many people who receive Medicaid SSI or SSI-related Medicaid because of a disability determined by the Disability Determination Bureau must try Medicaid SSI HMO enrollment. Ex: Care Wisconsin.	Effective Q12021: To simplify mapping, we removed the requirement to identify PayType 01 - identifies straight Medicaid FFS Paytype 02 - identified Medicaid HMO/PPO PayType 09 - Universally accepted mapping Plan names: Community Care Health Plan, Inc.
BGR	09	BadgerCare, Fee for ServiceBadgerCare Plus, HMO/PPO: Families - parents, pregnant women, children, and childless adults. **Most BGR patients have HMO plans - BGR/02**.	May include Trilogy Health, Community Care Health & Independent Health Care.

Payer ID	Pay Type	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website & comments Medicare Advantage plans = MPC 09
		Independent Care Health Plan (iCare) Joint venture of Humana and Milwaukee Center for Independence that serves children and adults with disabilities/special needs. Added Family Care Partnership in 2010 Medicaid & Medicare managed care. Review payer of last resort guidelines and advice. WI ForwardHealth has billing requirements that should be reviewed and adhered to. Online Handbook Display (wi.gov)	BadgerCare (families, pregnant women, & childless adults) typically HMO – in WIpop/837 file = BGR/09
CHA	03	VA Health Care/ OPTUM VA / TRICARE (CHAMPUS) **supplement** (Military / Veteran) **CHAMPVA** Supplement Insurance Plan. The Civilian Health & Medical Program of The Department Of Veterans Affairs (Champva).	About VA
C19	80	COVID-19 HRSA Uninsured Program NEW: Q120 Provider COVID-19 Vaccine Fact Sheet (hhs.gov)	
OTH	21	Other Organization Self-Funded, Self-Insured, Fee for Service/HMO/PPO (Ex. ACA, Tribal Services, municipalities, school districts, ASR Health Benefits, Third Party Benefit Plan or Benefit Plan Admin/Other Plan Administrators, etc.) **Private employer insurance types get mapped from this code.** *A quick google search will help identify the plan name and type.*	NEW: 1/1/2021 combined OTH 21 and 31 to one option: Use OTH 21 to map all private payers, Alliance and Group / Benefit/Third Party Plan Administrators, Managers or other types of organizations that are self-funded or have plan managers.
OTH	41	Workers Compensation Insurance https://oci.wi.gov/Pages/Consumers/WorkersComp.aspx	If there is no insurance cert number - user can use the pcontol or year of birth.
OTH	51	**Medicaid, Out of State: Ex. Minnesota, Iowa, Illinois, Michigan Medicaid Patients.**	
OTH	52	Other Government: 51.42/51.437/46.23 County Board Ex. Mental/Behavioral Health and Department of Corrections, and other County Dept. for aging, chronically ill or chemically dependent.	For use with patients coming from a jail / mental health facility or other county departments where the patient is under the care of the state.
OTH	54	Wisconsin Family Care Program (WI – DHS Program): https://www.dhs.wisconsin.gov/publications/p0/p00570.pdf ; Ex. Care Wisconsin: https://www.dhs.wisconsin.gov/news/releases/070717.htm **Category includes reporting for the previous mapping of OTH 59 and 71** – all are used to report free and/or subsidized government programs, nonprofit organizations, local health departments, and grant/research funds. To simply report, hospitals and ASCs can use this to capture all categories contained in this section including subsidized health care through grants, research, and other charity care. Wisconsin Well Woman Program / Susan G. Komen Funding Community Care Health Plan, Inc. / Community Care, Inc. Community Care Health Plan, Inc., provides care under two government programs: Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership Program (Partnership) and Independent Care Health Plan Eligible individuals choose from Care Wisconsin and My Choice Family Care, upon certification. Advocates4U, Connections, First Person Care Consultants, and TMG intend to support those choosing IRIS. *May also include Indian / Tribal Care or Children	NEW: 1/1/2021 category now includes code 59 and 71. IRIS (Include, Respect, I Self-Direct) Information Family Care, Family Care Partnership, and PACE Information Birth to 3 Program Information Children's Long Term Support Waiver Program and Children's Community Options Program Information whose care is paid from funds granted to the office of Indian Affairs.

Payer ID	Pay Type	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website & comments Medicare Advantage plans = MPC 09
OTH	61	Self-Pay: Insurance Cert field may be left blank with self-pay (Cert Number field must be blank) This field also includes cost sharing plans - because no claim is created, and a statement is invoiced. For example, ALtrua HealthShare, and Liberty Share.	State statute requires facilities to report self-pay encounters along with all other encounters.
OTH	99	Other or Unknown Payer: TPL, MVA, state funded crime victim or safe funds, and some other unknown payers that are not related to commercial, private, or other forms identified in the mapping table. rom auto insurance to crime victim claims Unknown Type (Ex: crime victim funds and claims, disability determination, unidentified programs or WI SAFE Fund (sexual assault). Other or Unknown **TPL** (Auto - Accident - State Farm Auto, American Family auto). No Fault insurance is medical coverage for injuries that are related to motor vehicles. In states where car insurance is mandatory no fault is always primary, no matter what other insurance coverage a person may have.,	Do not use this code to report or map unknown commercial (A99) or private insurance companies (OTH 21). This is not a catch all code. Alerts will be set up as well as frequent audits to work with facilities to make necessary corrections.

State of Wisconsin, Office of the Commissioner of Insurance – Guide to Health Care Insurance

1/1/2021	MED, T19, BGR	01 and 02	New: Users have the option to report only 09. This is intended to simply the processes of the hospital and ASC staff.
1/1/2021	T18	01/02/09	Combined to MED. Data shows only 25% of hospitals and ASCs use this code.

https://appliedga.com/medicare-carriers-by-state/

7.4.1. CLAIM FILING INDICATOR CODE

Definition: Code identifying type of claim or expected adjudication process. The first reported payer Claim Filing Indicator code must be associated with the primary payer.

One required element when submitting electronic claims is the claim filing indicator code. It identifies to the payer what type of claim is being submitted. When a patient has multiple insurances, it also indicates which payer is primary.

Purpose: Collection of the Claims Filing Indicator code will provide WHAIC and facility an additional **internal cross check** to verify payers are reported as accurately as possible.

Data Element: **837I/R 837P:** Loop 2000B / SBR09 **Field Details:** Situational (If collected, report code)

X12 Code	X12 Description	WHAIC Mapping / Description
09	Self-pay	OTH-61 - No payment expected or no insurance to bill
11	Other Non-Federal Programs	Other government, Department of corrections, Misc / other
12	Preferred Provider Organization (PPO)	Axx – 09 - Private Health Insurance, managed care unspecified
13	Point of Service (POS)	Private Health Insurance, managed care unspecified
14	Exclusive Provider Organization (EPO)	Private Health Insurance, managed care unspecified

X12 Code	X12 Description	WHAIC Mapping / Description
15	Indemnity Insurance	A Code – Private Health Insurance
16	Health Maintenance Organization – Medicare Risk	MPC-09 Medicare
17	Dental Maintenance Organization	OTH-99 Private Insurance
AM	Automobile Medical	OTH-99 – Other Insurance
BL	Blue Cross	Map to WHAIC A Code
CH	CHAMPUS – Civilian Health and Medical Program of the Uniformed Services	CHA-03
CI	Commercial Insurance Company	Map to correct "A" Code to represent Commercial Payer - Non-Medicare payer
DS	Disability	OTH-99
FI	Federal Employees Program	OTH-99, A code, OTH-21
HM	Health Maintenance Organization (HMO)	A Code – Commercial Insurance or MPC-09 Med Advantage
LM	Liability Medical	OTH-99
MA	Medicare Part A	Medicare
MB	Medicare Part B	Medicare
MC	Medicaid	T19-09 - Medicaid
OF	Other Federal Program, Medicare Part D Claims	Other Government, Department of Corrections
TV	Title V - **Title V funds support programs for children with special health needs**	Other Government Program: Maternal and Child Health Services Block Grant Program
VA	Veterans Administration / Affairs Plan	CHA-03
WC	Workers Compensation Health Plan	OTH-41
ZZ	Charity or Unknown	OTH-99 – Type of Insurance is unknown

7.4.2. PAYER ID NUMBER

Data Element: 837I, 837R, 837P: Loop 2010BB / REF01 (NF (PayerID Code), REF02 = Value

Field Details: Situational

- **Definition:** Support the Exchange of EDI Claims Using a Payer List and Payer ID. This field will have edits in 2024 on Commercial, Medicare, Medicaid and BadgerCare insurance plans. All other insurance types (self-insured, worker's comp, etc.) are encouraged to report the Payer ID but will not have edits. When using the services of a clearinghouse, it is critical that the proper Payer ID is used so the EDI claims are sent to the right payer.

- The Payer ID or EDI is a unique ID assigned to each insurance company. It allows provider and payer systems to talk to one another to verify eligibility, benefits and submit claims. The payer ID is five (5) characters, but it may be longer. It may also be alpha, numeric or a combination.

    - https://www.inovalon.com/payer-list/

- Insurance payers use what is called a payer id to route claims to the correct insurance company, or payer. Some insurances have the same payer id among all clearinghouses, while others may differ. Payer ids can be found in the patient's chart > demographics > insurances. If you start typing the name of the payer, you will be given a list of options.

    - https://support.drchrono.com/hc/en-us/articles/4408566426651-What-does-PRNT-mean-when-it-is-part-of-the-payer-id-

- **Purpose:** This field will allow WHAIC an internal and external cross check on accuracy of payer mapping and give data users a better result when reviewing payer assignment. Based on WHAIC research most facilities use an EDI Claims Payer List to identify or map a Payer ID to support their electronic transactions **are routed to the right health plan**.

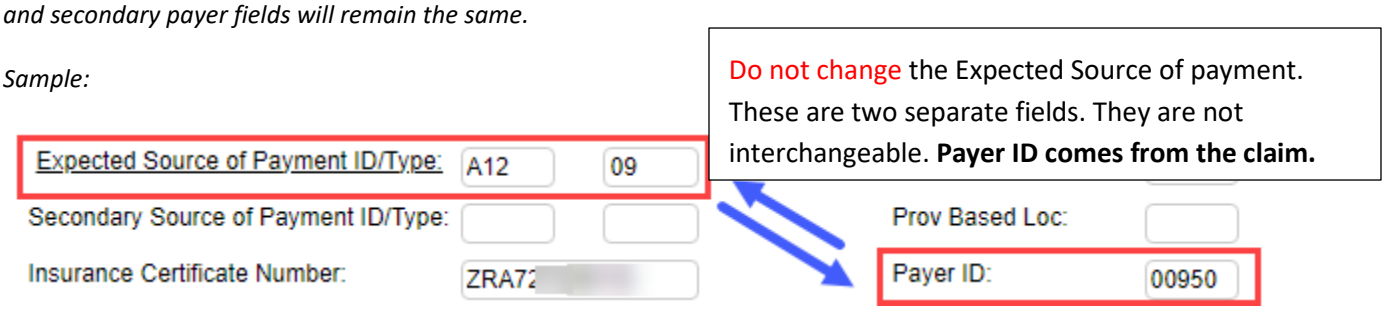
  Are payer IDs universal?
  Some national payers, such as Aetna (60054), Cigna (62308), and United Healthcare (87726) have universal payer IDs that can be used across all clearinghouses. Other payers can have different payer ids based on the clearinghouse.

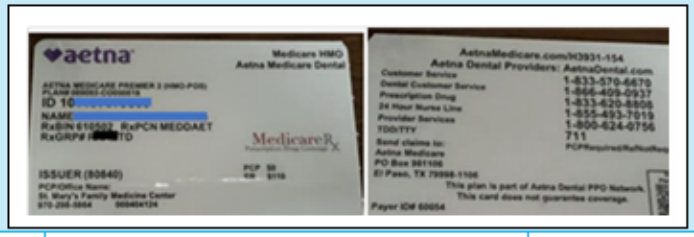
WHAIC Notes:

1) Our goal is to get the PayerID off the encounter/claim. Once we have consistency with the Payer ID, we can bump it up against an internal table and validate payers more frequently for accuracy.

2) Submitters should not replace the existing payer mapping fields with the Payer ID code as described above. The existing primary and secondary payer fields will remain the same.

Sample:



LOOP ID - 2010BB Payer Detail **LOOP 2010BB: PAYER NAME** **NM1*PR*1*Aetna*****PI*A10-09~** **REF*NF*60054**						
2010BB	NM101	Payer Entity ID Code	R	PR = Payer	
2010BB	NM102	Entity Type Qualifier	O	1 = Non-Person Entity *NM102 qualifies NM103	Discarded
2010BB	NM103	Payer Name	R/S	Name of Payer Organization as provided on the claim.	
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code *Self-pay requires OTH-61	R	WHAIC Values in Appendix 7.3 Element format is **AAA-99;** Example A21-09 Primary Source of Payment ID	SOPID is characters 1-3 - SOPTYPE is characters 5-6 The dash is preferred, but not required
2010BB	REF01	REF ID Qualifier for Payer/NAIC#	S	NF	Payer Identifier in the EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer ID	S	Enter the Value of the Payer ID. This value is found on the patient's insurance ID card. This value directs the claim to the correct payer or plan type (commercial, Medicare, ACA plan, etc.)	Refer to Appendix 7.3.2 for additional info.

7.3.3 ALERTS

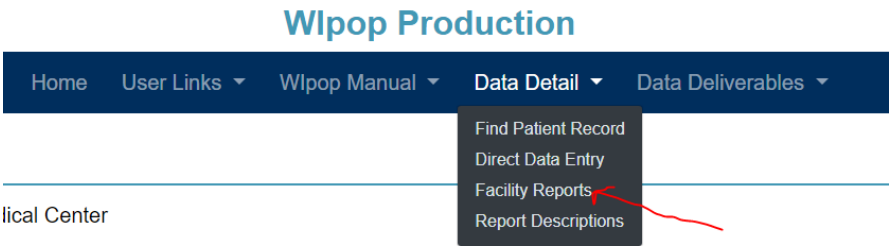
Alerts are not Edits or Errors. Alerts are intended to be an opportunity to review the data more closely and timely. Our intent is to allow ample time to make necessary changes before the end of the year. You are not required to work all alerts.

** The alert bell may draw your attention to specific areas of race, ethnicity, payer and inpatient and observation stays.*

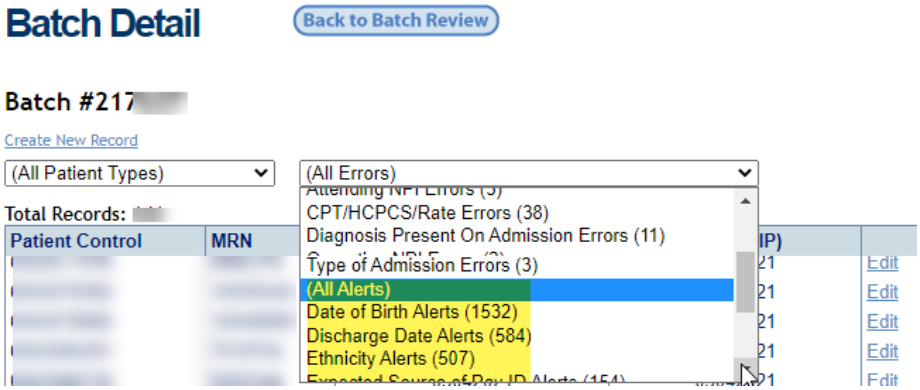
WIpop Batch files will contain an Alert Records section for each Patient Type on the far right of the screen.

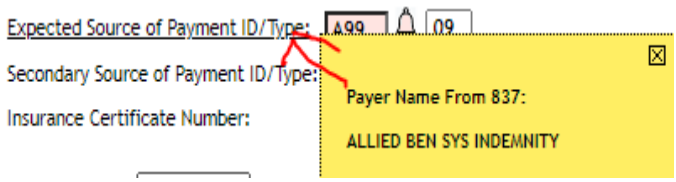
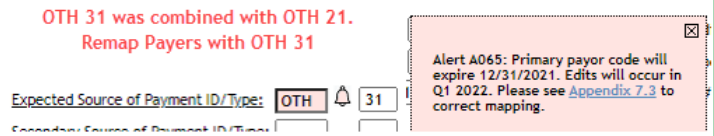
Alerts can be isolated and reviewed separately from other edits a couple of separate ways

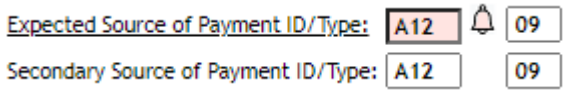
1. ***By running an inventory report from the Batch/Reports***



2. ***By viewing along with other invalid records in the Batch Detail Screen***



Alert Codes	Alert Defined	Alert reconciliation how to handle
A060	Unknown or Other Primary Payor. 	Verify the correct payer is assigned. In this record the Alert is produced for the A99 code. Clicking on the Expected Source of Payment will provide the name of the payer. A google search will lead the reviewer to noticing this is a Benefit Plan Admin. Or TPA. **The correct mapping should be OTH 21, NOT A99.**
A065	Primary Payor Code will expire 12/31/2021. See Appendix 7.3 for more information. 	Multiple payer codes have been combined or removed to reduce the amount of facility payer mapping required. Payer Alerts are set up to instruct submitters and editors to review Appendix 7.3 and adjust codes accordingly.

Alert Codes	Alert Defined	Alert reconciliation how to handle
		• MED and T18 – combined to MED-09 = Medicare, Medicare Sup / MediGap, Medicare Part A, B, C - all Medicare patients. • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance. • CHA 03 and OTH 55 – combined to CHA 03 = current and former military (insurance) benefits regardless of who is managing contract. • OTH 54, 59 & 71 – combined to OTH 54 = free/subsidized government programs, nonprofit organizations, health departments, and grant/research funds. • OTH 99 and 98 – combined to OTH 99 = TPL, MVA, state funded crime victim or safe funds, and some other unknown payers that are not related to commercial, private, or other forms identified in the mapping table. From auto insurance to crime victim claims. • *Facilities are no longer required to identify the Plan PayTypes: 01 – FFS and 02 - HMO/PPO for Medicare, Medicaid or BadgerCare. Please* ***report all payers using one option PayType = 09***
A067	Primary and Secondary Payors are the same. 	Verify patient has the same payer as primary and secondary. It is not uncommon to list two (2) Medicare payers if the patient has a dual Medicare plan. Typically, it is not common for patients to have the same duplicate plans such as BC Anthem.
A070	Unknown or Other Secondary Payor	Review claim and update patient account with the correct payer type plan type and ID. Reference A060 for additional information.
A075	Secondary Payor Code will be Invalid after Q12021. See Appendix 7.3 for more information.	Multiple payer codes have been combined or removed to reduce the amount of facility payer mapping required. Payer Alerts are set up to instruct submitters and editors to review Appendix 7.3 and adjust codes accordingly. • MED and T18 – combined to MED-09 = Medicare, Medicare Sup / MediGap, Medicare Part A, B, C - all Medicare patients. • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance. • CHA 03 and OTH 55 – combined to CHA 03 = current and former military (insurance) benefits regardless of who is managing contract. • OTH 54, 59 & 71 – combined to OTH 54 = free/subsidized government programs, nonprofit organizations, health departments, and grant/research funds. • OTH 99 and 98 – combined to OTH 99 = TPL, MVA, state funded crime victim or safe funds, and

Alert Codes	Alert Defined	Alert reconciliation how to handle
		some other unknown payers that are not related to commercial, private, or other forms identified in the mapping table. From auto insurance to crime victim claims. • F*acilities are no longer required to identify the Plan PayTypes: 01 – FFS and 02 - HMO/PPO for Medicare, Medicaid or BadgerCare. Please* ***report all payers using one option PayType = 09***
A080	Over 65 non-Medicare Payer should be mapped to MED. See Appendix 7.9 Medicare Advantage is to be mapped to MPC-09	This is not an edit, if the patient is still working and does not have Medicare, leave as is. However, most 65 and older patients have Medicare as a primary payer. Commercial plans offering Medicare Advantage is MPC – 09, Med Sup should be mapped to MED – 09.
A060	Unknown or Other Primary Payor	Verify payor assignment of A99, OTH 98 and OTH 99. Unknown commercial can be verified against this table and self-insured, BPA or TPAs should be googled and updated with OTH-21.
A065	Primary Payor code will be expiring 12/31/2021. Edits may occur in Q1 2021. Please see Appendix 7.3 for correct mapping.	To make it easier on the submitter, we are trying to reduce redundancy in payer mapping and code usage. Comments and suggestions are welcome. It is unnecessary to remap / code or assign new codes. We may reconsider the requirement to combine all codes into pay type – 09.
A067	Primary and Secondary Payors are the same.	Verify payer mapping is accurate. It is common to list two (2) Medicare payers if the patient has a dual Medicare plan. *Alerts will not be triggered for two Medicare Plans.*
A070	Unknown or Other Secondary Payor	Review claim and update patient account.
A075	Secondary Payor Code will be Invalid after Q12021.	To make it easier on the submitter, we are trying to reduce redundancy in payer mapping and code usage. Comments and suggestions are welcome. We may reconsider the requirement to combine all codes into pay type – 09.
A080	Over 65 non-Medicare Payer. Medicare Advantage Plans should be mapped to MED-09.	This is not an edit, if the patient is still working and does not have Medicare, leave as is. However, most 65 and older patients have Medicare as a primary payer. Commercial plans offering Medicare Advantage map to MPC-09, or Med Sup should be mapped to MED – 09. Disregard Alert if patient is >65 and still has commercial insurance through an employer with 20 or more employees. https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance
A090	Inpatient stay under 2 days	This alert is based on the CMS' Hospital Inpatient Admission Order and Certification requirements. Inpatient stays that are less than 2 days (excluding

Alert Codes	Alert Defined	Alert reconciliation how to handle
		discharge status codes: 02, 05, 07, 20 and 66) will trigger alerts.

7.5 Type of Bill (TOB)

Definition: A code indicating the specific type of bill (inpatient, outpatient, etc.). The first digit is a leading zero. The second and third digits are the facility code. The fourth digit is a frequency code. *Leading zero is not applicable to the EDI files, only to the paper UB-04 claim form, but for purposes of WIpop a leading zero will be provided if not supplied on the file.

WHAIC does not accept TOBs that end in 5-9 or any alpha character A-Z. Unlike insurance companies, we have no means to combine records, add late charges to an already processed record, replace a prior record with a new bill/record or void or cancel a previous record and replace it with an exact duplicate to show corrected claim detail.

Freestanding ambulatory surgery centers (FASC) that use the 837 Professional may continue to use 0999 in the type of bill field. However, according to the developers of the Professional Claim… have indicated that the use of bill type frequency codes are acceptable.

Type of Bill (TOB) WHAIC is limited by the types of bills we can collect and in return provide data back to the community. Typically, our data sets only include admit through discharge claims data for patients seen in a hospital (s. 50.33) or free-standing ambulatory surgery centers certified by CMS.

The following TOBs **are not to be included in the data files**, if provided, an edit will occur:

014X – Hospital – Lab services - non-patients	021X – 023X – Skilled Nursing Inpatient and outpt. 028X - Swing Bed	034X - Home Health Services NOT under a Plan of Treatment
041X – 043X – Religious Institutions / Christian Science *Does not meet the definition of hospital.	065X – 066X – Intermediate Care Level I & Level II *Defined as special needs facilities	071 - Rural Health Clinic * Exempt because Provider Based RHC submits the encounter under the CLINIC Medicare Part A number the Hospital.
073X - Clinic - Freestanding NOT associated with a hospital as a PBC.	076X - Clinic - Community Mental Health Center 077X - Clinic - Federally Qualified Health Center	079X - Clinic - other *Not associated with a hospital
081X – 082X – Hospice	084x - Free Standing Birth Center 086X - Residential Facility	089X - Specialty Facility - Other

DEFINITIONS FOR FREQUENCY CODES ACCEPTABLE FOR WHAIC

Non-Payment/Zero Claim (O) - applies to zero charge records- total charges = zero

Provider uses this code when it does not anticipate payment from the payer for the bill but is informing the payer about a period of non- payable confinement or termination of care. The "Through" date of this bill is the discharge date for this confinement, or termination of the plan of care.

Admit Through Discharge Claim (1) - applies to patients that are in and out of a facility in the same encounter of treatment. This code is to be used for a bill that is expected to be the only bill to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or course of treatment, and bills that represent an entire benefit period of the primary third-party payer.

Interim - First Claim (2): This code is to be used for the first of a series of bills to the same third-party payer for the same confinement or course of treatment.

Interim - Continuing Claim (3): This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted.

Interim - Last Claim (4): Used for the last of a series of bills, for which payment is expected, to the same third-party payer for the same confinement or course of treatment.

Do not send TOBs that end in 5-9 or any alpha character A-Z. Unlike insurance companies, we have no means to add late charges to an already processed record, replace a prior record with a new claim/record or void or cancel a previous record and replace it with an exact duplicate to show corrected claim detail.

Type of Bill Table

Type of Bill Code	Category of Service	Facility /Record Type
0110 0111 0112 0113 0114	Hospital Inpatient (including Medicare Part A) non-payment zero claim Hospital Inpatient (including Medicare Part A) admit through discharge claim **Type of Bill 111** represents a Hospital Inpatient Claim indicating that the claim period covers admit through the patient's discharge. Hospital Inpatient first interim claim Hospital Inpatient continuing interim claim Hospital Inpatient final interim claim	Hospital - **Medicare Part** A (**Hospital** Insurance) covers **inpatient hospital** services. This **means** patient pays a one-time deductible for all the **hospital** services for the first 60 days while in a **hospital**
0120 0121 0122 0123 0124	Hospital Inpatient (Medicare Part B only) non-payment zero claim Hospital Inpatient (Medicare Part B only) admit through discharge claim Hospital Inpatient first interim claim Hospital Inpatient continuing interim claim Hospital Inpatient final interim claim	Hospital - Outpatient: **Medicare Part B** (Medical Insurance) covers most doctor services when **inpatient**. CAH may use 012X when no part B
0130 0131 0132 0133 0134	Hospital Outpatient non-payment zero claim Hospital Outpatient admit through discharge claim Hospital Outpatient first interim claim Hospital Outpatient continuing interim claim Hospital Outpatient final interim claim	Hospital - Outpatient Ex. ER, Observation or Outpatient surgery services performed in a hospital.
0180 0181 0182 0183 0184	Hospital - Swing Bed CAH - Inpatient - Non-Covered Stay Hospital - Swing Bed CAH - Inpatient - Admit to Discharge Claim Hospital - Swing Bed CAH - Interim First Claim (status 30) Hospital - Swing Bed CAH - Interim Subsequent claims (status 30) Hospital - Swing Bed CAH - Interim last claim	Swing Bed is a term used to describe the use of inpatient hospital bed for either acute or skilled level of care: • Applies to rural hospitals with fewer than 100 beds • Swing bed status granted by CMS • Prior qualifying 3-day INP stay
0320 0321 0322 0323 0324	Home Health hospital-based (Medicare Part A) non-payment zero claim Home Health hospital-based (Medicare Part A) admit through discharge claim Home Health hospital-based (Medicare Part A) first interim claim Home Health hospital-based (Medicare Part A) continuing interim claim Home Health hospital-based (Medicare Part A) final interim claim	Hospital Outpatient Ex. Patient has less than a 3 day stay, but care is needed after discharged from the hospital. Patients can get care in other setting like home health care.
~~0710~~ ~~0711~~	Do not send RHC Records / Encounters to WHAIC ~~Rural Health Clinic hospital-based non-payment zero claim~~ ~~Rural Health Clinic hospital-based admit through discharge claim~~ ~~RHC visits may not take place at:~~ ~~An inpatient or outpatient hospital (including a Critical Access Hospital)~~ ~~A facility which has specific requirements that preclude RHC visits~~	~~RHC visits may take place:~~ • ~~In the RHC~~ • ~~At the patient's residence (including an assisted living facility)~~ • ~~In a Medicare-covered Part A Skilled Nursing Facility~~ • ~~At the scene of an accident~~
0720 0721 0722	Clinic - Hospital Based or Independent Renal Dialysis Center non-payment zero claim	Hospital based Outpatient Only - follow CMS guidelines for determination.

Type of Bill Code	Category of Service	Facility /Record Type
0723 0724	Clinic - Hospital Based or Independent Renal Dialysis Center admit through discharge claim Clinic - Hospital Based or Independent Renal Dialysis Center first interim claim Clinic - Hospital Based or Independent Renal Dialysis Center continuing interim claim Clinic - Hospital Based or Independent Renal Dialysis Center final interim claim	
0740	Clinic-Outpatient Rehabilitation Facility hospital-based non-payment zero claim Clinic-Outpatient Rehabilitation Facility hospital-based admit through discharge claim Clinic-Outpatient Rehabilitation Facility hospital-based first interim claim Clinic-Outpatient Rehabilitation Facility hospital-based continuing interim claim Clinic-Outpatient Rehabilitation Facility hospital-based final interim claim	Outpatient rehabilitation is a form of rehabilitation therapy in which patients travel to a clinic, hospital, or other facility specifically to attend sessions and then leave, rather than remain hospitalized the duration of their therapy, as is the case with inpatient **rehab.**
0750	Clinic-Comprehensive Outpatient Rehabilitation Facility hospital-based non-payment zero claim Clinic-Comprehensive Outpatient Rehab Facility hospital-based admit through discharge claim Clinic-Comprehensive Outpatient Rehabilitation Facility hospital-based first interim claim Clinic-Comprehensive Outpatient Rehabilitation Facility hospital-based continuing interim claim Clinic-Comprehensive Outpatient Rehabilitation Facility hospital-based final interim claim	A comprehensive outpatient rehabilitation facility is a facility that provides rehabilitation services after an illness or injury. It offers a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.
0781	Licensed Freestanding Emergency Medical Facility (OP)	Hospital owned OP Dept. usually off campus.
0830 0831 0832 0833 0834	Special Facility-Ambulatory Surgery Center non-payment zero claim Special Facility-Ambulatory Surgery Center admit through discharge claim Special Facility-Ambulatory Surgery Center first interim claim Special Facility-Ambulatory Surgery Center continuing interim claim Special Facility-Ambulatory Surgery Center final interim claim	Outpatient Surgery performed in a Ambulatory Surgical Center.
0850 0851 0852 0853 0854	Special Facility-Critical Access Hospital non-payment zero claim Special Facility-Critical Access Hospital admit through discharge claim hospital-based first interim claim hospital-based continuing interim claim hospital-based final interim claim	Outpatient Hospital - CAH

7.6 Place of Service (POS) or Type of Encounter Hierarchy

Place of Service for the 837I and 837R – Assigned by WHAIC

OUTPATIENT RECORD / Encounter TYPES – determined by Revenue Codes as defined below and place of service **hierarchy**.

Place of Service	Description of Service / Encounter Type	Details of revenue codes within the type of service *Most revenue codes require a CPT or HCPCS code*
3	**Observation Care:** Any record with a revenue code 0762.	0762 – Specialty Services – Observation Hours
1	**Outpatient Surgery:** Revenue codes 036X (not 0361), 0481, 049X or 0750, or any record from a freestanding ambulatory surgery center.	036X – Operating Room Services (*Not 0361 - see POS 6*) 0481 – Cardiac Cath 049X – Ambulatory Surgical Care 0750 – Gastro-Intestinal (GI) Services (proc not perf in OR)
2	**Emergency Room:** Revenue codes 0450, 0451, 0452, or 0459.	045X – Emergency Room (*Not 0456 - see POS 6*)
4	**Therapies:** Revenue codes in categories 041X-044X, or 093X-095X. This includes Respiratory, Physical, Occupational and Speech Therapies, Medical Rehabilitation (ex. cardiac rehab), Therapeutic Rehabilitation or Athletic Training, respectively.	041X – Respiratory Services 042X – Physical Therapy 043X – Occupational Therapy 044X – Speech Therapy – Language Pathology 093X – 095X – Medical Rehab & Other Therapeutic Services
5	**Outpatient Lab/Radiology**: Revenue codes in categories 030X, 031X, 032X-035X, 040X, 0480, 061X, 073X-074X, 086X or 092X. This includes Diagnostic and Routine Laboratory Testing, Diagnostic and Therapeutic Radiology, Nuclear Medicine, CAT Scans, Imaging, MRIs, EKGs and ECGs, EEGs. WHAIC does not accept TOB 014X - This category of codes excludes reference diagnostic laboratory services (non-patient laboratory specimens), type of bill 014X.	030X – Laboratory 031X – Pathology 032X – Radiology – Diagnostic 033X – Radiology – Therapeutic and/or Chemotherapy Administration 034X – 035X - Nuclear Medicine & CT Scan 040X – Other Imaging Services (mammography, US, PET) 061X – Magnetic Resonance Technology (MRT) (MRI) 073X – 074X - EKG/ECG & EEG (Electroencephalogram) 086X – Magnetoencephalography (MEG) 092X – Other Diagnostic Tests
6	**Other Outpatient Hospital Services:** May include but not limited to records with revenue codes in categories 026X, 028X, 0361, 038X-039X, 0456, 046X-047X, 048X [NOT 0481], 051X-052X, 053X, 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. Do NOT send Records that contain stand-alone revenue codes - or records without a face-to-face encounter: 027X - Medical/Surgical Supplies and Devices 029X- Durable Medical equipment 037X - Anesthesia *usually Professional Fee*	026X – IV Therapy 028X – Oncology 0361 - Minor Surgery (IV Therapy, CHEMO, Injections, minor suture) 038X – 039X Blood and Blood Components & Administration, Processing 0456 - Urgent Care 046X – 048X - Pulmonary Function, Audiology & Cardiology (Except 0481) 051X – 053X – Clinic, Freestanding Clinic & Osteopathic Services (PBL) 058X – 060X Home Health (HH) – Other Visits, Units of Service, & Oxygen 064X – Home IV Therapy Services 066X – Respite Care 069X - Pre-hospice / Palliative Care Service (prior to election of Hospice)

Place of Service	Description of Service / Encounter Type	Details of revenue codes within the type of service *Most revenue codes require a CPT or HCPCS code*
	039X - Admin., Processing & Storage for blood/ blood components 054X - Ambulance 062X - Medical / Surgical Supplies and Devices 096x - 099X - Pro Fee and Convenience Items	071X – Recovery Room 0760 – 0769 - Treatment Room & Other Specialty Services (*Not 0762) 077X – Preventive Care Services 0780 – Telemedicine – Facility Charges related to telemedicine svc 0790 – Extra-Corporeal Shock Wave Therapy 081X – Acquisition of Body Components 082X – 085X & 088X - Hemodialysis - Peritoneal Dialysis & Misc. Dialysis 090X – 092X – Behavioral Health
	01/2018 ** As defined in POS 6 - Records that contain revenue codes such as 054X, 037X and 062X that are not accompanied by other revenue codes indicating a face-to-face encounter on the record will receive an edit.	Cardiac Rehab phase III, patient going to a facility to exercise only, does not need to be submitted. The edit reads: 3214: This revenue code cannot be submitted as a standalone record.

7.7 WIPOP Coding Guidelines and Definitions for Data Submission

Accurate coding is required for proper billing, reimbursement, and compliance. WHAIC assigns, to the best of our ability, the principal and additional procedure codes based on current coding guidelines and revenue line-item detail.

The **primary/principal diagnosis code** - ICD-10-CM diagnosis code describing the condition established **after study** to be chiefly responsible for occasioning the admission of the patient for care or for the outpatient services provided during the visit. This definition does not apply to the coding of all outpatient encounters. If the physician does not identify a definite condition or problem at the conclusion of an outpatient visit or encounter the coder should report the documented chief complaint as the reason for the encounter/visit.

Additional / Other reportable diagnoses - are defined as those conditions that coexist at the time of the admission/outpatient visit or develop subsequently and affect patient care for the current episode of care. Usually, reportable other diagnoses affect length of stay, total charges or accurate DRG classification.

The 'principal procedure code' - The definition of a principal procedure is part of the Uniform Hospital Discharge Data Set (UHDDS): the standard set of data elements used for inpatient billing and statistical information. It is also included in some of the core measures from the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission. The principal procedure is the procedure performed for definitive treatment, rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

The 837 claims file should be properly coded using current coding guidelines for both inpatient and outpatient records. WHAIC will assign outpatient principal procedure codes based on surgical revenue codes in the revenue line-item detail and the current CPT and HCPCS surgical coding guidelines.

'**Additional procedures**' performed during the principal episode of care (or during the length of stay for inpatients) or that may include invasive or exploratory procedures (exploratory surgery is a surgery which is performed exclusively for diagnostic purposes, without the purpose of treating a disease). WHAIC will assign outpatient procedure codes based on the revenue line-item detail, CPT/HCPCS and costs (if duplicated.)

The **outcome of delivery,** Childbirth code Z37+, should be included on all maternal delivery records. It is always a secondary code. Codes in category Z37 should not be used on the newborn record. Newborn records must include diagnosis code Z38+. WHAIC performs periodic audits to compare the number of births to newborns.

Note: This complies with Wisconsin Statute 69.14(1) (d) 1 stating the place of birth is the location where the placenta is delivered. Therefore, if a delivery occurs at home or in-route to the hospital, and the placenta is delivered at the hospital, the "place of birth" is the hospital.

Cancelled Outpatient Surgery - when a patient **presents for outpatient surgery** (same day surgery), the reason for the surgery is coded as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication. The principal diagnosis is the condition that occasioned the patient's admission for surgery.

Factors influencing health status and contact with health services (Z00-Z99) Chapter 21 of the ICD-10-CM Official Coding Guidelines provides the parameters for use of these codes. Please note there are some codes that can only be used as principal **or** additional diagnosis codes.

Z Codes That May Only be Principal/First-Listed Diagnosis is in Appendix B of the ICD-10 CM Coding Book.

> The Z codes/categories identified in the coding guidelines may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined.

Social determinants of health (SDoH) ICD-10 Codes Z55 - Z65. These codes were developed by the World Health Organization to allow better specificity to the circumstances of the patients served in your community.

WHAIC supports and encourages all facilities to collect and report these codes on their claims and encounters sent through WIpop.

Healthcare providers and data users will be able to use these codes to document when and where a patient would benefit from a certain social service, i.e., transportation or access to nutritional food and other services.

Present on Admission (POA) Indicator

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 American Health Information Management Association, American Hospital Association, CMS and the National Center for Health Statistics (known as the "Cooperating Parties") publishes 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 in the WHAIC online manual annually:https://www.cdc.gov/nchs/icd/icd10cm.htm

The POA Indicator is applied to the principal diagnosis as well as all secondary diagnoses 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. **Do not use 1, or other value.**

7.7.2 REVENUE CODES

Revenue codes in medical billing are 4-digit numeric ids that are used in hospital bills to notify insurance companies what type of services wer4e provided to patients. These are 4-digit numbers always starting with **"0 (Zero)"**. We have updated the **list of Revenue Codes for Medical Billing** as per the latest information effective on 15 March 2020. The revenue codes in medical billing provide information to the insurance company on whether the services were performed like an emergency room service, operating room service, etc.

The revenue codes in the revenue line item detail directs the patient encounter / claim record to the correct place of service.

A more complex example to use would be a simple laceration repair of a wound on the scalp, trunk of the body, or the extremities such as hands and feet CPT 12001, which is the procedure code could be done in multiple places of service.

- Service could be done in the OR; revenue code 360. WHAIC POS = 1
- Service could d be done in the emergency room; revenue code 450. WHAIC POS = 2
- It could be done in the Urgent Care; that would be revenue code 0361 WHAIC POS = 6
- It could be done in a clinic; that would be revenue code 510. WHAIC does not take professional claims unless it is billed on an 837i as a PBL. There are at least 3 other revenue codes where this procedure could be performed. All records containing Revenue Codes require the exact dates of service if they are span dates.

Edits will occur with Revenue Codes 096X through 099x – Professional Fees if submitted to WHAIC.

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
010X	**All-inclusive Rate** 0100 – All-inclusive room and board plus ancillary 0101 – All-inclusive room and board	NA	Inpatient
011X	**Room and Board Private (one bed)** • 0110 - General • 0111 - Medical/Surgical/GYN • 0112 - OB • 0113 - Pediatric • 0114 - Psychiatric • 0115 - Hospice • 0116 - Detoxification • 0117 - Oncology • 0118 – Rehabilitation • 0119 - Other	NA	Inpatient
012X	**Room and Board Semiprivate (two beds)** • 0120 - General • 0121 - Medical/Surgical/GYN • 0122 - OB • 0123 - Pediatric • 0124 - Psychiatric • 0125 - Hospice • 0126 - Detoxification • 0127 - Oncology • 0128 – Rehabilitation • 0129 - Other	NA	Inpatient
013X	**Room and Board (3 and 4 beds)** • 0130 - General • 0131 - Medical/Surgical/GYN • 0132 - OB	NA	Inpatient

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	• 0133 - Pediatric • 0134 - Psychiatric • 0135 - Hospice • 0136 - Detoxification • 0137 - Oncology • 0138 – Rehabilitation • 0139 - Other		
014X	**Room and Board Deluxe Private** • 0140 - General • 0141 - Medical/Surgical/GYN • 0142 - OB • 0143 - Pediatric • 0144 - Psychiatric • 0145 - Hospice • 0146 - Detoxification • 0147 - Oncology • 0148 – Rehabilitation • 0149 - Other	NA	Inpatient
015X	**Room and Board Ward** • 0150 - General • 0151 - Medical/Surgical/GYN • 0152 - OB • 0153 - Pediatric • 0154 - Psychiatric • 0155 - Hospice • 0156 - Detoxification • 0157 - Oncology • 0158 – Rehabilitation • 0159 - Other	NA	Inpatient
016X	**Other Room and Board** • 0160 - General • 0164 - Sterile • 0167 - Self-care • 0169 - Other	NA	Inpatient
017X	**Nursery –** refer to the official UB-04 Data Specifications for further information Accommodation charges for nursing care to newborns and premature infants in nurseries. The level of care should be clinically evaluated on a daily basis, typically based on the resources provided to the infant. The assigned revenue code corresponds to the level of care determined during the daily evaluation. The levels of care and resulting revenue codes may, and will, fluctuate during the infants stay in the facility. • 0170 - General • 0171 - Newborn Level I • 0172 - Newborn Level II • 0173 - Newborn Level III • 0174 - Newborn Level IV • 0179 - Other	NA	Inpatient
018X	**Leave of Absence** • 0180 - General • 0182 - Patience convenience - charges billable	NA	Inpatient

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	• 0183 - Therapeutic leave • 0185 - Nursing home (for hospitalization) • 0189 - Other		
019X	**Subacute Care** Accommodations charges for subacute care to inpatients or skilled nursing facilities. *See official UB-04 Data Specification Manual for more information. • 0190 - General • 0191 - Level I • 0192 - Level II • 0193 - Level III • 0194 - Level IV • 0199 – Other	NA	Inpatient
020X	**Intensive Care Unit** Routine service charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit. (a) Includes hospital inpatient step-down units, Progressive Care Units and Definitive Observation Units. • 0200 - General • 0201 - Surgical • 0202 - Medical • 0203 - Pediatric • 0204 - Psychiatric • 0206 - Intermediate ICU[(a)] • 0207 - Burn Care • 0208 - Trauma • 0209 – Other	NA	Inpatient
021X	**Coronary Care Unit** Routine service charges for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical or surgical unit. • 0210 – General classification: Coronary care (CCU) • 0211 – Myocardial Infarction: CCU/MYO INFARC • 0212 – Pulmonary Care: CCU/Pulmonary • 0213 – Heart Transplant: CCU/Transplant • 0214 – Intermediate CCU: CCU/Intermediate • 0215-8: Reserved • 0219 – Other coronary Care CCU: CCU/Other Report when a discrete coronary care unit exists for rendering such services.	NA	Inpatient
022X	**Special Charges** **Charges incurred during an inpatient stay or on a daily basis for certain services**	No	NA – this is not a standalone rev code – POS based on other codes in record.
022X	**Incremental Nursing Charge**	No	NA – this is not a standalone rev code – POS

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	Extraordinary charges for nursing services assessed in addition to the normal nursing charge associated with the typical room and board unity. This code does not support unbundling of nursing charges from standard room and board.		based on other codes in record.
024x	**All Inclusive ancillary** A flat-rate charge that is applied on a daily basis or on a total stay basis for ancillary services only.		NA – this is not a standalone rev code – POS based on other codes in record.
025X	**Pharmacy** Charges for medication produced, manufactured, packaged, controlled, assayed dispensed, and distributed under the direction of a licensed pharmacist. • 0250 - General Classification • 0255 - Drugs Incident to Radiology • 0258 - IV Solutions • 0259 - Other Pharmacy Note: Submission of a Healthcare Common Procedural Coding System (HCPCS) code with revenue code 0258 requires the appropriate National Drug Code (NDC).	No	6 - Other Outpatient Encounter
026X	**IV Therapy** Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. 0260 - General Classification 0261 - Infusion Pump 0262* Pharmacy Services 0264* Supplies 0269* Other IV Therapy	YES-Op	6 - Other Outpatient Encounter
027X	**MEDICAL/SURGICAL SUPPLIES AND DEVICES** Charges for supply items required for patient care. 0270 - General Classification 0271 - Non-Sterile Supply 0272 - Sterile Supply 0273 - Take-home supplies 0274 – Medical / Surgical supplies and devices, prosthetic, and orthotic 0275 - Pace Maker 0276 - Intraocular Lens 0278 - Other Implants [(a)] Note: This code can be used to bill the subdermal contraceptive implant, or any other medically necessary, non-experimental implant as described below. Cochlear implant handling can also be billed using code 0278. ***Other examples of implants***: Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds. [(a)] Implantable: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.	Yes	6 - Other Outpatient Encounter

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
0280	**Oncology** Charges for the treatment of tumors and related diseases.		
0290	**Durable Medical equipment (DME)** 0290 – Durable Medical Equipment, general 0291 – Durable Medical Equipment, rental 0292 – DME – purchase of new 0299 – DME	Yes	NA – this is not a standalone rev code – POS based on other codes in record.
030X	**Laboratory-Clinical Diagnostic** Charges for the performance of diagnostic and routine clinical laboratory tests. 0300 - General Classification 0301 - Chemistry 0302 - Immunology 0303 – renal patient 0304 - Non-Routine Dialysis 0305 - Hematology 0306 - Bacteriology and Microbiology 0307 - Urology 0308 – Reserved Lab 0309 - Lab Note: Lab revenue codes require an HCPCS/CPT code.	Yes	5 – Outpatient Lab/Rad
031X	**Laboratory – Pathological** Charges for diagnostic and routine laboratory tests in tissues and culture. 0310 - General Classification 0311 - Cytology 0312 - Histology 0313 – general class 0314 - Biopsy 0315 – Pathology 0316 – reserved pathology 0317 – Reserved pathology 0319 – Other Lab Path	Yes	5 – Outpatient lab/rad
032X	**Radiology – Diagnostic** Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining, and interpreting radiographs and fluorography. 0320 - General Classification 0321 - Angiocardiography 0322 - Arthrography 0323 - Arteriography 0324 - Chest X-Ray 0325 – Reserved, diagnostic 0326 – Reserved diagnostic 0327 – Reserved diagnostic 0328 – Reserved diagnostic 0329 - Other Radiology Diagnostic	Yes	6 - Other Outpatient Encounter
033X	**Radiology – Therapeutic and/or Chemotherapy administration** **C**harges for therapeutic radiology services and chemotherapy administration required for the care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances. Excludes charges for chemotherapy drugs, which should be reported under the appropriate revenue code (025X/063X). 0330 - General Classification	Yes	5 – OLR

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0331 - Chemotherapy Administration-Injected 0332 - Chemotherapy Administration-Oral 0333 - Radiation Therapy 0335 - Chemotherapy Administration-IV 0339 - Other Radiology Therapeutic Note: When using 0331, 0332, or 0335 there must be RC 0636 on the record.		
034X	**Nuclear Medicine** Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. 0340 - General Classification 0341 - Diagnostic 0342 - Therapeutic 0343 - Diagnostic Radiopharmaceuticals 0344 - Therapeutic Radiopharmaceuticals 0349 - Other Nuclear Medicine	Yes	5 - OLR
035X	**Computer Tomographic (CT) Scan** Charges for Computerized axial tomography (CAT) CT scans of the head and other parts of the body. 0350 - General 0351 - Head 0352 - Body 0359 - Other	Yes	5
036X	**OPERATING ROOM SERVICES** Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment. 0360 - General 0361 - Minor surgery** 0362 - Organ transplant-other than kidney 0367 - Kidney transplant 0369 - Other operating room services	Yes	**POS 1 – OPS** ** except for 0361 – 0361 code is assigned to POS 6 according to WHAIC hierarchy.
037X	**ANESTHESIA** Charges for anesthesia services in the hospital. 0370 General 0371 Anesthesia incident to radiology 0372 Anesthesia incident to other diagnostic services 0374 Acupuncture 0379 Other anesthesia	NA	NA – not assigned based on stand- alone codes
038X	**Blood and Blood Components** 0380 - General 0381 - Packed red cells 0382 - Whole blood 0383 - Plasma 0384 - Platelets 0385 - Leucocytes 0386 - Other blood components 0387 - Other derivatives (Cryoprecipitates) 0389 - Other Blood and blood components	Yes	6 - Other Outpatient Encounter
039X	**Blood and blood component admin, processing, and storage**	NA	As a general rule it is not a

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	Charges for administration, processing, and storage of whole blood, red blood cells, platelets, and other blood components, such as plasma and plasma derivatives. 0390 - General Classification 0391 - Administration (e.g., Transfusions) 0392 – Processing and Storage 0399 - Other Blood Handling / Admin		stand-alone code.
040X	**Other Imaging Services** Charges for specialty imaging services for body structures 0400 - General Classification 0401 - Diagnostic Mammography 0402 - Ultrasound 0403 - Screening Mammography 0404 - Positron Emission Tomography (PET) Scan 0409 - Other Imaging Services	Yes	POS = 5 - OLR
041X	**RESPIRATORY SERVICES** Charges for respiratory services including administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy. 0410 - General Classification 0412 - Inhalation Services 0413 - Hyperbaric Oxygen Therapy **0419 –** Other Respiratory Services	Yes	POS = 4 - Therapy
042X	**PHYSICAL THERAPY (All Ages)** Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities. 0420 - General Class Physical Therapy 0421 - Visit Charge 0422 – Hourly 0423 – Group 0424 Evaluation or Re-Evaluation **0429 – Other PT**	Yes	POS = 4 - Therapy
043X	**OCCUPATIONAL THERAPY (Limited to Age 21 Years and Under)** Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work. 0430 – General – occupational therapy 0431 – OT Visit Charge 0432 – OT hourly charge 0434 – OT Evaluation or reevaluation 0439 – OT	Yes	POS = 4 - Therapy
044X	**SPEECH-LANGUAGE PATHOLOGY (Limited to Age 21 Years and Under)** Charges for services provided to persons with impaired functional communications skills. 0440 – Speech therapy - general 0441 - Visit Charge 0442 – Hourly charge 0443 – group therapy 0444 - Evaluation or Re-Evaluation	Yes	POS = 4 - Therapy

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0449 – Speech therapy		
045X	**EMERGENCY ROOM** Charges for emergency treatment to those ill and injured recipients who require immediate unscheduled medical or surgical care. 0450 - General Classification 0451 – EMTALA Emergency Medical Screening Services 0452 – ER Beyond EMTALA 0456 – Urgent Care [(a)] 0459 – Other ER	Yes	POS = 2 – ER/ED (a) = OHO POS 6 Urgent Care
046X	**PULMONARY FUNCTION** Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases. 0460 - General Classification 0469 - Other Pulmonary Function	Yes	POS = 6 - Other Outpatient Encounter
047X	**AUDIOLOGY** Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function. 0470 - General 0471 - Diagnostic 0472 - Treatment 0479 - Audiology	Yes	POS = 6 - Other Outpatient Encounter
048X	**CARDIOLOGY** Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests. 0480 - General Classification **0481 - Cardiac Cath Laboratory** 0482 - Stress Test 0483 - Echocardiology 0489 - Other Cardiology	Yes	POS = 6 Other Outpatient data. 0481 classified as OPS – POS 1 for WHAIC.
049X	**AMBULATORY SURGICAL CARE** Charges for ambulatory surgery that are not covered by any other category. 0490 – General Class Ambulatory Surgical Care 0499 – Other Ambulatory Surgical Care Note: Do not report *Observation with this code; report with revenue code 0762*.	Yes	POS = 1 – OPS
051X	**CLINIC** Charges for scheduled non-emergency outpatient clinic visits for the purpose of providing diagnostic, preventative, curative, and rehabilitative services. 0510 - General Classification 0511 – Chronic Pain Center 0512 – Dental Clinic 0513 - Psychiatric Clinic ** 0514 – OB-GYN Clinic 0515 – Pediatric Clinic 0516 – Urgent Care Clinic 0517 – Family Practice Clinic 0519 – Other Clinic	Yes	POS = 6 - Other Outpatient Encounter

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	Note: ***Use code 0513 in conjunction with the following revenue codes:* *0914 - Psychiatric Clinic Visit/Individual Therapy* 0918 - Psychiatric Testing 0944 - Drug Rehabilitation 0945 - Alcohol Rehabilitation		
052X	**Freestanding Clinic RHC/FQHC** • **Do not send this series of rev codes to WHAIC**	NA	NA – RHC/FQHC
053X	**Osteopathic Services** Charges for a structural evaluation of the cranium, entire cervical, dorsal, and lumbar spine by a doctor of osteopathy (DO). 0530 – General classification 0531 – Osteopathic Therapy 0539 – Other *These services are unique to osteopathic hospitals and cannot be accommodated in any of the existing rev codes.*		
054X	**Ambulance** 0540 – Ambulance, general 0541 – Ambulance, supplies 0542 – Ambulance, medical transport 0543 – Ambulance, heart mobile 0544 – Ambulance, oxygen 0545 – Ambulance, air 0546 – Ambulance, neonatal services 0547 – Ambulance, pharmacy 0548 – Ambulance, electrocardiogram (EKG) transmission 0549 – Ambulance *Do not send these to WHAIC as a stand-alone service		
055x	**Skilled Nursing** 0550 – Skilled nursing 0551 – Skilled nursing visit 0552 – Skilled nursing hourly charge 0559 – Other Skilled nursing	Y	
056x	**Home health medical, social services, general** Home Health (HH) charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis. 0560 – General Classification 0561 – Visit Charge 0562 – Hourly Charge 0569 – other Med. Social Services	Yes	
057x	**Aide/Home health visit** HH Charges for personnel (aides) that are primarily responsible for the personal care of the patient. 0570 – General Classification 0571 – HH Visit Charge 0572 – HH Hourly Charge 0579 – Other HH Aide	Yes	
058X	**Home health (HH) – Other Visits** HH agency charges for visits other than physical therapy, occupational therapy, or speech therapy, requiring specific identification. 0580 – General Classification		

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0581 – HH Visit Charge 0582 – HH Hourly Charge 0589 – Other HH Aide		
059x	**Home Health (HH) Units of Service** Home Health (HH) charges for services billed according to the units of service provided. 0590 – General Classification	Yes	
060X	**Home Health ((HH) – Oxygen** Home Health (HH) agency charges for oxygen equipment, supplies or contents, excluding purchased equipment. 0600 - General 0601 - Stat/Equip/Supply or contents 0602 - Stat/Equip/Supply Under 1 LPM 0603 - Stat/Equip Over 4 LPM 0604 - Portable Add-on 0609 - Other	Yes	POS = 5 OHO
061X	**MAGNETIC RESONANCE TECHNOLOGY (MRT)** Charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body. 0610 - General Classification 0611 - MRI-Brain (including Brain Stem) 0612 - Spinal Cord (Including Spine) 0614 - MRI-Other 0615 - MRA-Head and Neck 0616 - MRA-Lower Extremities 0618 - MRA-Other 0619 - Other MRT	Yes	POS = 4 OLR
062X	**MEDICAL/SURGICAL SUPPLIES- EXTENSION OF 027X** Charges for supply items required for patient care. This category is an extension of 028X for reporting additional breakdown where needed. 0621 - Supplies Incident to Radiology 0622 - Supplies Incident to Other Diagnostic Services 0623 - Surgical Dressings 0624 – U.S. Food and Drug Administration (FDA) investigational devices	Yes	6 - Other Outpatient Encounter
063X	**PHARMACY- DRUGS REQUIRING SPECIFIC IDENTIFICATION** This category is an extension of 025X for reporting detailed coding where needed. 0631 – Drug, single 0632 – Drug, multi 0634 – Pharmacy, extension of 025X Erythropoietin (EPO) less than 10,000 units 0635 - Pharmacy, extension of 025X Erythropoietin (EPO) 10,000 or more units 0636 - Pharmacy, extension of 025X Pharmacy/Coded Drugs	Yes	6 - Other Outpatient Encounter
064X	**Home IV Therapy Services** Charges for intravenous therapy services performed in the patient's residence. For home IV providers enter the HCPCS code for all equipment, and all types of covered therapy.	NA	NA
065X	**Hospice** 0650 – Hospice 0651 – Hospice, Routine home care 0652 – Hospice, continuous home care 0656 – Hospice, general inpatient care (non-respite)		

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	WHAIC does not typically accept straight hospice patient care – distorts quality data.		
066X	**Respite Care** Charge for non-hospice respite care		
067X	**Outpatient Special Residence Charges** Residence Arrangements for patients requiring continuous outpatient care.		
068x	**Trauma Response** Charges representing the activation of the trauma team. Every hospital is assigned a trauma level sub-code from 4 to 1, with 1 being the highest level of trauma capability – there are usually only two or three such facilities per state. These numbers replace the x in revenue code series 68x. The final digit is designated by the state or local government authority authorized to do so, and these assignments are verified by the American College of Surgeons. 0680 - Not used 0681 – Level I Trauma 0682 – Level II Trauma 0683 – Level III Trauma 0684 – Level IV Trauma 0689 – Other Trauma Response		
069X	**Pre-hospice/Palliative Care Services** Services that are provided prior to the formal election of hospice care. These services may consist of evaluation, consultation and education, and support services. No specific therapy is excluded from consideration.	Yes	6 - Other Outpatient Encounter
070X	**CAST ROOM** Charges for services related to the application, maintenance, and removal of casts. 0700 - General Classification	No	6 - Other Outpatient Encounter
071X	**RECOVERY ROOM** 0710 - General Classification Note: Use code 0710 to bill routine post-operative monitoring during a normal recovery. Recovery room services must not be billed as observation services.	No	6 - Other Outpatient Encounter
072X	**LABOR ROOM/DELIVERY** Charges for labor and delivery room services provided by specially trained nursing personnel to patients. Includes: prenatal care during labor, delivery, postnatal care in recovery room, and minor gynecologic procedures performed in a delivery suite. 0721 - Labor 0722 - Delivery 0723 – Circumcision 0724 – labor room delivery birthing center 0729 – labor room delivery	No	
073X	**EKG – ECG (Electrocardiogram)** Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments. 0730 - General Classification 0731 - Holter Monitor 0732 - Telemetry 0739 - Other EKG - ECG	Yes	POS = 5 - OLR
074X	**EEG (Electroencephalogram)**	Yes	5 – OLR

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders. 0740 - EEG/General 0749 - Other EEG		
075X	**GASTRO-INTESTINAL SERVICES** Any service or procedure room charges for endoscopic procedures not performed in the operating room. 0750 - General Classification 0759 - Other Gastro-Intestinal	Yes	POS = 1 - OPS
076X	**TREATMENT/OBSERVATION ROOM** Charges for patients requiring treatment room services or patients placed under observation. 0760 – Specialty Services 0761 - Treatment Room 0762 - Observation Room (POS 3) 0769 – Other Specialty Services Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for an admission to the hospital as an inpatient. More information is available in the Official UB-04 Data Specification Manual.	Yes	POS = 6 all *Except 0762 = POS 3
077X	**Preventative Care Services** 0770 – Preventative care services, general 0771 – vaccine administration		6 – Other outpatient
0780	**Telemedicine – Facility Charges related to telemedicine** Facility charges related to the use of telemedicine services.	Yes	6 - Other Outpatient Encounter
0790	**Extra-Corporeal Shock Wave Therapy (Formerly LITHOTRIPSY)** Charges for the use of lithotripsy in the treatment of kidney stones. Extra-corporeal shock wave therapy 0790 - General Classification	Yes	6 - Other Outpatient Encounter
080X	**Inpatient Renal Dialysis** Charges for the use of equipment designed to remove waste when the body's own kidneys have failed. The waste may be removed from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis). 0800 – General Classification 0801 – Inpatient Hemodialysis 0802 – Inpatien5t Peritoneal (NONCAPD) 0803 – Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD) 0804 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD) 0809 – Other Inpatient Dialysis		
081X	**Acquisition of body components** 0811 – Acquisition of body components, living donor 0812 – cadaver donor 0813 – unknown donor 0814 – Acquisition of body components, donor bank 0819 – donor		

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
082X	**HEMODIALYSIS – OUTPATIENT** 0820 - Hemodialysis Outpatient/General 0821 - Hemodialysis Outpatient/Composite 0824 - Hemodialysis Outpatient/Maintenance/100 percent 0829 - Other Outpatient Hemodialysis	Yes	6 - Other Outpatient Encounter
083X	**PERITONEAL DIALYSIS - Outpatient** 0830 - Peritoneal Dialysis/General 0831 - Peritoneal Dialysis Outpatient/Composite Rate 0834 - Peritoneal Dialysis/Maintenance/100 percent 0839 - Other outpatient peritoneal dialysis	Yes	6 - Other Outpatient Encounter
084X	**Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home** 0840 - General 0841 - Composite or other rate 0842 - Home supplies 0843 - Home equipment 0844 - Maintenance/100% 0845 - Support Services 0849 - Other	Yes	6 - Other Outpatient Encounter
085X	**Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home** 0850 - General 0851 - Composite or other rate 0852 - Home supplies 0853 - Home equipment 0854 - Maintenance/100% 0855 - Support Services 0859 - Other	Yes	6 - Other Outpatient Encounter
086X	**Magnetoencephalography** 0860 – General 0861 - MEG	Yes	6 - Other Outpatient Encounter
087X	**Cell/Gene Therapy** For claims submitted on or after April 1, 2019, hospitals may report the CAR T-cell-related revenue codes 087X (Cell/Gene Therapy) and 089X (Pharmacy) established by the National Uniform Billing Committee (NUBC). When billing charges separately for tracking these services when furnished in the outpatient setting, providers must submit: 0871 – HCPCS 0537T with revenue code 0871 0872 – HCPCS 0538T with revenue code 0872 0873 – HCPCS 0539T with revenue code 0873 0874 – Remember that Medicare pays for the administration of CAR T-cells in the hospital outpatient setting separately under CPT code 0540T with Revenue Code 0874, which is assigned to status indicator “S”. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE19009.pdf	Yes	6 – Other Outpatient Encounter
088X	MISCELLANEOUS DIALYSIS Charges for dialysis not identified elsewhere. 0880 - General Classification 0881 - Ultrafiltration 0882 – Home Dialysis Aid Visit 0889 – Misc Dialysis	Yes	6 - Other Outpatient Encounter

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
089X	Pharmacy – Extension of 025X and 063X The category is an extension of 025x and 063x for reporting additional breakdown where needed. 0890 – Reserved (se 0250 for general classification) 0891 – Special Processed Drugs FDA Approved CELL Therapy 0892 - Special processed Drugs – FDA Approved GENE Therapy Reference UB-04 Data Specification for more information	NA	
090X	Behavioral Health Treatments/Services (also see 091X, and extension of 090X) Charges for prevention, intervention, and treatment services in the areas of mental health, substance abuse, developmental disabilities, and sexuality. Behavioral Health Care Services are individualized, holistic, and culturally competent and may include on-going care and support non-traditional services. 0900 - General 0901 - Electroshock 0902 - Milieu therapy 0903 - Play therapy 0904 - Activity therapy 0905 - Intensive outpatient services - psychiatric 0906 - Chemical dependency 0907 - Community behavioral health program - day treatment	Yes	6 - Other Outpatient Encounter
091X	**Behavioral Health Treatment / Services – Extension of 090X** Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment. Behavioral Health Treatments/Services - Extension of 090X 0911 - Rehabilitation 0912 - Partial hospitalization - less intensive 0913 - Partial hospitalization - intensive 0914 - Individual therapy 0915 - Group therapy 0916 - Family therapy 0917 - Biofeedback 0918 – Testing 0919 - Behavioral health treatments	Yes	6 - Other Outpatient Encounter
092X	Other Diagnostic Services 0920 - General 0921 - Peripheral vascular lab 0922 - Electromyelogram 0923 - Pap smear 0924 - Allergy test 0925 - Pregnancy test 0929 - Other	Yes	4
093X	Medical Rehabilitation Day Program 0931 - Half day 0932 - Full day	Yes	4
094X	**Other Therapeutic Services - See also 095X** 0940 - General 0941 - Recreational 0942 - Education/training 0943 - Cardiac rehabilitation	Yes	5

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0944 - Drug rehabilitation 0945 - Alcohol rehabilitation 0946 - Complex medical equipment - routine 0947 - Complex medical equipment - ancillary 0948 - Pulmonary rehabilitation 0949 – Other		
095X	**Other Therapeutic Services (Extension of 094X)** 0951 - Athletic training 0952 - Kinesiotherapy	Yes	5
096x – 098X	Professional fees should not be submitted to WIpop	NA	NA

7.8 Point of Origin for Admission or Visit

Required on all inpatient and outpatient services

Definition: A code indicating the point of patient origin for this admission or visit. Focus on where the patient came from before presenting to the health care facility.

According to the Official UB-04 Data Specification Manual "This code list is designed to focus on patients' place or point of origin (PoO) rather than the source of a physician order or referral. The existence of a physician order or referral is no longer relevant and has been removed from the definitions. (. . .). Based on this definition, the emergency room code was deactivated and eliminated effective July 1, 2010.

The codes are basically meant to be taken literally."

Value	Definition	Usage Notes
1	Non-Health Care Facility Point of Origin Usage Note: Examples: Includes patients coming from home or workplace and patients receiving care at home (such as home health services).	For Inpatients: The patient was admitted to this facility. For Outpatients: The patient presented for outpatient services. Note: This is to be taken in the most literal sense.
2	Clinic or Physician's Office Usage Note: Patient seen in clinic and directly admitted to a facility.	For Inpatients: The patient was admitted to this facility. For Outpatients: The patient presented to this facility for outpatient services.
3	(Discontinued 10/1/07)	Reserved for assignment by the NUBC.
4	Transfer From a Hospital (Different Facility) **Usage Notes:** Excludes Transfers from Hospital Inpatient in the Same Facility (See Code D)	Inpatient: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient. Outpatient: The patient was transferred to this facility as an outpatient from an acute care facility.
5	Transfer From A Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF)	Inpatient: The patient was admitted to this facility as a transfer from a SNF, ICF or ALF where he or she was a resident. Outpatient: The patient presented to this facility for outpatient or referenced diagnostic services from a SNF, ICF or ALF where he or she was a resident.
6	Transfer From Another Health Care Facility	Inpatient: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. Outpatient: The patient presented to this facility for services from another health care facility not defined elsewhere in this code list.
7	(ED Discontinued 7/1/10)	Reserved for assignment by the NUBC.
8	Court/Law Enforcement Usage Note: Includes transfers from incarceration facilities	Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. Outpatient: The patient presented to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available	Inpatient: The patient's Point of Origin is not known. Outpatient: The patient's Point of Origin is not known.*Not valid for Medicare outpatients.
D	Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer	Inpatient: The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer. Outpatient: The patient received outpatient services in this facility as a transfer from within this hospital resulting in a separate claim to the payer.

		Usage Notes: For the purposes of this code "Distinct unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation services, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital resulting in a separate claim to the payer.
E	Transfer from Ambulatory Surgery Center *recognized by Medicare 1/4/10	Inpatient: The patient was admitted to this facility as a transfer from an ambulatory surgery center. Outpatient: The patient presented to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.
F	Transfer from a Hospice facility	Inpatient: The patient was admitted to this facility as a transfer from hospice facility. Outpatient: The patient presented to this facility for outpatient or referenced diagnostic services from a hospice facility.
G	**Transfer from a Designated Disaster Alternative Care Site.**	The patient was transferred to this facility from a Designated Disaster Alternative Care Site for inpatient or outpatient services.
H-Z		Reserved for assignment by the NUBC.

7.8.1 PRIORITY (TYPE) OF ADMISSION OR VISIT

Definition: A code indicating the priority of this admission and/or visit.

Required on **Inpatient and **outpatient** (ED, OBS & OPS) encounters.*

Code ID	Code Name	Definition of Inpatient / Outpatient Visit that applies to code
1	Emergency	The patient requires **immediate medical intervention** as a result of severe, life threatening or potentially disabling conditions.
2	Urgent	The patient requires **immediate attention** for the care and treatment of a physical or mental disorder. The patient is admitted to the first available and suitable accommodation.
3	Elective	The patient's condition permits adequate time for services to be scheduled.
4	Newborn	Baby's first admission upon their birth. Must use Point of Origin either "5" – Born Inside this hospital or "6" born outside this hospital. (See Appendix 7.7.1)
5	Trauma Center	Visit to trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation. *Use Revenue Code 068x to capture trauma activation charges.
6-8		Reserved for assignment by the NUBC
9	Information Not Available	The hospital does not have this information in its records.

7.8.2 CODE STRUCTURE FOR NEWBORNS

Used with Priority Type of Admission 4 or Visit Code 4

Newborn Structure for Inpatient Only

Code	Name	Definition
1-4	NA	Reserved for assignment by the NUBC
5	Born Inside this Hospital	A baby born inside this Hospital
6	Born Outside of this Hospital	A baby born outside of this Hospital
7-9	NA	Reserved for assignment by the NUBC

Notes: *Information taken directly from NUBC Manual*

1. "Born Inside this Hospital" means anywhere within the hospital which **could include the ED, elevators, lobbies, waiting rooms, etc.**
2. "Born Outside of this Hospital" can mean any of the following possibilities:
    a. Born in the family car and brought to hospital for initial care
    b. Born in an ambulance and brought to hospital for initial care
    c. Born at home and brought to hospital for initial care

The age of the newborn is irrelevant in terms of the UB-04 Data Set. Any human should only have a Priority (Type of Admission) = 4 once in their lifetime. For a newborn that is transferred or readmitted, Code 4 – Newborn is NOT used. In this case, the appropriate code would most likely be emergency, urgent, or elective. The Point of Origin for Admission or Visit would be 4 if transferred to the hospital or 1 if the baby went home first.

Other Examples:

- For the baby's first admission upon their birth, FL 14 Code 4 – Newborn should be used. FL 15 would be either newborn Code 5 – Born Inside this Hospital or Code 6 – Born Outside this Hospital.
- In the case of a baby transferred to another hospital, the receiving hospital would use FL 15 Code 4 – Transfer from a Hospital (Different Facility); FL 14 would likely be either 1 – Emergency or 2 – Urgent, but not 4 – Newborn.

Newborn records should contain diagnosis code Z38+

7.9 Patient Discharge Status Codes

Required on all Institutional claims – i.e., 837i or 837r

Definition: A code indicating the disposition or discharge status of the patient at the end of service for the period covered on the bill/record or claim.

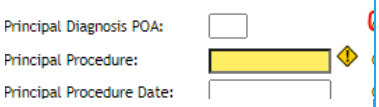
01	Discharged to home or self-care (routine discharge). **Usage Note:** Includes discharge to home; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated. Note: discharge to jail or law enforcement is now code 21 effective 10/1/09.
02	Discharged/transferred to another short-term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care. **Usage Note**: Medicare—indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61—Swing Bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 or Code 64.
04	**Discharged/Transferred to a facility that provides Custodial or Supportive Care. Usage Note**: Typically defined at the state level for specifically designated intermediate care facilities (ICF). Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification, and for state designated Assistant Living Facilities. **Usage Note**: Per NUBC instructions, use this code when the patient is transferred to a nursing facility and the nursing facility only has certified skilled beds, but the patient does not qualify for a skilled level of care, the nursing facility is certified for both skilled and intermediate level of care and the patient is transferred to intermediate, the facility is Medicare-certified and the patient resides there and receives only non-skilled services.
05	**Discharged/transferred to a Designated Cancer Center or Children's Hospital**. **Usage Note**: A Medicare distinct part unit or facility must meet certain Medicare requirements and is exempt from the IPPS; Children's hospitals and cancer centers are two examples. Discharged/transferred to a Designated Cancer Center or Children's Hospital. Also note, SNF's or swing beds, IRFs LTCH and Psychiatric hospitals or psychiatric distinct parts have specific patient status codes. **Usage Note:** Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://www3.cancer.gov/cancercenters/centerslist.html
06	Discharged/transferred to Home Under Care of organized home health service organization in anticipation of covered skill care. **Usage Note**: Report this code when the patient is discharged/transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services. Not used for home health services provided by a DME supplier or from a Home IV provider for home IV services. (Effective 2/23/05)
07	Left against medical advice (AMA) or discontinued care.
08	Reserved for assignment by the NUBC.
09	Admitted as an inpatient to this hospital. **Usage Note**: For use only on Medicare outpatient claims. Applies only to those Medicare outpatient services that begin greater than three days prior to an admission.
20	Expired. Per NUBC: Occurrence code 55 also required.
21	Discharge/Transfer to Court/Law Enforcement. **Usage:** This code includes transfers to incarceration facilities such as jail, prison, or other detention facilities.
30	Still Patient
40	Expired at home.

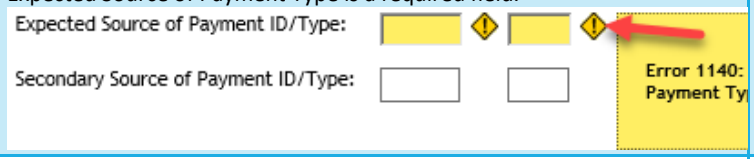
	Usage Note: For use only on Medicare and Tricare claims for hospice care. DO NOT SEND to WHAIC / WIpop
41	Expired in a medical facility such as a hospital, SNF, ICF or freestanding hospice. Usage Note: For use only on Medicare and Tricare claims for hospice care. DO NOT SEND to WHAIC / WIpop
42	Expired, place unknown. **Usage Note:** For use only on Medicare and Tricare claims for hospice care. DO NOT SEND to WHAIC / WIpop
43	Discharged/transferred to a federal health care facility. **Usage Note:** Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration Hospital, or a Veteran's Administration skilled nursing facility. To be used at discharge whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
50	Discharged to Hospice—Home. **Usage Note:** Report this code if the patient is discharged to his or her home or an alternative setting that is the patient's home, such as a nursing facility, and the patient will receive in-home hospice service.
51	Discharged to hospice—medical facility (certified) providing hospice level of care.
61	Discharged/transferred to a hospital-based Medicare approved swing bed. Usage Note: Medicare—used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital. **Usage Note:** This is a valid code for Medicare billing for hospitals, SNFs, HHAs and RNHCIs.
63	**Discharged/transferred to a Medicare-certified long-term care hospital. Usage Note:** For hospitals that meet the Medicare criteria for LTCH certification. Long-term care hospitals are certified under Medicare as short-term acute care hospitals with an average inpatient LOS greater than 25 days.
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare. Usage Note: Acute care hospitals, SNFs, hospices, and outpatient hospital providers are required to report this patient status code, if appropriate, although the use of this code does not affect payment for these facilities.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH). This code should be used when the hospital is a designated CAH.
69	Discharged/transferred to a designated disaster alternative care site.
70	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list.
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission.
82	Discharged/transferred to a short-term general hospital for inpatient care w/ a planned acute care inpatient readmission.
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification w/a planned acute care hospital inpatient readmission.
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission.
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission.
86	Discharged/transferred to home under care of organized home health service organization with planned acute care hospital inpatient readmission.

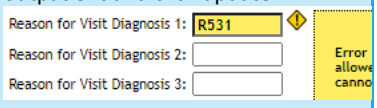
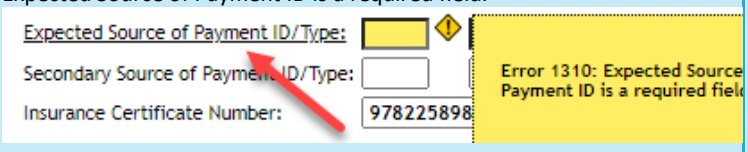
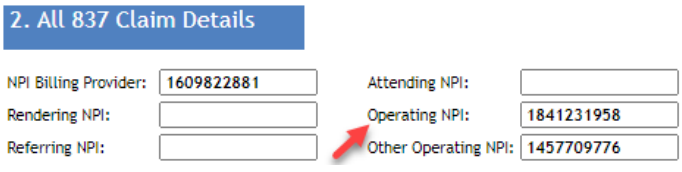
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission.
88	Discharged/transferred to federal health care facility with a planned acute care hospital inpatient readmission.
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission.
91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission.
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.
93	Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission.
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

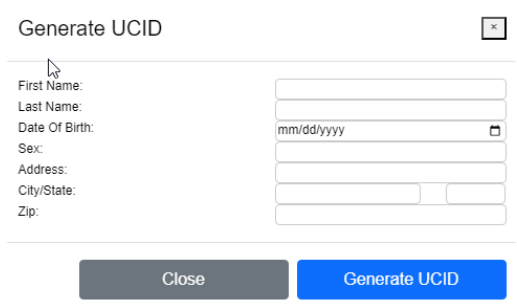
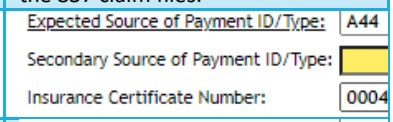
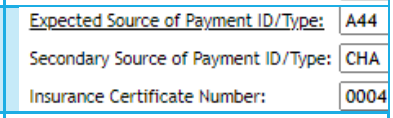
7.10 Edit Codes and Descriptions

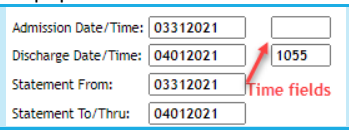
Notes are provided to help users work and/or clear edits.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ▲	Notes and fixing edits Click "Update" in WIpop to clear edit
1000	PTTYPE	The Patient Type supplied is invalid. Assigned by WHAIC unless DDE.	1=INP OR 2=OP
1005	SERVCODE	The Place of Service Code supplied does not match the revenue codes associated with this patient. See Appendix 7.5 - Place of Service Direct Data Entry users must consult manual and enter accordingly.	WHAIC assigns place of service using the revenue line-item detail, based on the hierarchy of codes outlined in Appendix 7.5 with some exceptions.
1006	SERVCODE	This facility type "FASC" must use place of service 1 (OPS)	Applies to DDE users
1010	BDAT	Date of Birth is a required field. MMDDYYYY	Verify DOB in MR
1030	ZIP	Zip Code is a required field. Unless patient is homeless – then record must contain condition code 17.	Condition Code 17 must be used for homeless or unknown on WIpop screen.
1040	SEX	Gender is a required 1 alpha character field. M and F also allow O (other) or U (unknown). Q424 Added X – NonBinary Option. Examples of O or U might include transgender, baby born with both parts, Agender, Androgynous, Bigender, nonbinary, etc. Condition code 45 is a billing code used in Medicare to identify claims related to transgender, intersex, and gender-expansive issues: • Purpose Condition code 45, also known as "Ambiguous Gender Category", allows claims to bypass sex-related edits and be processed normally. • When to use This code should be used for inpatient and outpatient claims related to transgender, intersex, and gender-expansive issues.	If O or U, Enter Condition Code 45 in the first unused condition code in Section 2. All 837 Claim Detail in the Edit Record Screen of WIpop. 
1050	RACE	Race is a required field for the state mandated discharge data collection. Race may be documented as declined (7) or unknown (9). The patient determines this field. Facility should not choose for the patient or map data to specific races.	See Appendix 7.2 Race and Ethnicity Codes. Batches will be denied if >25% of records are supplied with denied or unavailable.
1060	ADMS	Point of Origin is a required field for this type of patient record.	See Appendix 7.7 or 7.7.1 in the case of newborns.
1065	RACE	Race 1 and Race 2 fields cannot contain the same value.	Delete race 2 and click update.
1070	ADMT	Type of Admission is a required field for this type of patient record. Required on INP records.	See NUBC / UB-04 Guidelines
1080	ADAT	Admission Date is a required field for this type of patient record. Applies to INP and ED records.	Applies to Inpatient and ED records.
1081	ADAT	Admission Date is a required since Discharge date is provided.	One without the other will create an edit.
1090	DXP_REQ	Principal Diagnosis is a required field.	Check claim or EMR for diagnosis ode.
1091	DXP_POA	Principal Diagnosis Present on Admission is a required field. Applies to INP records. Acceptable values are Y, N, U, W and Blank for exempt.	See Coding Guidelines Appendix 7.6.
1092	DXP_POA	Principal Diagnosis Present on Admission does not correspond to accepted values. Acceptable values are Y, N, U, W and **blank** for exempt.	If you have a 1, E or a value other than what is acceptable, delete the value and click update.
1093	DXP_POA	Principal Diagnosis Present on Admission is exempt from the reported Principal Diagnosis and cannot be submitted. Refer to the current ICD-10 Coding Guidelines.	If exempt from reporting, field must be blank. Remove the value (Y, N, U, W) and hit update. *Most Status Codes "Z" range are exempt*
1094	DXP_POA	Principal Diagnosis Present on Admission is not allowed on this patient type.	PoA is only allowed on inpatient records. Delete the value and update record.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
1100	DXA	Admitting Diagnosis is a required field. Applies to INP records.	Edit will occur if provided on OP records. Delete if the code exist on an outpatient record.
1110	PINA	Attending NPI is a required field. Applies to INP and ED records.	Edit will occur if missing, review record and add NPI.
1120	DDAT	Discharge Date is a required field for this type of patient record.	Applies to INP and ED records/encounters.
1121	DDAT	Discharge Date is a required since Admission date is provided.	Cannot have one without the other.
1130	PTSTATUS	Discharge Status is a required field for this type of patient record.	See Appendix 7.8 – according to the NUBC it is a required field on all institutional claims.
1140	SOPTYPE	Expected Source of Payment Type is a required field. 	Appendix 7.3 Expected Source of Payment for correct mapping. Commercial payer codes start with 'A' - example: Aetna is A10 – 09. The A10 is the Payment ID and the 09 is the Payment Type code.
1150	TC	Total Charges is a required field. *Must match total charges in revenue detail.	Exclude professional services if on the record.
1160	BILLTYPE	Type of Bill is a required field. See Appendix 7.4 Type of Bill.	See UB-04 Data Specification Manual (NUBC). User may reference Appendix 7.4 to review acceptable TOB.
1170	SERVCODE (Aka POS)	The SERVCODE is the same as Place of Service (POS) supplied is invalid. See Appendix 7.5 Place of Service for correct Mapping requirements.	WHAIC will assign based on revenue code detail or type of facility.
1180	MRN	Medical Records Number is a required field.	Special characters are not acceptable, example: <1231>
1190	STPERIODF	Statement Covers Period From is a required field for this patient record. From means the date the service started.	Required on OBS, Therapies, Lab/Rad and other hospital outpatient data.
1200	STPERIODT	Statement Covers Period 'Through 'To' is a required field for this patient record. 'To' means the date the service ended.	Required on OBS, Therapies, Lab/Rad and other hospital outpatient data
1220	REVCODE	Revenue Code is a required field for this type of patient record.	All outpatient records require revenue codes except for FASC.
1240	UNITSERV	Units of Service is a required field.	Positive whole numbers only.
1245	UNITSERV	Units of Service must be greater than zero when Revenue Charge is greater than or equal to zero.	Units are required – must be 1 or greater. Units in the revenue line-item detail cannot be '0'
1250	REVCHG	Revenue Charge is a required field. Cannot be left blank.	$0 is acceptable
1260	DX	Additional Diagnosis is a required field when an injury code exists in the S and some T ranges.	Add an external cause code from the V00 – Y99 ICD-10 coding book range to explain – how, what, and/or where accident occurred.
1261	DXRV1	Reason for Visit 1 is required for this type of patient record. One code required for RHC 013x and 085x, and 078x with Revenue Codes 045x, 0516, 0526, or 0762. Up to 3 codes allowed for any outpatient record.	This definition is provided according to the NUBC coding guidelines.
1262	DXRV2	Reason for Visit 2 cannot be submitted without Reason for Visit 1.	Adjust record according to edit.
1263	DXRV3	Reason for Visit 3 cannot be submitted without Reason for Visit 1 & Reason for Visit 2.	Adjust record accordingly.
1265	DXRV1	Reason for visit 1 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct and you want an override.
1266	DXRV2	Reason for visit 2 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
1267	DXRV3	Reason for visit 3 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct
1269	DX	Additional Diagnosis not allowed if Principal Diagnosis not submitted.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct.
1270	PR	Additional Procedure is a required field. Valid when facility creates an additional procedure.	WHAIC adds from the 837-claim file, applies to DDE users only.
1271	DXRV1	Reason for visit 1 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	Delete the code if the record is not outpatient and click update. 
1272	DXRV2	Reason for visit 2 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	Delete the code if the record is not outpatient and click update.
1273	DXRV3	Reason for visit 3 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	Delete the code if the record is not outpatient and click update.
1274	DXRV1	Reason for Visit 1 is a duplicate of another Reason for Visit diagnosis	Delete duplicate.
1275	DXRV2	Reason for Visit 2 is a duplicate of another Reason for Visit diagnosis	Delete duplicate and update accordingly.
1280	PRDATE	Additional Procedure Date is a required field when additional procedure is supplied. Effective 01/18	WHAIC assigns based on revenue code details. But DDE users should verify EMR for details.
1310	SOPID	Expected Source of Payment ID is a required field. 	Appendix 7.3 Expected Source of Payment for correct mapping. Commercial payer codes start with 'A' - example: Aetna is A10 – 09. The A10 is the Payment ID and the 09 is the Payment Type code. Click on the underline to see who the payer listed on the claim is to map correctly.
1340	PINB	Operating Provider NPI 1 is required on outpatient surgery records. 	Must identify the physician/other qualified health care provider who performed surgery. It is unnecessary to populate the Attending on any record besides INP and ED. Other Operating NPI should be identified if there is a secondary surgeon on the record.
1350	ETHN	Ethnicity is a required field. See Appendix 7.2	See Appendix 7.2 for list of acceptable codes.
1360	UCID	Unique (encrypted) Case ID is a required field.	Complete the questions in the "Generate UCID box to create the

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
			UCID and populate the WIpop screens.
1365	PRP	Principal Procedure must be specified for outpatient surgery encounters / patient record. WHAIC pulls the principal procedure in from the claim file unless it is not included.	Mostly applies to anyone doing direct data entry facility. Required for outpatient surgery records.
1370	PRP	Evaluation & Management codes are not an acceptable Principal Procedure.	Use appropriate procedural CPT/HCPCS code. Applies to DDE. WHAIC populates all 837 files.
1375	PRP	Principal Procedure required if Operating Provider NPI 1 is reported.	Required on OPS records.
1380	PRP	Principal Procedure required when Procedure Date is reported.	WHAIC populates the principal and procedure date.
1385	PRP	Principal Procedure must be specified if Other Provider NPI 2 is reported.	WHAIC assigns procedure codes – contact WHAIC for review.
1390	PRP	Principal Procedure must be specified when Additional Procedures are reported.	Applies to DDE – WHAIC populated procedure codes based on revenue line-item detail.
1395	ADPRPD	Principal Procedure code does not appear in the revenue lines. All CPT/HCPCS codes must be identified in the revenue lines below. *This section is intended to identify services that meet the definition of "procedure."	Typically applies to direct data entry of records. This means you cannot populate the principal without repeating it along with the cost of the procedure in the rev line detail.
1396	ADPRPD	Additional Procedure code does not appear in the revenue lines. All CPT/HCPCS codes must be identified in the revenue lines below. *This section is intended to identify services that meet the definition of "procedure."	Typically applies to direct data entry of records. This means you cannot populate the additional procedure code(s) without repeating it along with the cost of the procedure in the rev line detail.
1400	PRPD	Principal Procedure Date required if Principal Procedure is reported.	Generally, applies to DDE because WHAIC assigns the date to the WIpop table based on the detail in the 837 claim files.
1410	SOPTYPE2	Secondary Source of Payment Type is required when Secondary Source of Payment ID is specified.	
1420	SOPID2	Secondary Source of Payment ID is required when Secondary Source of Payment Type is specified.	
1555	CERTNUM	Insurance Certificate Number is a required field unless self-pay.	For self-pay (OTH-61) use NULL or Blank
1590	LVDAYS	Leave Days cannot be a value greater than zero for this type of patient record.	Delete value and click update.
1600	PINB	Operating Provider NPI 1 cannot be specified if Principal Procedure is not reported.	Delete Operating NPI or add Principal Procedure
1605	PINC	Other Provider NPI 2 cannot be specified if Principal Procedure is not reported.	Delete NPI 2.
1610	PINC	Other Provider NPI 2 cannot be specified if Operating Provider NPI 1 is not reported.	Delete NPI 2 or add operating NPI.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
2010	BDAT	Date of Birth (DOB) does not correspond to a valid date (mmddyyyy).	Review record and update accordingly.
2015	BDAT	Date of Birth cannot be **after** Admit, Principal Procedure or Statement Covers From date.	Verify DOB in EMR and correct WIpop record.
2020	ADAT	Admission Date does not correspond to a valid date (mmddyyyy).	
2021	ATIME	Admission Time does not correspond to a valid time (hhmm)	
2022	ATIME	Admission Time must be blank when Admission Date is blank	
2030	PRPD	Principal Procedure Date does not correspond to a valid date (mmddyyyy).	
2040	DDAT	Discharge Date does not correspond to a valid date (mmddyyyy).	Correct date field and click update.
2041	DTIME	Discharge Time does not correspond to a valid time (hhmm)	Correct time field and click update
2042	DTIME	Discharge Time must be blank when Discharge Date is blank	
2050	STPERIODF	Statement Covers Period From does not correspond to a valid date.	Format date: mmddyyyy
2060	STPERIODT	Statement Covers Period To does not correspond to a valid date.	Format date: mmddyyyy
2065	STPERIODT	The date specified does not fall within the boundary of the working quarter. **Discharge date** is used to determine which quarter to use when reporting to WHAIC. For example, if service started on 06/30 and ended on 07/01, the record should be included in the 3rd quarter data submission. *This does not apply to outpatient surgery records.*	This record should be pulled into the following quarter if it crosses a quarter (*This does not apply to outpatient surgery records*.) This applies to both inpatients and most outpatient. Inpatient is based on discharge date and outpatient data like OBS, Therapies and lab/radiology are based on statement through date.
2066	STPERIODF	Statement Covers Period From must match the minimum service date in submitted revenue records.	Verify the statement from and through match the revenue record dates of service.
2067	STPERIODT	Statement Covers Period To must be no more than one day greater than the maximum service date in submitted revenue records.	
2070	SERVDATE	Service Date does not correspond to a valid date (mmddyyyy).	Review file: DTP*434 Loop
2075	SERVDATE	Service Date is a required field for this type of patient record.	Review file: DTP*434 Loop
2080	PRDATE	Additional Procedure Date does not correspond to a valid date.	The date must be formatted: mmddyyyy. Applies to direct data entry, WHAIC adds the additional procedure dates from revenue line-item details.
2090	TC	Total Charges cannot be less than zero.	Value must equal the value in revenue sect.
2100	UNITSERV	Units of Service do not correspond to a valid non-zero data format (nnnnnnn).	A value of 1 must be used – whole numbers only.
2310	LVDAYS	Leave Days must be a non-negative integer value (nnn).	Calculated by WHAIC
2311	LVDAYS	Leave Days should be less than Length of Stay.	Calculated by WHAIC
2340	UCID	Unique Case ID is not properly formatted. The value must contain 64 characters.	AKA – UCID.
2345	UCID	Unique Case ID is a required field.	
2350	DDAT	LOS cannot be greater than 7 days for ER (Discharge Date minus Admit Date).	Review the claim, EMR and correct accordingly. If correct, contact WHAIC to do an override if necessary.
3020	ZIP	ZIP Code does not correspond to accepted values.	Verify in the patient record and update. For out of country patients, use 00000

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
3030	SEX	Gender does not correspond to accepted values. Value of U or O requires Condition Code 45 if transgender or ambiguous gender.	If U or O, add Condition Code 45 to first available space in WIpop.
3040	RACE	Race does not correspond to accepted values.	See Appendix 7.2
3045	RACE2	Race 2 must be valid if specified.	See Appendix 7.2
3046	RACE	Declined or Unavailable race cannot be combined with another valid race. Two or more valid races may be included.	Delete unavailable or declined race when valid race is provided and hit update.
3050	ADMS	Point of Origin does not correspond to accepted values.	Review Claim or NUBC for correct Point of Origin or (AKA Source of Admission)
3060	ADMT	Type of Admission does not correspond to accepted values. See Official NUBC UB-04 Manual for values.	Refer to Appendix 7.7.1 for Admit Type listing.
3070	DXP	Principal Diagnosis does not correspond to accepted values, or code was deleted.	Verify accuracy of code choice. Refer to the current ICD-10 Manual.
3080	DXA	Admitting Diagnosis does not correspond to accepted values, or code was deleted.	Verify accuracy of code choice. Refer to the current ICD-10 Manual.
3110	PINA	Attending Provider NPI does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/
3120	PINB	Operating Provider NPI 1 does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/
3130	PINC	Other Provider NPI 2 does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/
3136	PIND	Rendering Provider does not correspond to accepted values.	Verify NPI before contacting WHAIC. Often in the ASC file, the rendering provider is the same as the operating NPI.
3137	PINF	Referring Provider does not correspond to accepted values.	Verify NPI before contacting WHAIC. Referring NPI is not the same as the billing NPI. Verify the NPI number for the Referring Provider is a human and not a facility.
3140	PRP	Principal Procedure does not correspond to accepted values, or code was deleted. Verify code in CPT or HCPCS if OP.	If outpatient record, verify code is a valid CPT or HCPCS. INP record – verify code with ICD-10 PCS
3145	PRP	Principal Procedure contains a valid procedure code, but not a valid principal procedure code. May be an add-on code or non-procedure code like a DME or Supply code.	If outpatient record, verify code in CPT or HCPCS. INP record – verify code with ICD-10 PCS
3150	PTSTATUS	Discharge Status does not correspond to accepted values. See Appendix 7.8 - Discharge status or Official NUBC UB-04 Specifications.	See Appendix 7.8 - Discharge status or Official NUBC UB-04 Specification
3180	BILLTYPE	Type of Bill does not correspond to accepted values.	See Appendix 7.4 – some TOBs are not acceptable
3181	BILLTYPE	Type of Bill 0999 is not allowed for hospitals.	Hospitals must use the TOB that is on the claim form.
3185	BILLTYPE	Zero charge records require Nonpayment/Zero charge Bill Type. See Appendix 7.4 - Type of Bill	As per NUBC guidance, type of bill must end in zero for total charges to be equal to zero.
3186	BILLTYPE	Type of bill (TOB)must match the record type. Edit 3186 will apply when either of these states is true:	This is a new 2020 edit to avoid hospitals and ASCs pre-mapping or

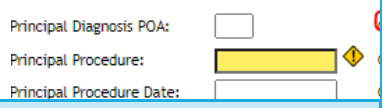
Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ▲	Notes and fixing edits Click "Update" in WIpop to clear edit
		• The record is inpatient and TOB is NOT in the 110 – 121 range • The record is outpatient and TOB is in the 110-121 range	assigning records to a specific TOB without regard to what is on the claim.
3210	REVCODE	Revenue Code does not correspond to accepted values. The whole file will reject if revenue code is longer than 4 digits. Transaction | Claim | Error 1 | 2 | Error on field REVCODE (loop 2400 SV201), maximum length 4, value = 0360A	Revenue codes are 4 digits and the leading zero, if applicable, must be present. Verify in UB-04.
3211	LVDAYS	At least one revenue record WITH a valid 018x revenue code must exist WHEN Leave Days is NOT 0 OR empty.	WHAIC assigns based on rev record detail.
3214	REVCODE	This revenue code cannot be submitted as a standalone record. 01/2018 **edit updated to avoid over-reporting of stand-alone ambulance claims.	Records that contain revenue codes 054X, 037X and 062X that are not accompanied by other revenue codes indicating a face-to-face encounter on the record will receive an edit.
3215	REVCODE	Revenue code cannot include professional charges. Professional Rev codes 096X - 098X excluded.	Delete line item, adjust the total charges if necessary.
3216	REVCODE	FASCs are not required to use revenue codes, if one is provided the acceptable range is: 0250, 0278, 0279, 0329, 036+, 0400, 0481, 049+, 0636, or 0750	Most FASC should be submitting data using the 837P which does not have a space for the revenue codes.
3220	HCPCSRATE	HCPCS/Rate Code must be accepted value or valid rate.	If code is valid, contact WHAIC and we will update table.
3225	HCPCSMOD1	HCPCS Modifier 1 does not correspond to accepted values.	WHAIC only accepts valid NUBC Modifiers. Exclude Vendor, Internal or Payer Modifiers.
3226	HCPCSMOD2	HCPCS Modifier 2 does not correspond to accepted values.	WHAIC only accepts valid NUBC Modifiers. Exclude Vendor, Internal or Payer Modifiers.
3227	HCPCSMOD3	HCPCS Modifier 3 does not correspond to accepted values.	WHAIC only accepts valid NUBC Modifiers. Exclude Vendor, Internal or Payer Modifiers.
3228	HCPCSMOD4	HCPCS Modifier 4 does not correspond to accepted values.	WHAIC only accepts valid NUBC Modifiers. Exclude Vendor, Internal or Payer Modifiers.
3230	DX	Additional Diagnosis does not correspond to accepted values, or code was deleted. Verify code in the ICD-10 CM	Verify code in the ICD-10 CM and adjust accordingly.
3235	HCPCSMOD1	Records for professional services are not acceptable.	Delete line items, adjust the total charges if necessary.
3236	HCPCSMOD2	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3237	HCPCSMOD3	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3238	HCPCSMOD4	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3240	PR	Additional Procedure does not correspond to accepted values, or code was deleted.	If the code is valid, contact whaicinfocenter@wha.org to request a code review.
3245	PRMOD1	Additional Procedure Modifier 1 does not correspond to accepted values.	Review current CPT or HCPCS and UB Manual.
3246	PRMOD2	Additional Procedure Modifier 2 does not correspond to accepted values.	Consult with current CPT or HCPCS Manual
3247	PRMOD3	Additional Procedure Modifier 3 does not correspond to accepted values.	Review current CPT or HCPCS and UB Manual.
3248	PRMOD4	Additional Procedure Modifier 4 does not correspond to accepted values.	Review current CPT or HCPCS and UB Manual.

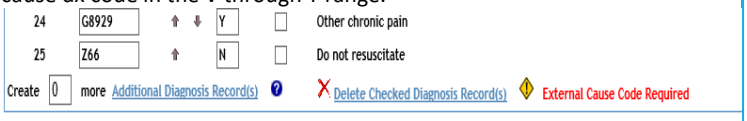
Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
3250	ETHN	Ethnicity does not correspond to accepted values.	See Appendix 7.1.2 Race and Ethnicity.
3340	CCODE1	Condition Code 1 does not correspond to accepted values	Review claim and NUBC Specifications.
3341	CCODE2	Condition Code 2 does not correspond to accepted values	Review claim and NUBC Specifications.
3342	CCODE3	Condition Code 3 does not correspond to accepted values	Review claim and NUBC Specifications.
3343	CCODE4	Condition Code 4 does not correspond to accepted values	Review claim and NUBC Specifications.
3350	CCODE1	Condition Code 1 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3351	CCODE2	Condition Code 2 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3352	CCODE3	Condition Code 3 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3360	CCODE1	Condition Code 1 must be populated first if other Condition Code exist	If Condition Code 1 is blank, move Condition Code 2 value up.
3361	CCODE2	Condition Code 2 cannot be blank if other Condition Code is not blank	
3362	CCODE3	Condition Code 3 cannot be blank if other Condition Code is not blank	
3770	SOPID	OTH-54 is obsolete as of Q1 2022. Use CHA-03 instead.	NEW Edit 2022: OTH-54 was redundant and eliminated.
3771	SOPID2	OTH-54 is obsolete as of Q2 2022. Use CHA-03 instead.	NEW Edit 2022: OTH-54 was redundant and eliminated. Combine all military with CHA-03
3772	SOPID	OTH-31 is obsolete as of Q22022. Use OTH-21 instead.	OTH-31 was redundant and was combined with OTH-21.
3773	SOPID2	OTH-31 is obsolete as of Q22022. Use OTH-21 instead.	OTH-31 was redundant and was combined with OTH-21.
3775	SOPID	Must be accepted Source of Payment ID and Type combination. See Appendix 7.3 Expected Source of Payment Mapping.	See Appendix 7.3 Expected Source of Payment Mapping.
3785	SOPID2	Must be accepted Secondary Source of Payment ID and Type combination. See Appendix 7.3 Expected Source of Payment Mapping.	See Appendix 7.3 Expected Source of Payment Mapping.
3805	PRPMOD1	Principal Procedure Modifier 1 does not meet accepted values.	Review modifier in proper Manual.
3806	PRPMOD2	Principal Procedure Modifier 2 does not meet accepted values.	Review modifier in proper Manual.
3807	PRPMOD3	Principal Procedure Modifier 3 does not meet accepted values.	Review modifier in proper Manual.
3808	PRPMOD4	Principal Procedure Modifier 4 does not correspond to accepted values.	Review modifier in proper Manual.
3810	PRPMOD1	Principal Procedure Modifier 1 is a duplicate of another Principal Procedure Modifier	Review and remove duplicate.
3811	PRPMOD2	Principal Procedure Modifier 2 is a duplicate of another Principal Procedure Modifier	Review and remove duplicate.
3812	PRPMOD3	Principal Procedure Modifier 3 is a duplicate of another Principal Procedure Modifier	Review and remove duplicate.
3815	PRPMOD1	Principal Procedure Modifier 1 cannot be blank when a later Principal Procedure Modifier is not blank	Review and remove duplicate.
3816	PRPMOD2	Principal Procedure Modifier 2 cannot be blank if other Modifier exist	Review and remove duplicate.
3817	PRPMOD3	Principal Procedure Modifier 3 cannot be blank if other Modifier exist	Review and remove duplicate.
3820	PRMOD1	Additional Procedure Modifier 1 is a duplicate of another Additional Procedure Modifier	Review and remove duplicate.
3821	PRMOD2	Additional Procedure Modifier 2 is a duplicate of another Additional Procedure Modifier	Review and remove duplicate.
3822	PRMOD3	Additional Procedure Modifier 3 is a duplicate of another Additional Procedure Modifier	Review and remove duplicate.
3825	PRMOD1	Additional Procedure Modifier 1 cannot be blank when a later Additional Procedure Modifier is not blank	Review and remove duplicate.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ▲	Notes and fixing edits Click "Update" in WIpop to clear edit
3826	PRMOD2	Additional Procedure Modifier 2 cannot be blank when a later Additional Procedure Modifier is not blank	Review and remove duplicate.
3827	PRMOD1	Additional Procedure Modifier 3 cannot be blank when a later Additional Procedure Modifier is not blank	Review and remove duplicate.
3830	HCPCSMOD1	HCPCS/CPT Modifier 1 is a duplicate of another Modifier	Review and remove duplicate.
3831	HCPCSMOD2	HCPCS/CPT Modifier 2 is a duplicate of another Modifier	Review and remove duplicate.
3832	HCPCSMOD3	HCPCS/CPT Modifier 3 is a duplicate of another Modifier	Review and remove duplicate.
3835	HCPCSMOD1	HCPCS/CPT Modifier 1 cannot be blank when other Modifier exist.	Move modifier to correct position.
3836	HCPCSMOD2	HCPCS/CPT Modifier 2 cannot be blank when other Modifier exist.	Move modifier to correct position.
3837	HCPCSMOD3	HCPCS/CPT Modifier 3 cannot be blank when other Modifier exist	Move modifier to correct position.
3900	MARITALS	Marital Status does not correspond to accepted values. See Appendix 7.11 for acceptable codes or contact WHAIC to update our table.	This is not a required field, but if collected must match table in Appendix 7.11
3930	AUTOACD	Auto Accident State does not correspond to accepted values	This is a 2-digit value based on National State Abbreviations. http://www.50states.com/abbreviations.htm
3950	BLKGRP	Census Block Group - a 12-digit number. Field is created based on address and specification in 837 Companion Guide.	Value created by WHAIC within 24 hours after the file is submitted with the patient address.
4010	DDAT	Discharge Date outside boundaries for selected quarter. Change the DOS or delete the record and resubmit in correct quarter.	Applies to IP and ED only. It verifies the discharge date is within the correct quarter.
4020	SERVDATE	Service Date outside boundaries of the admission and discharge dates (72 hours prior to admission date is allowed). **For Emergency Department (ED) records:** Place of service (POS) assignment is based on the established hierarchy and use of revenue codes as defined in Appendix 7.5. In order to accommodate services that occur in the emergency department (ED) and the uniform billing rules, two new bypass edits for services rendered in the ED have been created. See explanation below. a. For hospitals that provide recurring specialty type services such as infusions or dialysis in the ED and the patient is also treated for a minor procedure or service during the course of the recurring visits in the ED: • WHAIC will bypass edits for recurring outpatient hospital records with multiple revenue line items for outpatient lab/radiology or other outpatient services and also has an ED visit that occurred during the course of treatment. In order for the bypass edit to work the record must contain multiple service dates, a 0450 rev code, a statement 'From and Through' date of at minimum 7, 14 or 30 days that match the service dates in the revenue line item detail. To clarify: 1. If the encounter/record has less than seven (7) days of service line items, the record is ED. 2. If the encounter/record has more than seven (7) days, the place of service will be determined by the OHO revenue codes. b. For hospitals that perform a minor outpatient surgery procedure such as a suture in the ED, the record will be counted and included in the ED record volume: • WHAIC will overlook revenue code 0361 (minor surgery) on an ED record as long as there is at least one revenue code of 0450, 0451, 0452, or 0459. This bypass edit allows the ED record take precedence over the outpatient surgery revenue code. **c. OHO DATA:** For all other hospital outpatient (OHO) data, the 0361 revenue line will not be used to set the place of service, unless it's the only revenue line on the record.	4020 applies to IP and ED only. It applies if any of these are true: • Revenue service date is after the discharge date • IP, and Revcode 030+, and servdate is more than 10 days prior to admit date • IP, and Revcode NOT 030+, and servdate is more than 3 days prior to admit date • ED, and servdate is more than 3 days prior to admit date. Edit Reviewed 07/2021 for accuracy.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
4025	SERVDATE	Service Date outside boundaries of Statement Period. Dates in revenue line item must match the statement from/through dates.	Applies to OHO only. It applies if the revenue service date is before the statement period from date, or after the statement period through date.
4030	PRPD	Principal Procedure Date occurs outside boundaries of the admission and discharge dates (72 hours prior to admission date is allowed).	Applies to inpatient, outpatient surgery or any other data type that has a principal procedure.
4035	SERVDATE	Service Date outside accepted date range. For outpatient surgery (OPS) records: 01/2018 WHAIC cannot accommodate every scenario that might occur on any given claim or circumstance, however; in an effort to reduce the number of edits for services or encounters on records for claims that occur within the 90-day global surgical period (such as cataract surgeries that are often performed on both eyes within the 90-day global surgery period), we have made an exception. If there is an LT or RT modifier on any revenue line, then all revenue lines are allowed to have a service date up to 90 days after the principal procedure date. We will look for the highest charge first to account for the initial service data. If two or more revenue line items have the same (highest) charge, the earliest service date will be marked as the principal procedure. *Defined in 12/2017 Newsletter* New 2/18: PRE-OP visits that occur ***within 7 days*** of the outpatient surgery will not receive an edit.	4035 applies to OPS only. It applies if any of these are true: • Revenue service date is more than seven (7) days before the principal procedure date • Revenue service date is more than ten days after the principal procedure date To correct the edit, adjust the date to meet the criteria. WHAIC does not include DOS in the data sets we release, so it is acceptable for the facility to adjust the dates on the record to accommodate the record and clear the edit.
4040	BDAT	Date of Birth exceeds human lifespan of 124 years.	Review MR, EMR or claim for accurate DOB.
4060	DXP	Principal Diagnosis contains a valid diagnosis code, but not a valid Principal diagnosis code.	Verify the ICD-10 CM dx code and make a swap of another code on the record according to the appropriate coding guidelines.
4070	DXA	Admitting Diagnosis contains a valid diagnosis code, but not a valid admitting diagnosis code.	Review the medical record/documentation for a new code.
4071	DXA	Admitting Diagnosis is not allowed for this patient type and cannot be submitted. Do not include admitting diagnosis on outpatient records.	Admitting diagnosis code is not allowed on outpatient records. Delete the code.
4400	PRPD	Principal Procedure Date outside boundaries for selected quarter.	Verify the date. If the DOS is for previous quarter, delete the record. If deleting more than 5 records, email WHAIC to caveat.
4405	PRPD	Principal Procedure date does not fall in Statement Period.	OPS records are defined by surgery date.
4410	PRPD	Principal Procedure Date cannot be before Birth Date.	Review claim and/or EMR.
4480	DDAT	Discharge Date cannot be before Birth Date.	Review claim and/or EMR.
4500	VALCODE1	Value Code 1 does not correspond to accepted values.	Review claim, EMR or consult NUBC.
4501	VALCODE2	Value Code 2 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4502	VALCODE3	Value Code 3 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4503	VALCODE4	Value Code 4 does not correspond to accepted values	Review code.
4504	VALCODE1	Value Code 1 is a duplicate of another Value Code	Review claim and/or EMR.
4505	VALCODE2	Value Code 2 is a duplicate of another Value Code	Remove duplicate.
4506	VALCODE3	Value Code 3 is a duplicate of another Value Code	Remove duplicate.
4507	VALCODE1	Value Code 1 cannot be blank when a later Value Code is not blank	
4508	VALCODE2	Value Code 2 cannot be blank when a later Value Code is not blank	

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ▲	Notes and fixing edits Click "Update" in WIpop to clear edit
4509	VALCODE3	Value Code 3 cannot be blank when a later Value Code is not blank	
4510	VALAMT1	Value Code 1 Amount cannot be blank when Value Code 1 is not blank	
4511	VALAMT2	Value Code 2 Amount cannot be blank when Value Code 2 is not blank	
4512	VALAMT3	Value Code 3 Amount cannot be blank when Value Code 3 is not blank	
4513	VALAMT4	Value Code 4 Amount cannot be blank when Value Code 4 is not blank	
4514	VALAMT1	Value Code 1 Amount must be blank when Value Code 1 is blank	
4515	VALAMT2	Value Code 2 Amount must be blank when Value Code 2 is blank	
4516	VALAMT3	Value Code 3 Amount must be blank when Value Code 3 is blank	
4517	VALAMT4	Value Code 4 Amount must be blank when Value Code 4 is blank	
4600	OCC1	Occurrence Code 1 does not correspond to accepted values	Review codes.
4601	OCC2	Occurrence Code 2 does not correspond to accepted values	Review codes
4602	OCC3	Occurrence Code 3 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4603	OCC4	Occurrence Code 4 does not correspond to accepted values	
4604	OCC1	Occurrence Code 1 is a duplicate of another Occurrence Code	
4605	OCC2	Occurrence Code 2 is a duplicate of another Occurrence Code	
4606	OCC3	Occurrence Code 3 is a duplicate of another Occurrence Code	
4607	OCC1	Occurrence Code 1 cannot be blank when a later Occurrence Code is not blank.	
4608	OCC2	Occurrence Code 2 cannot be blank when a later Occurrence Code is not blank.	
4609	OCC3	Occurrence Code 3 cannot be blank when a later Occurrence Code is not blank.	
4610	OCCSTART1	Occurrence Code 1 Start cannot be blank when Occurrence Code 1 is not blank.	
4611	OCCSTART2	Occurrence Code 2 Start cannot be blank when Occurrence Code 2 is not blank.	
4612	OCCSTART3	Occurrence Code 3 Start cannot be blank when Occurrence Code 3 is not blank.	
4613	OCCSTART4	Occurrence Code 4 Start cannot be blank when Occurrence Code 4 is not blank.	
4614	OCCSTART1	Occurrence Code 1 Start must be blank when Occurrence Code 1 is blank.	
4615	OCCSTART2	Occurrence Code 2 Start must be blank when Occurrence Code 2 is blank.	
4616	OCCSTART3	Occurrence Code 3 Start must be blank when Occurrence Code 3 is blank.	
4617	OCCSTART4	Occurrence Code 4 Start must be blank when Occurrence Code 4 is blank.	
4618	OCCEND1	Occurrence Code 1 End must be blank when Occurrence Code 1 Start is blank.	
4619	OCCEND2	Occurrence Code 2 End must be blank when Occurrence Code 2 Start is blank.	
4620	OCCEND3	Occurrence Code 3 End must be blank when Occurrence Code 3 Start is blank.	
4621	OCCEND4	Occurrence Code 4 End must be blank when Occurrence Code 4 Start is blank.	
4650	OCCSTART1	Occurrence Code 1 Start does not correspond to a valid date (mmddyyyy).	
4651	OCCSTART2	Occurrence Code 2 Start does not correspond to a valid date (mmddyyyy).	
4652	OCCSTART3	Occurrence Code 3 Start does not correspond to a valid date (mmddyyyy).	
4653	OCCSTART4	Occurrence Code 4 Start does not correspond to a valid date (mmddyyyy).	
4654	OCCEND1	Occurrence Code 1 End does not correspond to a valid date (mmddyyyy).	
4655	OCCEND2	Occurrence Code 2 End does not correspond to a valid date (mmddyyyy).	
4656	OCCEND3	Occurrence Code 3 End does not correspond to a valid date (mmddyyyy).	
4657	OCCEND4	Occurrence Code 4 End does not correspond to a valid date (mmddyyyy).	
4658	OCCEND1	Occurrence Code 1 End cannot be before Occurrence Code 1 Start.	
4659	OCCEND2	Occurrence Code 2 End cannot be before Occurrence Code 2 Start.	

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
4660	OCCEND3	Occurrence Code 3 End cannot be before Occurrence Code 3 Start.	
4661	OCCEND4	Occurrence Code 4 End cannot be before Occurrence Code 4 Start.	
5010	ADAT	Admission Date must be equal to Birth Date when Principal Diagnosis is 'Z38' with a fourth digit of 0, 3 or 6.	Newborn baby born inside a hospital
5020	ADAT	Admission Date can be no more than two days after Birth Date when Principal Diagnosis is 'Z38' with the fourth digit NOT 0, 3 or 6.	Means baby was born outside of hospital and was later admitted.
5030	PRP	Principal Procedure is gender specific and does not match Gender specified. This requires a 45 in first available Condition Code field.	Add condition code 45 to one of the condition code fields to bypass edit. 
5050	DDAT	Discharge Date cannot occur before Admission Date.	Verify Dates of Service on claim.
5070	BDAT	Date of Birth must be less than or equal to the Admission Date.	Review claim or EMR details.
5120	DX	Additional Diagnosis is a duplicate of Principal Diagnosis. Verify if the procedure was performed twice.	Verify procedure performed twice. Review the claim and revenue code details and the additional procedures. Delete extra code.
5151	DXP	Code first rule specifies that diagnosis xxx must be sequenced before diagnosis yyy.	Review coding guidelines and/or EMR. WHAIC is not an insurance company. Our goal is to record services rendered. Users may flip codes or provide documentation to WHAIC to do an override.
5166	DX	Additional Diagnosis requires a corresponding Primary or Additional Diagnosis which was not found.	Review medical record to determine all codes submitted.
5167	DXP	Principal Diagnosis requires a corresponding Additional Diagnosis which was not found.	Review EMR and claim. Update record accordingly.
5180	TC	The sum of all Revenue Charges must equal the Total Charge.	Click on the "Calculate Total Charge" in the Revenue line item.
5191	ADMS	Source of Admission must be '5', or '6' if the Type of Admission equals '4' (newborn).	Review claim and/or NUBC guidelines.
5210	ADMT	Admit Type cannot equal '4' (newborn) if Age in Days is calculated as greater than '1' and Point of Origin equals 6.	Review claim and/or NUBC guidelines.
5240	DXP	Principal Diagnosis is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5250	DXA	Admitting Diagnosis is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit..
5255	ADMT	Admit Type must equal '4' when Age Days is calculated as less than one day.	
5256	ADMT	Admit Type cannot equal '4' (newborn) for this type of patient record.	Review EMR and Claim
5257	ADMT	Admit Type cannot equal '4' (newborn) if Age in Days is calculated as greater than '0' and Point of Origin equals 5.	
5258	ADMT	Admit Type must be 5 when 068x revenue code in on the record.	
5260	DX	Additional Diagnosis is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5270	DXRV1	Reason for Visit 1 is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5271	DXRV2	Reason for Visit 2 is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5272	DXRV3	Reason for Visit 3 is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5305	REVCODE	At least one revenue record is required.	Review claim and add details to record.
5310	DX	Duplicate Additional Diagnosis codes are not allowed.	Delete duplicate code.
5312	DX_POA	Diagnosis Present on Admission is exempt from the reported Diagnosis and cannot be submitted. Field must be blank if exempt from reporting.	Delete the value in the POA field and click update.

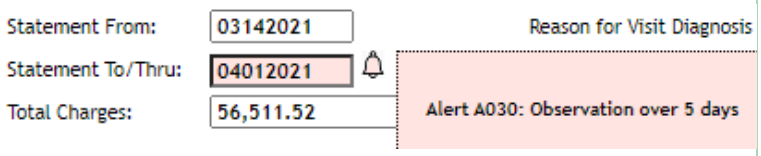
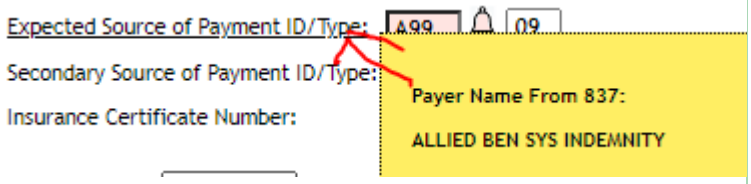
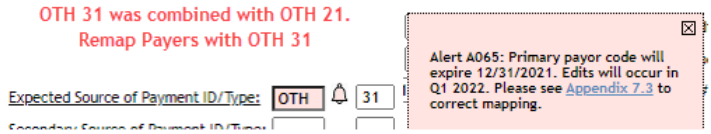
Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
5313	DX_POA	Diagnosis Present on Admission is not allowed on this patient type.	Only allowed on inpatient records. Delete the value and click update.
5314	DX_POA	Diagnosis Present on Admission does not correspond to accepted values.	Only values are Y, N, W, U and blank if exempt from reporting.
5315	DX_POA	Diagnosis Present on Admission is a required field. Correct values are Y, N, W, U and blank if not required.	Review EMR and claim, update accordingly.
5330	PRP	Principal Procedure is age specific and does not match Date of Birth specified.	Review EMR/claim to verify DOB. Update record.
5340	PR	Additional Procedure is age specific and does not match Date of Birth.	Review EMR/claim to verify DOB. Update record..
5355	PR	This code does not meet the definition of a procedure. This edit applies to codes that start with A, B, E, J or 8, if the code is in the 992 range, or if the code is in the 00 – 01 range and does not end with a letter.	This applies to direct data entry. Do not use E&M Codes, pathology, simple blood draws 36415, supply codes, DME codes, etc. in the procedure fields.
5360	PR	Additional Procedure is gender specific and does not match the Gender specified.	Review EMR / Claim. If accurate, add condition code 45 to one of the four condition code fields to bypass the edit.
5370	DX	Diagnosis codes in the S-T range, w/some exceptions require an external cause dx code in the V through Y range. 	At least one external cause code must be specified when a diagnosis exists in the S – Injury Code range. Add a 1 to "Create" box and click on the more "Additional Diagnosis Records" to add a line item.
5390	HCPCSRATE	This revenue code requires an HCPCS or CPT code. Reference Coding Guidelines.	Most outpatient revenue codes require a corresponding CPT/HCPCS code defining what was performed or provided.
5400	PBLID	Provider-based Location ID does not correspond to accepted values.	Contact WHAIC to update the PBL Table.
6040	SERVCODE	Place of Service cannot be specified for this type of patient record.	INP records do not require a place of service.
8500	PROVID	NPI Billing Provider NPI is a required field and must be valid.	Populate NPI number of the billing facility. WHAIC uses the NPPES to validate NPI numbers.

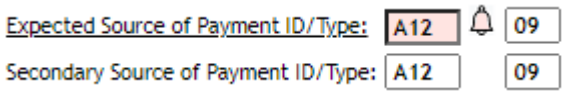
7.10.1 ALERT CODES

WHAIC follows CMS lead on most edits and definitions as it relates to inpatient, observation, and other patient status / stays. Our Alerts are set up with that in mind in order to stay consistent with our validation reports and quality of the data.

Alerts are not Edits or Errors. Alerts are intended to be an opportunity to review the data more closely and timely. Our intent is to allow ample time to make necessary changes before the end of the year. * The alert bell may draw your attention to specific areas of race, ethnicity, payer, and inpatient/observation stays. Examples might include patients over 65 reported as non-Medicare, other/unknown payer, race declined/unavailable, OBS over 5 days, IP under 2 days, unknown payer, etc. WIpop Batch files will contain an Alert Records section for each Patient Type on the far right of the screen. You are not required to work all alerts!

Alert Code	Alert Defined and what it might look like	Alert reconciliation how to handle and examples
A010	Race is Declined.	Review EMR and update patient account if race is in the EMR.
A011	Race is Unavailable.	Review EMR and update patient account. *Continue to encourage and remind patient registration of the importance of asking / including

Alert Code	Alert Defined and what it might look like	Alert reconciliation how to handle and examples
		this detail in the EMR even with all the COVID testing and vaccination encounters.
A020	Ethnicity is Declined	Review EMR and update patient account if ethnicity is in the EMR.
A021	Ethnicity is Unavailable	Review EMR and update patient account. Continue to encourage and remind patient registration of the importance of asking / including this detail in the EMR even with all the COVID testing and vaccination encounters
A030	Observation over 5 days. 	Review EMR and Claim – verify correct use of rev code 0762 with multiple days in hospital. Adjust record if needed. **According to CMS**: Observation services are not expected to exceed 48 hours in duration. Observation services greater than 48 hours in duration are seen as rare and exceptional cases. If medically necessary, Medicare will cover up to 72 hours of observation services.
A060	Unknown or Other Primary Payor. 	Verify the correct payer is assigned. In this record the Alert is produced for the A99 code. Clicking on the Expected Source of Payment will provide the name of the payer. A google search will lead the reviewer to noticing this is a Benefit Plan Admin. Or TPA. **The correct mapping should be OTH 21, NOT A99.**
A065	Primary Payor Code will expire 12/31/2021. See Appendix 7.3 for more information. 	Multiple payer codes have been combined or removed to reduce the amount of facility payer mapping required. Payer Alerts are set up to instruct submitters and editors to review Appendix 7.3 and adjust codes accordingly. • MED and T18 – combined to MED-09 = Medicare, Medicare Sup / MediGap, Medicare Part A, B, C - all Medicare patients. • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance. • CHA 03 and OTH 55 – combined to CHA 03 = current and former military (insurance) benefits regardless of who is managing contract. • OTH 54, 59 & 71 – combined to OTH 54 = free/subsidized government programs, nonprofit organizations, health departments, and grant/research funds. • OTH 99 and 98 – combined to OTH 99 = TPL, MVA, state funded crime victim or safe funds, and some other unknown payers that are not related to commercial, private, or other forms identified in the mapping table. From auto insurance to crime victim claims. • *Facilities are no longer required to identify the Plan PayTypes: 01 – FFS and 02 - HMO/PPO for Medicare, Medicaid or BadgerCare. Please **report all payers using one option PayType = 09*** **A067** Primary and Secondary Payors are the same. Verify patient has the same payer as primary and secondary. It is not uncommon to list two (2) Medicare

Alert Code	Alert Defined and what it might look like	Alert reconciliation how to handle and examples
		payers if the patient has a dual Medicare plan. Typically, it is not common for patients to have the same duplicate plans such as BC Anthem.
A070	Unknown or Other Secondary Payor	This code has been suspended.
A075	Secondary Payor Code will be Invalid after Q12021. See Appendix 7.3 for more information.	Multiple payer codes have been combined or removed to reduce the amount of facility payer mapping required. Payer Alerts are set up to instruct submitters and editors to review Appendix 7.3 and adjust codes accordingly. • MED and T18 – combined to MED-09 = Medicare, Medicare Sup / MediGap, Medicare Part A, B, C - all Medicare patients. • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance. • CHA 03 and OTH 55 – combined to CHA 03 = current and former military (insurance) benefits regardless of who is managing contract. • OTH 54, 59 & 71 – combined to OTH 54 = free/subsidized government programs, nonprofit organizations, health departments, and grant/research funds. • OTH 99 and 98 – combined to OTH 99 = TPL, MVA, state funded crime victim or safe funds, and some other unknown payers that are not related to commercial, private, or other forms identified in the mapping table. From auto insurance to crime victim claims. • *Facilities are no longer required to identify the Plan PayTypes: 01 – FFS and 02 - HMO/PPO for Medicare, Medicaid or BadgerCare. Please* ***report all payers using one option PayType = 09***
A080	Over 65 non-Medicare Payer should be mapped to MED. See Appendix 7.9	This is not an edit, if the patient is still working and does not have Medicare, leave as is. However, most 65 and older patients have Medicare as a primary payer. Commercial plans offering Medicare Advantage is MPC-09, Med Sup should be mapped to MED – 09.
A090	Inpatient stay under 2 days.	**According to CMS**: **Inpatient services defined** "An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."

WIpop Registration and Roles

January 2024

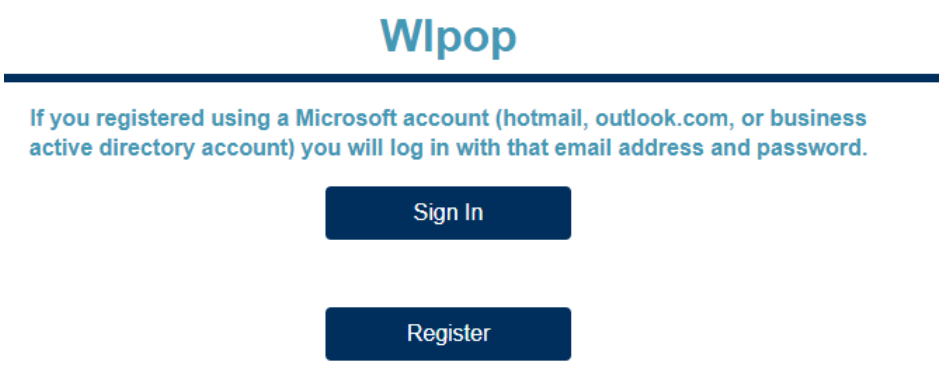
7.11 WIpop Registration

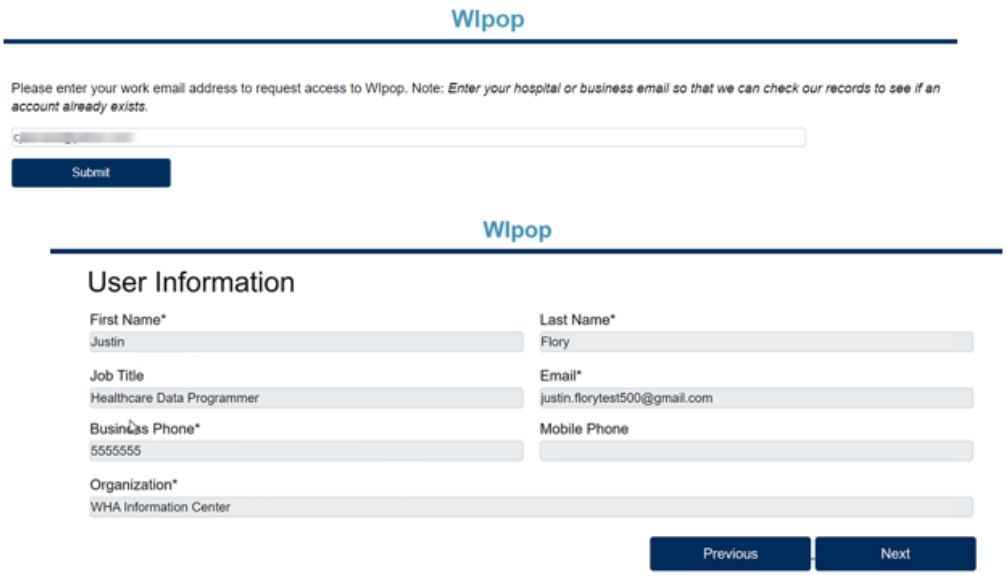
To use the secured WHAIC portal to submit, correct or complete discharge data users will NOT need a WHAIC Username or Password. Users will use their own facility email address and password.

The WHAIC uses a single sign-on authentication method that allows users to sign in using one set of credentials to multiple software systems. In other words, users sign into the WHAIC applications using their personal/facility Microsoft 365 work account.

Creating an Account:
To register, open site **https://wipopicd10.whainfocenter.com/** enter your email. Our system will check for an active account.

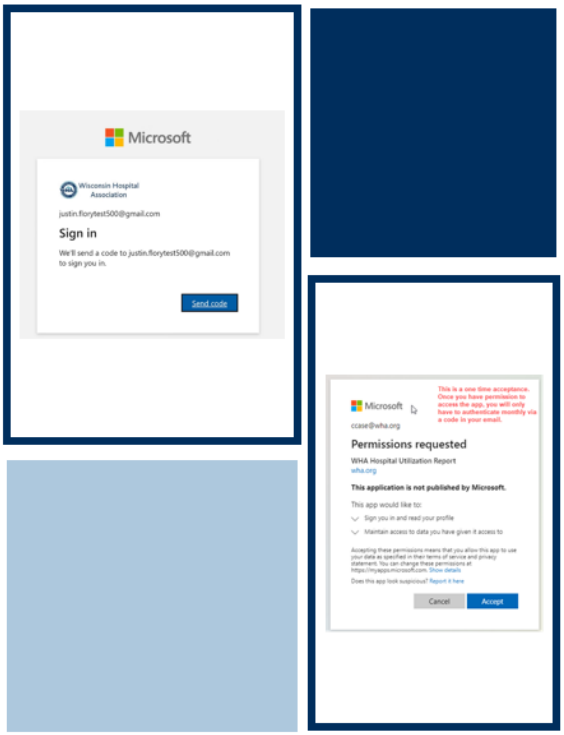
If no email is found or registered, the user will be required to register as a WIpop User and select a role based on what role the user intends to play in the discharge data submission process and choose all facilities that will apply to that position. Below is a description of roles.





Once registered, WHAIC will receive an email to review and approve for specific access requested. Primary contact will be notified of newly registered users.

Once approved, the user will receive an authentication email to validate the users' credentials and establish the identity of the user.



Authentication

- The left side is what you can expect from an authentication point
- The Right slide is a one-time acceptance to access our secured site

WIPOP ROLES

Roles are designations assigned by the facility to manage and oversee the statutorily required and timely data submissions and corrections to the quarterly inpatient and outpatient data.

> *Users that need to add newly acquired sites to perform edits or submit data to their account once registered and approved must contact WHAIC to add or update facility listing.*

The Primary Contact will:

- Oversee and monitor access requests and requirements in WIpop. Notify WHAIC with changes that cannot be made in the WIpop app.
- Serve as primary contact to address issues with the data or timely submission/training.
- Receive confirmation emails of:
  - data submissions,
  - notice of affirmation, and
  - newly registered WIpop Users
- Have access to the data deliverables site to download/share the facility data.
- Retrieve and review all profile and validation reports for review, distribution, and accuracy.
- Authority (granted / delegated) to electronically sign and submit affirmation statement.

The Secondary Contact will:

- Oversee and monitor access requirements in WIpop and contact WHAIC with changes
- Receive all profile and validation reports for review, distribution, and accuracy.
- Have access to the data deliverables site to validate/download the facility data; and
- Serve as back up contact when there are issues with the data.

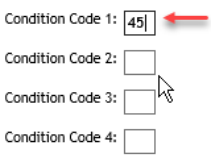
WIpop Only Role will:

- Have authority to upload data.
- Run reports out of WIpop; and
- Clear/fix edits.

If your account is deactivated, contact **whainfocenter@wha.org** to reactivate it.

7.12 Data Dictionary

The 837 Data Dictionary is intended to provide an explanation/description for the fields located in WIpop

Field Name and Description
Facility Number: The unique 3-digit identification number assigned to each facility by WHAIC. This number must be used to upload your files and correspond with WHAIC. Appendix 7.1 has a list of all hospitals and ASCs three (3) digit facility ID numbers.
Patient Control Number (PCN) or Pcontrol: The unique alpha or numeric number assigned to the record by the facility. This code is used for reference in correspondence, problem solving, edit corrections and return of grouped data. The PCN is different from the medical record number, which identifies an individual patient and remains constant through multiple facility visits. The patient control number provides linkage of all record types containing patient-related data for a specific discharge. Must be numeric (0-9) and/or alphabetic (A-Z). UB-04 NUBC Definition: Patients' unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services (accounts receivable) containing the financial billing records and any postings of payment.
Patient Type: One-digit entry identifies the status of the patient at the time of discharge. WHAIC Required - Use the following codes: 1 = Inpatient 2 = Outpatient
Place of Service (POS): assigned to Outpatient Records Only. One-digit entry identifies the location / type of unit or area where the patient received outpatient services. WHAIC assigns POS by this hierarchy and codes below (See Appendix 7.5 for further information): **Outpatient** 3 = Observation Care (OBS) 1 = Outpatient Surgery (OPS) 2 = Emergency Department (ED) 4 = Therapy (PT/OT/ST) 5 = Outpatient (Lab/Radiology excluding referenced diagnostic services) 6 = Other Outpatient Hospital data
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.
Date of Birth: The patient's month, day, and complete year of birth. This date should be recorded in numeric form with a two-digit entry for the month/day and a four-digit entry for the year (mmddyyyy). For example, if the birth date is July 10, 1950, record 07101950. The entire birth date should be provided.
Census Block Group -Address, City, State and Zip is used to create the patient's census block group. The census block group, not the address, will be stored in the WIpop database and used in the discharge data. SECTION 8. 153.50 (6) (am) of the statutes is created to read:153.50 (6) (am) Hospitals or ambulatory surgery centers shall submit the patient's street address to the entity under contract under s. 153.05 (2m) (a) as directed by the entity. The entity may only use the street address to create a calculated variable that does not identify a patient's address or to convert the data element to the corresponding U.S. bureau of the census track and block group. The entity shall destroy the street address information upon the creation of the variable or upon the conversion to the census tract and block group.
Sex/Gender: F = Female; M = Male; X = Non Binary, O= Other, U = Transgender or Ambiguous gender - ***Use condition code 45 in any of the Condition Code fields* to override the edit.**   

Marital Status: a person's state of being single, married, separated, divorced, or widowed.

If collected and stored in the EMR, WHAIC expects it to be sent in the data files.

ZIP Code: The five-digit code assigned by the U.S. Postal Service. Valid ZIP codes should be provided whenever possible. *Use five zeroes ('00000') for persons with an address that does not include a valid U.S. ZIP code.* If the ZIP code is unknown, such as for homeless patients, this field should be left blank and populate Condition Code 1 with '17'.

***Race 1**:* This information is based on self-identification and is to be obtained from the patient, relative, or responsible party. If a patient chooses not to answer the facility should enter the code for declined. In the most basic sense, race is defined as populations or groups of people divided based on various sets of physical characteristics from genetic ancestry. Do not default race categories to declined or duplicate field as this will cause the file to be rejected.

Ethnicity: This information is based on self-identification as is to be obtained from the patient, relative, or responsible party. If a patient chooses not to answer, the code for declined may be used. An ethnicity is a population of human beings whose members identify with each other, based on a real or presumed common genealogy or cultural traits.

Mexican or Latino is not a race, according to the OMB they usually identify as Caucasian based on color of skin or region.

Race 2 (optional): An additional Race 2 element may be collected and reported. This information is based on self-identification and is to be obtained from the patient, relative, or responsible party.

Language: A **language** is a system of communication which consists of a set of sounds and written symbols which are used by the people of a particular country or region for talking or writing. ...the English **language**.

If collected by the facility, the data is expected to be sent with the file.

UCID: WHAIC cannot accept PHI i.e., Patient Names or SSN in the data. Therefore, hospitals and freestanding ambulatory surgery centers are required to include a 64-character Unique Case Identifier (UCID) in the claims file. This data element has been collected by the WHAIC since 2013. Its primary purpose is to assist hospitals and ambulatory surgery centers in identifying when a readmission occurs at a facility other than where the original admission or ambulatory surgery occurred.

There are two approaches to developing the 64-character UCID. One is to use the WHAIC 837 File Handler program, also known as the "black box". This program will accept your 837 file as input, creating an output file with patient names removed and add the UCID. The other approach is to create your own program to generate the UCID. The formula first applies a name standardization algorithm (New York State Identification and Intelligence System). The standardized name, combined with date of birth and gender, is then hashed using the SHA 256 hash function to produce the 64 - character UCID.

As of Q42023 the WHAIC 837 File Handler program is embedded in the WIpop site. The facility no longer needs to download a program nor instructions from WHAIC.

The UCID is unique to the patient; however, there are times such as with twins where we can get the same value if they have similar names.

As a means to further protect patient data, the UCID is not included in the public dataset .

All 837 Claim Details Section 2

Insurance Certificate #: Insured's insurance identification number assigned by the payer organization. Term sometimes referred to member ID, Group number, plan number, insurance number, etc. If the record is for a self-pay case (OTH/61) the field may be zero-filled or left blank. (UB-04 FL 60) (CMS-1500 Form Locator 1A). An edit will occur when Expected Source of Payment field is filled in and there is no insurance number identified. *unless self-pay

NPI Billing Provider: The unique national provider identifier (NPI) number assigned to the facility submitting the bill. When the billing provider is an organization's health care provider, the organization's health care provider's NPI or its subpart's NPI is reported in this field. When a health care provider organization has determined that it needs to enumerate its subparts, it should report the NPI of a subpart as the billing provider. The subpart reported as the billing provider must always represent the most detailed level of enumeration as determined by the organization health care provider and must be the same identifier sent to WHAIC. Report all subpart NPIs to WHAIC.

Referring Provider - The referring **provider** is the provider who sends the patient to another provider for services. For example - patient's primary care **provider** referring his/her patient to a specialist.

Attending NPI: Required on Inpatient and Emergency dept. records – All National Provider Identifier (NPI) numbers *"a physician or other qualified health care professional"* are acceptable as of January 1, 2017, Dates of Service (DOS) even if the primary responsibility for a patient is a non-physician caregiver for example, dentist, psychologist, podiatrist, nurse midwife, physician assistant, nurse practitioner, or chiropractor.

Not required for any other data type

Operating NPI: Required For outpatient surgery records. All National Provider Identifier (NPI) numbers are acceptable as of January 1, 2017, DOS even if the primary responsibility for a patient is a non-physician caregiver (e.g. dentist, psychologist, podiatrist, nurse midwife, physician assistant, nurse practitioner, or chiropractor).

Acceptable for all other data types like Inpatient and Emergency Department if a procedure were performed and a qualifying CPT code and procedure date is provided, an NPI number would be expected.

Other Operating NPI: NPI numbers for *"a physician or other qualified health care professional"* are acceptable even if the primary responsibility for a patient is a non-physician caregiver (e.g., dentist, psychologist, podiatrist, nurse midwife, physician assistant, nurse practitioner, or chiropractor). Cannot provide this without the operating NPI1.

Rendering Provider - rendering provider is the healthcare provider who performed (or rendered) the services. For a solo practice, usually the billing provider and the rendering provider are the same entity. However, the two providers are still treated separately by the insurance companies when processing your claims.

Expected Source of Payment ID: The first three characters from the primary payer code (expected to pay the greater share) from the UB-04 form. For example, Wisconsin Medical Assistance (Medicaid) patients must be coded as "T19," with payer type of fee-for-service or 01 and workers comp is recorded as OTH/41. See Appendix 7.3 for appropriate codes.

Expected Source of Payment Type: The fourth and fifth characters of the payer code from the UB-04 form. This field identifies the payer group, for example FFS, HMO, Workers Compensation, Self-pay, other, etc.

Payer ID Number: Support the Exchange of EDI Claims Using a Payer List and Payer ID. This field will not have edits. When using the services of a clearinghouse, it is critical that the proper Payer ID is used so the EDI claims are sent to the right payer.

- **Purpose:** This field made available as an internal and external cross check if a Payer Identification or NAIC Code is reported on the EDI claims file. Based on WHAIC research most facilities use an EDI Claims Payer List to identify or map a Payer ID to support their electronic transactions **are routed to the right health plan**.

Secondary Source of Payment ID: The first three characters from the secondary payer as defined by Appendix 7.3.

*Situational does not mean optional.

Secondary Source of Payment Type: The fourth and fifth characters of the secondary payer code as defined by Appendix 7.3.

Accident State – The accident state field contains the two-digit state abbreviation where the accident occurred.

Hospital and Provider-based location / facility ID (PB): Splitting hospital services and outpatient charges into professional and facility components is called "provider-based billing" and patients receive two charges on the bill for services provided. One charge represents the facility or hospital charge, and one charge represents the professional or physician fee.

Hospital Services:

Hospitals that own and submit claims for ALL hospital services in off-campus (sister/parent) hospitals that are not separately licensed and share the same Medicare number as the main hospital as WHAIC does not collect the physical location of services from the claim at this time.

WHAIC established a NEW Policy Statement: Identification of ALL Hospital Services in ON and OFF-campus facilities.

Purpose: This policy has been established to ensure accuracy and consistency of reporting for all discharge data collected from off-campus hospitals and outpatient facilities that share the same Medicare number as the main hospital. Inpatient and outpatient data are available for a wide range of uses including, but not limited to, research, publications, commercial health care operations, understanding market trends/market share analysis, policy decision making, and other consumer care purposes.

Policy Statement: WHAIC requires all hospitals to report inpatient and outpatient hospital services, performed in off-campus locations from the main hospital, **with an assigned location identifier / provider-based identifier**. This policy applies to all hospitals performing billing services regardless of if the encounters are provider-based billing or affiliated location outside of the four walls of the main hospital that share the same Medicare number.

*The value of the data increases when the user understands the type of services rendered **and the location** in which those services were obtained*.

Leave Days: The total number of days a room was held for an inpatient while away from a facility. Consists of all 018X revenue codes (charges for holding a room while the patient is temporarily away from the hospital - applies to inpatient stays). WHAIC will calculate & populate based on admit / discharge, revenue code 018X and number of units.

Point of Origin: A code indicating where the patient (literally) came from before presenting to the facility for this admission or outpatient visit. For example, an auto accident patient was taken to the ER of Hospital A by ambulance, stabilized, then transferred to a Level I Trauma Center - Hospital B where he/she received additional treatment in the ED, and then is admitted as an inpatient to Hospital B. The Point of Origin on claim 1 is where the patient came from before presenting to the health care facility.

Admit Type: A code indicating the priority of this admission/visit.

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn
5 = Trauma

Discharge (Patient) Status: A code indicating patient discharge status as of the ending service date of the period covered in the record. For example, a patient discharged to home or self-care would be recorded as '01'. See for appropriate codes.

NUBC: Required on all institutional claims

Type of Bill: A code indicating the specific type of bill (inpatient, outpatient, interim claims, etc.). The first digit is an optional leading zero. The second and third digits combined are a facility code. The fourth digit defines the frequency.

FASCs may routinely use '0999' since type of bill is not a standard data element on the CMS-1500 form.

Admission Date/Time

Discharge Date: Inpatient and Outpatient ED - Record the month, day, and year of discharge, with a two-digit entry for the month and day and a four-digit entry for the year (mmddyyyy). The stay may have ended by order of physician, against medical advice, or by death. Transfers to SNF or ICF as well as to swing bed should be considered a discharge. For example, a discharge occurring on May 8, 2015, would be recorded as 05082015.

Discharge Hour: Inpatient only - Code indicating the discharge hour of the patient from inpatient care.

Statement Covers Period FROM: Hospital Outpatient: Observation, Therapies, Lab and radiology and other outpatient except ED and OP Surgery - The beginning and ending service dates of the period included on the record submitted. For services received on the same day, the "From" and "Through" dates will be the same. Enter dates as month, day, and year (mmddyyyy). For example, a patient starting physical therapy May 8, 2011, and finishing physical therapy on May 12, 2011: "From" should be recorded 05082011 and "Through" should be recorded as 05122011.

Statement Covers Period THROUGH: Hospital Outpatient: Observation, Therapies, Lab and radiology and other outpatient except ED and OP Surgery - The beginning and ending service dates of the period included on the record submitted. For services received on the same day, the "From" and "Through" dates will be the same. Enter dates as month, day, and year (mmddyyyy). For example, a patient starting physical

therapy May 8, 2011, and finishing physical therapy on May 12, 2011: "From" should be recorded 05082011 and "Through" should be recorded as 05122011.

Total Charge: Total covered and non-covered charges related to the episode of care that is being reported, excluding the professional component. The charge should be entered with two place decimals (-)nnnnnnnn.nn. This is always assumed to be positive. For example, $8204.05 would be recorded as 8204.05 or $155,327.00 would be recorded as 155327.00. The field should equal zero ('0') if there are no charges. *Note: Total charge in the Primary Record must match the total charge(s) in the Revenue Record.*

Principal Diagnosis - ICD-10 code taken from the claim

Admitting Diagnosis - ICD-10 code taken from the claim. WHAIC can accept as many as the hospital records.

Patient's Reason for Visit: The ICD-10-CM diagnosis code describes the patient's reason for seeking care at the time of outpatient registration. One code required for TOB 013x and 085x, and 078x with Revenue Codes 045x, 0516, 0526, or 0762. Up to three codes allowed for any outpatient record.

045x – Emergency Room

0516 – Clinic – Urgent Care Clinic

0526 – Freestanding Clinic - Urgent Care Visit

0762 – Observation

Principal Procedure: Required on Outpatient Surgery Records – WHAIC will assign the principal procedure based on OPS revenue codes. Every effort to choose the CPT/HCPCS procedure code most related to the principal diagnosis and performed during the episode of care will be made. It is the facility that must verify.

Inpatient Records – An ICD-10 procedure code should be entered in the primary record for inpatient records where applicable. 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 invasive or exploratory in nature it may 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. (UB-04 FL 74 for inpatient records.) Refer to the official coding guidelines for best coding practices.

Principal Procedure Date: WHAIC will populate the principal procedure date based on the month, day, year the principal procedure was performed as identified in the revenue record details. ,

Principal Procedure Modifier: Outpatient Records – A data element to be *used with CPT or HCPCS Level II codes when applicable*. CPT or HCPCS Level II modifiers may be used in this field as applicable and coded on the record and/or claim. 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 entered. When there is more than one modifier that applies to a specific code, the modifier that has the most impact on payment should be listed first.

Condition Code 1: Code '17' should be entered for all inpatient and outpatient cases where a patient is homeless at the date of admission for inpatients, or date of service for outpatients when there is an unknown ZIP code.

Condition Code 1-4: WHAIC will accept all condition codes as deemed acceptable by the uniform billing requirements outlined by the NUBC – UB-04 Manual but will record only the first 4 on the claim file.

Code '45' Ambiguous Gender Category – used to allow the gender related edits to be bypassed. Example would be for transgender, hermaphrodites, or have ambiguous genitals.

Transgender – persons relating to or identifying with opposite sex.

Hermaphrodites – persons with both male and female sex organs.

Ambiguous genitalia – external genitals do not appear to be M or F or characteristics of both

837I Claim - Hospital Detail

Value Codes and Amounts – A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization.

See the Official UB-04 Data Specification Manual for appropriate code usage.

Occurrence Codes and Dates – The code and associated date defining a significant event relating to the bill that may affect payer processing. Occurrence codes should be entered in alphanumeric sequence.

See the Official UB-04 Data Specification Manual for appropriate code usage. Codes identified as Payer Codes used for Payer Internal use Only will be edited.

Occurrence Span Codes and Dates – A code and the related dates that identify an event that relates to the payment of a claim. These codes identify occurrences that happened over a span of time.

See the Official UB-04 Data Specification Manual for appropriate code usage.

Additional Diagnoses and External Cause Codes:

Additional Diagnosis and External Cause Codes: The ICD-10-CM codes corresponding to additional conditions that co-exist in addition to the principal diagnosis listed on the Record, and which have an effect on the treatment or length of stay. Facilities should submit all additional diagnosis codes that apply to each record. WIpop will accept an unlimited number of diagnosis codes. *Do Not Enter Decimals*

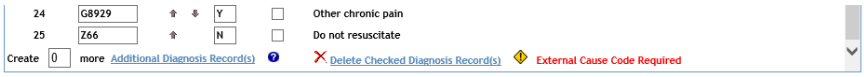
External Cause Code Range: The ICD-10-CM code used to identify the external cause of injury, poisoning, adverse effect, or cause of morbidity. As per the State Statute, facilities submitting data to WHAIC must report an external cause code as appropriate.

At least one external cause diagnosis code is required for inpatient, observation, emergency department and outpatient surgery - records with Place of Service 1-3. Place of Service 4-7 record types allow for external cause codes, but they are not required. (UB-04 FL 72 1a-1c) (CMS-1500 FL 21-(2-4). WHAIC cannot edit for the 7th character associated with the coded injury.

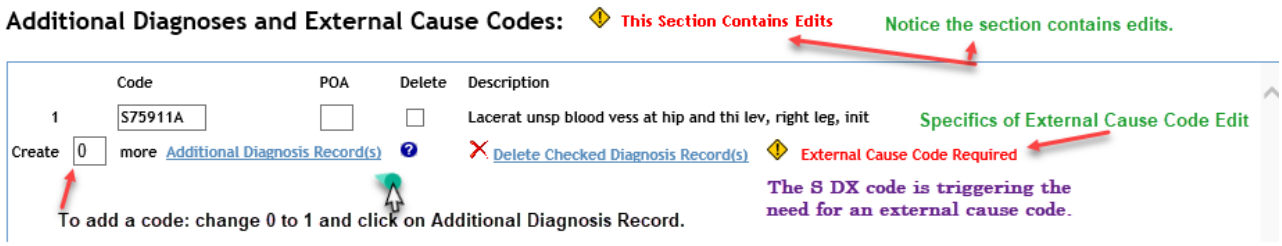
The external cause code edit 5370 applies to inpatient, outpatient surgery, emergency room, and observation with diagnosis codes in the S through T range, with some exceptions require an external cause diagnosis code in the V through Y range.

The edit will appear at the end of the section as displayed in the below.

At least one external cause code must be specified when a diagnosis exists as described in Section 5.1.6. ** External cause of injury codes are acceptable, but not required on Other Hospital Outpatient (OHO) records. This includes place of service 4-6.



REPORTING EXTERNAL CAUSE CODES: To add an additional diagnosis (external cause code) enter a number in the 'create' box and click the underline 'Additional Diagnosis Record(s)'



Present on Admission Indicator for Additional Diagnosis Codes: Inpatient only - The eighth digit of all additional diagnosis codes submitted on the record. Required to identify conditions known at the time of admission, and those that were clearly present, but not diagnosed, until after the admission took place. The five reporting options are: Y = yes, N = no, U = no information in the record, W = clinically undetermined and blank = exempt from POA reporting. Please see CMS.gov for further information.

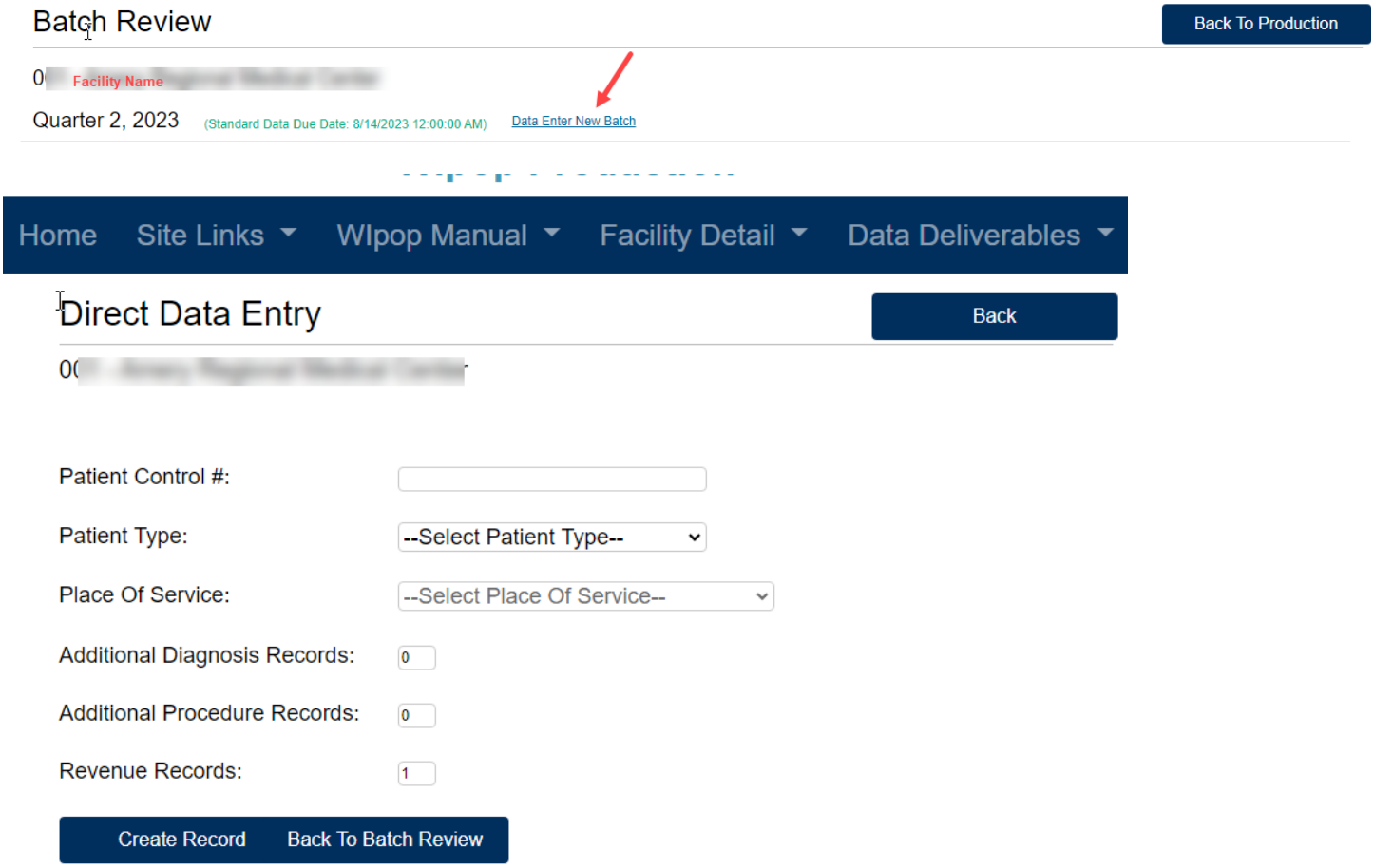
Additional Procedure Section
Additional Procedures: **Inpatient** - The ICD-10-PCS codes corresponding to procedures performed other than the principal procedure (do not duplicate principal procedure) listed on the Primary 'A' Record that were also performed during the episode of care. Facilities should submit all additional procedure codes that apply to each record. **Outpatient** - The CPT/HCPCS codes corresponding to additional procedures other than the principal procedure All significant procedures other than the Principal Procedure Code are to be reported here, unlimited. They are reported in order of significance, starting with the most significant. Codes that do not meet the definition of procedure will receive an edit:
Additional Procedure Modifier: *Outpatient* A data element used as applicable when CPT or HCPCS Level II codes are coded in the HCPCS/CPT field in the record or claim. When there is more than one modifier, the modifier that has the most impact on payment should be listed first. Only 4 modifiers will be displayed in WIpop.
Additional Procedure Date – date of the additional procedure.
Revenue Record Section
Service Date: The date that a service was provided (mmddyyyy). *Required on outpatient records only*. If used on an inpatient record the service date must be within 3 days prior to the admit date and cannot be after the discharge date. For ED (place of service 2 records) the service date must be within 3 days prior to the admit date and cannot be after the discharge date. For all other hospital outpatient records the service date must be on or between the "from and through" dates.
Revenue Code: A code which identifies a specific accommodation, ancillary service, or billing calculation. This data element is not required for freestanding ambulatory surgery centers (FASC).
HCPCS/CPT/HIPPS Rates: Inpatient: The Room and Board (Rates) should be reported with two-place decimals. For example, a charge of $455.00 would be recorded as 455.00. Under the Inpatient Rehabilitation Facility PPS, a five-digit HIPPS Rate/CMG Code (AXXYY-DXXYY) may be reported with revenue code 0024. Rates are always assumed to be positive. Outpatient: HCPCS/CPT codes are required for outpatient services unless the instructions in the NUBC Manual state otherwise.
HCPCS/CPT Level I or II Modifiers: Outpatient – applicable when CPT or HCPCS codes are used, and a modifier is recorded on the claim or record. When more than one modifier applies to a specific code, the modifier that has the most impact on payment should be listed first.
Units of Service: 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, etc. The value must be a positive number and a minimum of '1' regardless of if the charge is zero or greater than zero.
Charge: Charges (By Revenue/HCPCS/CPT Code): Total charges related to the revenue code or HCPCS/CPT code recorded. Total charges include both covered and non-covered charges. Positive charges should be entered with two-place decimal. For example, $2456.50 should be entered 2456.50. Any adjustment or credit to revenue service line should be entered with signed negative character (-) and two-place decimal. For example**,** a negative adjustment of $10.00 should be entered as –10.00**.** ***Total Charges in the revenue detail must match the total charges in the Primary Record.***

7.13 Manual Data Entry Instructions

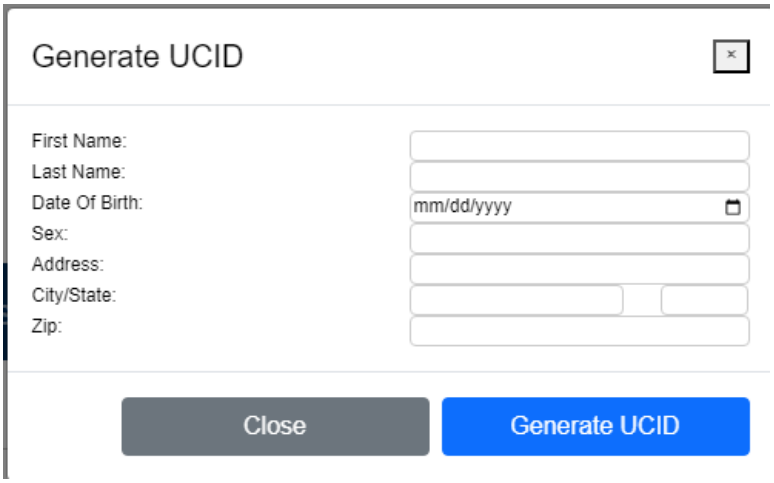
Click update in the record to begin, this highlights the required fields

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 the required fields



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.
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'.
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.
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.*
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.
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	
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, which 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.
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.
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.

7.14 Marital Status Codes

Collection of Marital Status is SITUATIONAL or Optional to provide support for facilities that collect this information. WHAIC will collect this field, but we do not have plans at this time to include it in any of our publications.

Situational/*Optional field in the 837 file, submit if collected. See Section 5.4 and 5.5 of Companion Guide*

Code	Display	Definition
A	Common Law	
B	Domestic Partner	Person declares that a domestic partner relationship exists.
C	Not Applicable	Child
D	Divorced	Marriage contract has been declared dissolved and inactive.
I	Single	Currently not in a marriage contract.
K	Unknown	Details cannot be obtained.
M	Married	A current marriage contract is active.
P	Partner	Life Partner
R	Unreported	Question not answered.
S	Separated	Separated
U	Unmarried	Single, Divorced or Widowed
W	Widowed	Spouse has died.
X	Legally Separated	Legally Separated

*Details and values in table are taken from ASC X12N - Insurance Subcommittee and AHRQ – Agency for Healthcare Research and Quality

7.15 Terms, Acronyms, and Definitions

Name	Acronym	Definition
Affirmation Statement	NA	A document that when electronically signed and submitted by an authorized representative of the facility affirms, to the best of the signer's knowledge, all data submitted are complete and accurate. The primary contact must access the Affirmations Statement from the Data Deliverables / Affirmations tab through the Portal.
Caveat		If data errors are discovered after the validation period closes or WHAIC releases the data the facility may notify WHAIC of data errors to be documented in future datasets.
Clinical Classification Software	CCS	The clinical classification software for ICD-10 is one of a
Critical Access Hospital	CAH	Critical access hospital" means a hospital that is designated by the department as meeting the requirements of 42 USC 1395i-4 (c) (2) (B) and is federally certified as meeting the requirements of 42 USC 1395i-4 (e).
Data Profile		A summary of all submitted data and a summary of the number of records received by WHAIC from a facility.
Data Type		Inpatient, Outpatient, Outpatient Surgery, Observation, Emergency Room.
Direct Data Entry	DDE	Direct data entry is performed by a handful of small ASCs that do not have access to a vendor to create a claim file to submit data. User should hit enter before entering data to populate most of the required fields.
Enhanced Ambulatory Patient Groupings	EAPG	Enhanced Ambulatory Patient Groups (EAPGs) is a visit- based patient classification system used to organize and pay services with similar resource consumption across multiple settings.
Emergency Department (ED)	ED/ER	The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. Emergency department personnel may also respond to certain situations within the hospital such cardiac arrests. The emergency department is also called the emergency room or ER.
Hospital		**a)** "Hospital" means any building, structure, institution, or place that does all of the following: **1.** Offers inpatient, overnight care on a 24-hour-a-day basis, or on an as-needed basis in the case of a critical access hospital. **2.** Devotes itself primarily to the maintenance and operation of facilities for the diagnosis and treatment of, and medical or surgical care for, 3 or more nonrelated individuals, designated "patients" in this chapter, suffering from illness, disease, injury, or disability, whether physical or mental, or who are pregnant. **3.** Regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery, obstetrical care, or other definitive medical treatment, except as otherwise provided for critical access hospitals in this chapter. https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/124
Inpatient	INP	A patient is admitted to a room for an overnight stay or for numerous days with continuous general nursing services in an area of an acute care facility. Examples of treatment areas for admission: ICU, Labor and Delivery, Cardiology Units or General Medicine Units.
Medicare Advantage		The definition by Medicare.Gov is that it is a plan that beneficiaries can collect Medicare benefits through private insurance companies approved by and under contract with Medicare
Non-OHO		A term used by WHAIC to represent data types for patients in the hospital setting: Inpatient, Emergency Room, Outpatient Surgery and Observation encounters.
Observation	*OBS*	*Observation status* is an administrative classification of patients seen and/or treated in a hospital setting who have unstable or uncertain conditions potentially serious enough to warrant close observation, but usually not so serious to warrant admission to the hospital. These patients may be placed in beds usually for less than 24 hours without formal admission to the hospital. These hospital patients are neither inpatient nor outpatient. Patients are placed in a hospital bed (often in an inpatient unit) after displaying signs or symptoms that require additional medical work up or evaluation in order to provide a more definitive diagnosis—but do not need the level of services provided in an inpatient setting. Observation stays are usually limited to 24 hours then the physician must determine whether patients' condition warrants an inpatient admission or discharge.
Ordering Physician		A physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service. The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name.

Name	Acronym	Definition
		• Effective for claims with dates of service on or after October 1, 2012, all claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require that the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.
Other Hospital Outpatient Data (OHO)	OHO	Also known as OHO. Records that do not fall in the category of inpatient, outpatient surgery, observation, or ER. These records have associated revenue codes and distinct place of services based on the location or service.
Outpatient	OP	A patient that receives a diagnosis and/or treatment at a hospital but does not stay overnight. Examples of treatment in this environment: observation care, emergency department, clinic, radiology, or laboratory service.
Outpatient Surgery	OPS	This term is also referred to as ambulatory surgery, same-day surgery or day surgery in which patients have a surgical procedure that does not require an overnight hospital stay. Outpatient surgery can be a distinct unit within a hospital or a freestanding ambulatory surgery facility.
Patient		The person is receiving health care services. The term patient in this guide is intended to convey the case where the Patient loop (Loop ID-2000C) is used. In Loop ID-2000C, the patient is not the same person as the subscriber, and the patient is a person (for example, spouse, children, others) who is covered by the subscriber's insurance plan and does not have a unique member identification number. However, the patient receiving services can be the same person as the subscriber. In that case all information about that person is carried in the Subscriber loop (Loop ID-2000B).
Place of Service	POS	The location of where a service is rendered to a patient. Patients can be inpatient or outpatient and based on revenue code and the hierarchy in the WIpop manual, WHAIC will assign the location.
Primary Record		Demographic and patient claim details of services rendered and by whom.
Rendering Provider		If the practitioner **rendering** the service is part of a billing group (even two people), report the individual practitioner's National **Provider** Identifier (NPI) in the **Rendering Physician #** area (2310B loop, segments NM108 [XX] and NM109 [NPI], of the 837P electronic claim or Item 24J of the CMS-1500 paper claim form).
Reference Lab		Any lab performing clinical laboratory diagnostic tests (or the interpretation /report of such tests, or both) without a face-to-face encounter between the individual and the lab billing for the test and/or interpretation/report.
Referring physician		A **referring physician** is a **physician** who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering physicians is defined as a **physician** or when appropriate a non-**physician** practitioner who orders services for the patient.
Revenue Record		This is unique to the WIpop system. Revenue Center codes, HCPCS/CPT/HIPPS Rates, number of units and total charges.
Social Determinants Of Health	SDOH	Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. https://health.gov/healthypeople/objectives-and-data/social-determinants-health
Service Provider / Billing Provider NPI		In many instances the Service Provider is an organization; therefore, the Service / Billing Provider NPI reported would belong to an organization health care provider. The Service Provider may be an individual only when the services were performed by, and will be paid to, an independent, non-incorporated individual. When an organization health care provider has determined that it has subparts requiring enumeration, that organization health care provider will report the NPI of the subpart as the Service Provider. The subpart reported as the Service Provider. MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner.
Summary Profile		A summary of the number of records submitted to WHAIC, broken down by quarter, year to quarter and month. Also includes tables, graphs and a 12-month overview of total records.
Student		An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or resident.
Validation		The action taken by the facility to check or prove the validity or accuracy of the data submitted.
Value Code		A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. It has two pieces - a code and an amount. Examples include Units of Blood furnished; Patient Liability Amount; Professional Component Charges which are combined billed; etc.
AHA		American Hospital Association
AHIMA		American Health Information Management Association
AMA		American Medical Association

Name	Acronym	Definition
ASC		Ambulatory Surgery Center
CAH		Critical Access Hospital
CDC		Center for Disease Control
CM		Clinical Modification (i.e., diagnosis codes)
CMS		Center for Medicaid and Medicare Services
CPT		Current Procedural Terminology
CRM		Contact Relationship Management
DHS		Wisconsin Department of Health Services
EAPG		Enhanced Ambulatory Payment Group
EDAS		Electronic Data Affirmation Statement
FASC		Free Standing Ambulatory Surgery Center
FAQ		Frequently asked questions
FL		Field Length
FY		Fiscal year
HCPCS		Health Care Procedural Coding Set
HIPAA		Health Insurance Portability and Accountability Act
IC		Information Center
ICD-10		International Classification of Disease tenth revision
INP		Inpatient
IPPS		Inpatient Prospective Payment System
IT		Information Technology
NCCI		National Correct Coding Initiative
NCHS		National Center for Health Statistics
NPI		National Provider Identifier
NUBC		National Uniform Billing Committee (UB-04)
OBS		Observation Records
OHO		Other Hospital Outpatient data
OIG		Office of Inspector General
OP		Outpatient
OPPS		Outpatient Prospective Payment System
OPS		Outpatient Surgery
PBL		Provider Based Location
PCS		Procedural Coding System
PHI		Protected Health Information
PII		Patient identifiable information
POA		Present on Admission
PoO		Point of Origin
SPR		Summary Profile Report
TOB		Type of Bill
UCID		Unique Case Identifier (64 Character – WHAIC Specific)
WHA		Wisconsin Hospital Association
WHAIC		Wisconsin Hospital Association Information Center
WIpop		Wisconsin inpatient and outpatient (data submission system)

7.16 Frequently Asked Questions (FAQ)

How to search a PDF? http://www.wikihow.com/Search-for-a-Word-or-Phrase-in-a-PDF-Document Use your Mouse and do a RIGHT Click to bring up the search box.

By default, if you open Adobe Reader and press CTRL + F, you will get the normal search box. It is located at the top right. To use the advanced PDF search option, you can choose Advanced Search from the Edit drop down menu or press SHIFT + CTRL + F. Enter the phrase you are searching for in the search box.

Topic	Question	Answer	Content added / last updated
A - F			
Additional Procedure	How will WHAIC add additional procedures to my data?	Outpatient surgery Procedures are based on the revenue codes 036X, 0481, 049X and/or 750. The principal procedure will be assigned first and then any additional procedures located within the revenue line-item detail coded in addition to one of the revenue codes described above will be assigned to the additional procedure section along with any modifier(s) and date of service in the revenue line-item detail. Errors may occur if we inadvertently pull out an "add-on" code and populate it in the principal. If this occurs, the data submitter/editor may have to manually swap out the codes	12/1/17
Added Facility	I was assigned a new facility in the system to work edits. How do I get access?	*Users that need to add newly acquired sites to perform edits or submit data to their account once registered and approved must contact WHAIC to add or update facility listing and access rights.*	01/2020
Access	I no longer have access to the WIpop site to submit or correct edits, what happened.	For security purposes, WIpop Users automatically deactivate after 8 months of inactivity in the system and Primary and Secondary users automatically deactivate after 15 months. To reactivate an account, email us at whainfocenter@wha.org. Once account is reactivated, user must log in to the portal before COB of Friday of the week in which it was reactivated.	01/2020
Address	Why was my file rejected for missing a few addresses?	**File rejected if:** Our system is set-up to reject files if Greater than 10% of records missing address that allows us to create census block group detail. File will also reject if the race and ethnicity is not collected, or file is submitted with greater than 25% missing or listed as unknown / unavailable.	07/2019
Alerts	What is an Alert, and do I have to correct them?	Alerts are not Edits or Errors. Click here for more information. Alerts are intended to be an opportunity to review the data more closely and timely. Our intent is to allow ample time to make necessary changes before the end of the year. * The alert bell may draw your attention to specific areas of race, ethnicity, payer and inpatient and observation stays. Examples might include patients over 65 reported as non-Medicare, other/unknown payer, race declined/unavailable, OBS over 5 days, IP under 2 days, unknown payer, etc. WIpop Batch files will contain an Alert Records section for each Patient Type on the far right of the screen. **You are not required to work all alerts.** Click here for more information.	03/2020
Assign Principal Procedure	How will WHAIC assign the principal procedure to my outpatient records?	Outpatient surgery Procedures are based on the revenue codes 036X, 0481, 049X and/or 750. Assignment of principal procedure code to OUTPATIENT Surgery records is based on the revenue line item detail and the corresponding CPT code.	12/1/17
Birth Date	How do I handle an unknown birth date?	If the patient's age is unknown, use January 1 (0101) as the birth date and the four-digit year based on the age or the best information available.	11/30/17

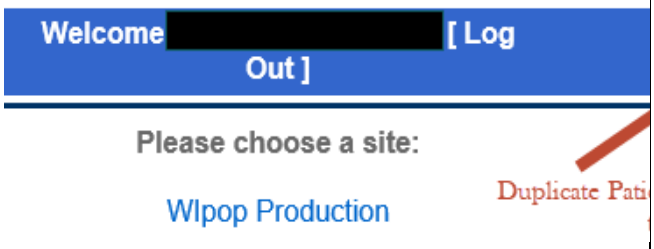
Census Block Group	We had a problem populating the Census Block Group – what would cause that?	The Census Block group is based on the US Census, so generally it only works on residential addresses. It will not work with PO Boxes or industrial districts.	12/1/17
Charity care	Should we report charity care?	Yes, you are required to report and include all services rendered to patients regardless of payment method.	12/1/17
Charity Care	*How should we report Charity Care?*	If you submit data electronically, use the 837I, 837R or 837P to create a record (fake claim) and submit the patient details along with the rest of the data. Or, add patient records via direct data entry.	12/1/17
Data Submission	When trying to upload files, I received a rejection of file error that the files contain too many claims - over the 5000 limits. Is there a way for me to split them so they will upload, or will I need to go back and ask them to create a smaller file? Will this also be an issue in Production?	Yes, split the file or submit based on INP vs. OP data. An 837 file can contain any number of transaction envelopes, but each transaction is limited to 5,000 claims. This is noted in section 3.4 of our spec (http://whainfocenter.com/uploads/PDFs/WIpop837_Manual/Section3.pdf) The software that creates your 837 should be able to handle this rule, as it is a common restriction, not unique to us. The rule applies to production files too.	02/18
Data Submission	My files seem to get hung up and then I resubmit them because I didn't receive a successful batch upload email. This results in a rejection of the file.	The issue is the same file was uploaded while the first one was still processing. When a file is processing, WHAIC can only process 500 records at a time so our system doesn't lock up since we have over 200 facilities that could submit at any given time. Batch processing isn't instant and can take upwards of 20-30 minutes to process depending on file size. So, when the user uploads a second file, the first file had 1500 records processed and in our system (hence the 1500 duplicate records). We are working on the timing and will send a batch response email out that explains "A file with this name is currently being processed. Please wait until the first file is finished before attempting to upload the same file again" Long story short, the way to prevent this for now is just to wait for the file to process before trying to upload it again.	02/2024
Datatype	What place of service / data type does revenue code 0361 – minor surgery fall into?	For hospitals that perform minor outpatient surgery procedures using rev code 0361 such as a suture in the ED or during any outpatient visit, the record will be counted and included an outpatient visit according to the place of service hierarchy. For example, 0361 in the ER/ED data would remain in the ED records. **To clarify:** After considerable review and consultation with several hospitals and professional coders, WHAIC made the decision to exclude revenue code 0361 (minor surgery) from the outpatient surgery data type. Our research showed this revenue code to be used most frequently with services related to infusions, injections, sutures, etc. that did not require a surgeon.	12/2018
Date of Service	*What is the logic or definition of how discharge data should be pulled on, i.e., what date is used?*	To be completely literal, we assign the quarter as such: For IP and ED, use discharge date For OPS, use the principal procedure date For all other outpatient services (OBS, Therapy, Lab/Rad and other OP hospital services use the statement through date.	03/18
Discharge Date and Time	The Discharge date is required on Inpatient and Emergency claims. The Discharge hour is required only on inpatient claims. What should we use for time on ER claims?	We would like the discharge time even on ER claims. But if the time just isn't available, you can report it as 0000 (i.e., 201709060000) using DTP02 = DT, or you can use DTP02 = D8 and only report the date.	12/1/17

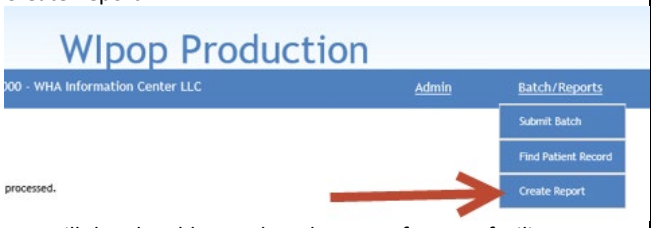
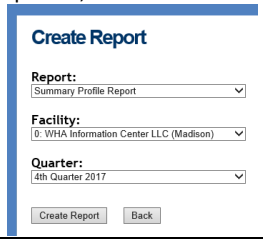
Discharge Status	Can we use discharge status 30?	Yes, in the 837 claims files discharge status 30 is acceptable on interim type of bills. The intent of the 837 claim file to gain access to more information and make it less difficult for users.	01/18
Discharge Status	Why do we get an edit on Discharge status codes 40, 41 or 42 – expired Hospice?	We do not accept those values because they are indicative of a hospice patient expiring during a hospital stay. Having those codes skews quality data in the publications.	12/17
Discharge Status Codes	I saw that it is required for INP/ER claims? Will the file reject if the Patient Status is present on OP claims as well?	CMS requires patient discharge status codes for hospital inpatient claims, skilled nursing claims, outpatient hospital services, and all hospice and home health claims. The WI Statute has patient discharge status required on INP and ED claims. WHAIC encourages hospitals to provide discharge data according to the CMS guidelines and include it on all OP records. The two-digit discharge status codes identify where the patient is going upon transfer from the acute inpatient setting. The most common discharge status codes are: Inpatient hospital (02), Nursing home that accepts Medicare and/or Medicaid (03, 61 or 64), Home Health Agency (06), Rehabilitation facility (62), Long-term care hospital (63)	12/17
Duplicates in the file	How do I correct duplicate records in my file?	**Resubmit the batch with the phrase "exclude_duplicates" somewhere within the file name.** (minus the quotation marks) Example file name: Q218 IN OP exclude_duplicates.txt	12/2019
Edits	What is Code-First Rules?	ICD-10 has a coding convention that requires the underlying or causal condition be sequenced first followed by the manifested condition, which is referred to as the "code first" guideline. For example, if a patient is on the antidepressant drug Tryptanol (amitriptyline), and this drug is what caused the patient's weight gain, it is considered an adverse effect and is the underlying or causal condition of the patient's obesity. Therefore, diagnosis code T43.015 (adverse effect of tricyclic antidepressants) must be coded first.	
Edits	How will WHAIC account for the wide variety of services that occur in the emergency department (ED), that are allowed based on CMS and the uniform billing guidelines?	For hospitals that provide recurring specialty type services such as infusions or dialysis in the ED and the patient is also treated for a minor procedure or service during the course treatment or recurring visits in the ED: • WHAIC will bypass edits for recurring outpatient hospital records with multiple revenue line items for outpatient lab/radiology, therapy or other outpatient hospital services and the record also includes an ED revenue code for a visit that occurred during the course of treatment. In order for the bypass edit to work the record must contain multiple service dates, a 0450 revenue code, a statement 'From and Through' date of at minimum 7, 14 or 30 days that match the service dates in the revenue line item detail. **To clarify:** 1. If the encounter/record has less than seven (7) days of service line items, the record is ED. 2. If the encounter/record has more than seven (7) days, the place of service will be determined by the OHO (OP HOSPITAL) revenue codes.	12/2017
Edits	Why are edits occurring for referring provider and billing provider?	You cannot use a facility NPI as the referring provider. The referring provider either needs to be the NPI of a person or left blank. *Referring NPI is not a required field.	4/2018
Edits	What are the Medicare Code Edits	The WHAIC edits are taken from the CMS tools and resources: Reference: Definitions of Medicare Code Edits_v_39_revised_7_16_21.pdf	01/2022

File	What is an 837 file	EDI HEALTH CARE CLAIM TRANSACTION SET (837) Used to submit health care claim billing information, encounter information, or both, except for retail pharmacy claims (see EDI Retail Pharmacy Claim Transaction). It can be sent from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. Source: HIPAA EDI Document Standard | EDI Basics	
File	Our hospital's bill approx. 600 837Ps monthly, these are not FASC. Do you only accept 837P format for FASC?	Yes, WHAIC will only accept the 837P from a FASC, unless they choose to have an 837I or R created by an affiliated hospital. The 837P would represent the professional piece of the billing from a hospital, WHAIC only collects the facility portion and would need to have revenue codes included with the hospital 837 file, which the 837P does not support.	
File name Convention	For production, what are the file name parameters? Does the Facility ID# need to be part of the file name? Is there are valid file extension (.DAT,.TXT,etc)	There are no file name convention requirements or extension requirements to upload data to WIpop/WHAIC.	07/2019
How data collected	How are data collected?	Data is collected from acute care facilities, including Psych, Rehab and State Mental Health facilities. WHAIC does not collect discharge data from federally regulated facilities such as the Veterans Hospitals. Data must be submitted to WHAIC using an EDI claims file format and our secured web / portal. Only the items necessary to create and store the nonidentifiable data are stored in the WHAIC database.	
G-R			
Gender/Sex	*What should I do with an **unknown gender or Other**?*	Gender/Sex may be U or O if the patient has an ambiguous gender or is transgender. Condition Code 45 must be used in any of the 4 Condition Code options in order to bypass the edits.	11/30/17
Language	The specs state that you are looking for the "Primary method of communication, either spoken or written." In Epic there are two different language fields collected. The first is "Caregivers Language" further defined as "Preferred language of the patient" and then Patient Language further defined as "Patients spoken language." Can you confirm which field you are looking for us to include?	WHAIC preference is to document the natural language spoken by the patient. "Patients spoken language" See Appendix 7.2.1 for the Mapping of Language codes	7/2019
NPI	*What about NPI numbers of residents? How about students?*	**Yes**, NPIs will be accepted for **residents.** NPIs will be accepted of the physician or qualified practitioner who was primarily and largely responsible for the patient's medical care and treatment. **Medical students do not have a license number or NPI number.**	11/30/17
NPI number	*For outpatient data, how is WHAIC defining "attending NPI?"*	According to the state statute, the ER/ED data is the only type of outpatient encounter/record where the attending NPI field must be populated. Edits will not occur if the attending is populated on other records.	11/30/17
Obtaining access to WIpop	How do I obtain access to the WIpop system?	To get access to WIpop all users must register first:	10/30/17

		http://www.whainfocenter.com/uploads/PDFs/WIpop837_Manual/Appendix_710.pdf Approval may take 24-48 business hours if all relevant information is present. WHAIC staff will not automatically approve anyone that has a different email address than that of the hospital staff. Primary contacts are copied on all newly registered individuals requesting access to a facility. It is the primary contacts to notify WHAIC if the user should not be approved.	Updated: 8/18
Outpatient Surgery	*Are FASCs required to report type of admission?*	No, as per the 837P technical spec, type of admission is not a required data element for FASCs.	11/28/17
Payer	*Self-Pay*	Reporting Self-pay is required. See the 837 technical file specification for details. The field appears as OTH – 61 in WIpop.	
Payer	*What if my Payer is not listed on your Payer table?*	Contact WHAIC with the payer's name and we will investigate if it's a commercial or private payer plan. If we plan to add a commercial payer, it will be added at the first of the year. Before contacting WHAIC, please do a quick google search to verify if the payer is actually a third-party benefit administrator	12/1/17
Payer	*Payer ID* We have a small number of claims that are sent paper and not electronically. We do not print these claims in-house but instead place a payor ID of PSCXX in our electronic claim form. When our clearinghouse sees the PSCXX they know not to electronically send the claim and instead print the claim for us and mail this to the payor.	Now that you are asking for the Payor ID, you will get the PSCXX, unless I do something to exclude them. Are you fine seeing the PSCXX or do you want these to instead be blank, to signify they were not sent electronically?	2/2024
Place of Service Edits	*I want to change the place of service, but it will not change.*	If after correcting edits for all the other data types and you mark each of them complete as you fix edits, you cannot move a record into that closed/completed data type. You must open the entire batch and leave them open until all edits are completed.	12/2018
Payer Data	*We used to be able to use **OTH for commercial plans** / payers. How come I am getting edits now?*	Effective with 1/1/18 all commercial plans are either reassigned a specific "A" code to identify the actual payer, or the use of A99 may be used for unknown commercial payer types. WHAIC will update the Commercial payer table annually in January if new payers are on the OCI website. Users will be notified during the annual training.	12/1/17
Provider-Based Locations	I just want to confirm that the PBL segment should go in Loop 2300 NTE02. Is there anything else that is needed for the PBL segment?	If you are using the Epic software, you are correct, just set NTE01 = UPI and NTE02 to the PBL ID number. It is our understanding that the Epic 837R software was not built with the PBL or "service facility" look in mind, so accommodations as above was designed.	
Provider-Based Locations	When do we have to report our Provider-based location data?	PBLs are outpatient departments of the hospital and as such we are required by statute to collect the facility component of all services and claims billed as an outpatient hospital claim. If a hospital has a shared Medicare number with facilities at different locations and claims are submitted to Medicare using the hospitals billing system then it's a provider-based location. Splitting a hospital outpatient charge into professional and facility components is called "provider-based billing." Records from a hospital outpatient department (AKA Provider Based Location (PBL)) with the same Medicare provider number should be submitted according to the 837I or R Technical specifications outlined in Loop 2310E, Element NM101, NM108 and NM109.	12/1/17

		Patients receive two charges on the bill for services provided; one charge represents the facility or hospital charge and the other charge represents the professional or physician fee. WHAIC only wants the facility component of all services provided at the PBL regardless of whether the payer accepts provider-based billing or not. Hospitals that acquire or intend to submit claims using provider-based billing or in the event that a PBL closes, or the facility no longer bills as PB, contact WHAIC to terminate the PBL ID. PBL FAQ LINK	
Race/Ethnicity	With the new revisions to the race codes, can the facility send main or subcategory or both?	Yes, the file may contain both main and subcategory.	12/2024
Race/Ethnicity	Can you provide an example of what the new codes would look like in the file?	DMG*D8*19960913*M*S*RET:R5^RET:E2^RET:R502^RET:R503****ZZ*ENG When translated in the file it looks like this: DMG*D8*19960913*M*S*5:2:502:503****ZZ*ENG Race 1 = 5 Ethnicity = 2 Race 2 = 502 Race 3 = 503	12/2024
Race/Ethnicity	If a facility has different categories in the patient registry such as Chinese American – but it's not on the WHAIC list as a viable category, should the facility roll that up to the proper Asian category for WHAIC?	Yes, the facility may choose to map to the main category code 2 or subcategory 201.	12/2024
Race/Ethnicity	For reporting of ethnicity in the hospitals 837 claim file – In 2026, can hospitals still submit the ethnicity segment, but WHAIC ignores that in the file/parser.	Once WHAIC transitions to the new collection requirement, users do not have to update their files to remove the ethnicity. Facilities may still submit how they do now, meaning the Ethnicity field will be ignored effective 1/1/2026. We feel this is likely to be the easiest and most cost-effective way for facilities to do this.	12/2024
Race/Ethnicity	Does WHAIC have information on how to collect race and ethnicity?	WHAIC follows the minimum standards defined by the OMB. Facilities may collect as many races as it so chooses. All races collected must map to the ones defined in Appendix 7.2. We have posted additional information in terms of how to answer questions from patients. click on the link: http://www.whainfocenter.com/uploads/PDFs/Updates/Race_and_Ethnicity.pdf	11/30/17
Race/Ethnicity	Which race response option is appropriate when a patient is Hispanic or Latino?	According to the OMB, the most common response options for race in this situation is 'white.' Patients should always be self-reporting their race and ethnicity.	11/30/17
Race/Ethnicity	Who should select the race and ethnicity response options for newborns?	The mother should select the response options for the newborn.	11/30/17
Race/Ethnicity	*Which response option* should be selected if the patient is multiracial?	Multiracial is no longer be an option (effective 1/1/14). WHAIC collects up to 2 race choices. The OMB states "respondents who wish to identify their multi-racial heritage may choose more	11/30/17

		than one race; there is no "multi-racial" category." Since we follow the same language as the OMB, sites may collect and report more than one race for patients that choose to pick more than one race. See the technical specification to report in the correct field.	
Race/Ethnicity	*Why was my file rejected?*	**File rejected if:** Greater than 10% of records missing address for census block group detail Greater than 25% of records with a race or ethnicity of unavailable / denied	
Record Submission	Sometimes we do not have accurate and complete records available to meet the data submission deadlines.	Facilities must adhere to the standard deadlines as outlined by the statute. We would want the data as accurate and complete as possible, so with that, submit as much as is available. This allows WHAIC the opportunity to produce the data sets in a timely manner. The submission deadline for first quarter IP, ED, OBS, OPS and OHO records is May 15 with edits due May 25. An extension request may be submitted through WIpop if necessary. Additional time is available to upload more data if necessary during the validation process.	10/30/17
Record Use	Is our data ever sold? (If so, to whom)?	Yes. Data is publicly available to purchase, provided the purchaser follows the data use agreement. The majority of sales are to the hospitals and surgery centers.	10/30/17
Record Submission	*Why didn't I get* confirmation of my record submission?	If the batch fails, a transaction email will be sent with the batch number and error report. On the bottom of this email, a comment: The file submitter will receive this message, with applicable patient control numbers added, in his/her WHAIC portal messages at https://portal.whainfocenter.com The portal message will have pcontrols for invalid records. 	12/1/17
Record Submission	Should we submit charges from our clinic?	WHAIC **does not** collect professional charges. We do however collect Provider-Based Clinic data, also referred to as other outpatient hospital data such as diagnostic, laboratory, radiologic and other repetitive services as well as any other facility-based charges if the same Medicare provider number is shared with the submitting hospital and the same financial system is used. WHAIC will assign the place of service of 4,5 or 6 depending on the revenue codes in the OHO hierarchy table.	12/1/17
Record Submission	Adjusted and Interim Bills/Records	We can accept records with a Type of bill that ends in 1 – Admit through Discharge, 2 – Interim First Claim, 3 – Interim Continuing Claim and 4 – last claim. Note however that we do not accept duplicate records. WHAIC does not operate in the same manner as a claims processing or clearing house site in that we cannot detect duplicate records and do a search and replace for records on the same patient nor can we do any other modifications to the records. Each record that comes in is treated independent of the other.	12/1/17

Record Submission	Should facilities submit records for services provided at no charge? Drug screens, or free clinic service like blood pressure clinic?	Services provided at no charge **should not be** submitted to WHA Information Center. An example of this would be a reference lab, or 'free blood pressure clinic.' Services that are provided and charged based on ability to pay should be submitted. For example, if the patient is not billed because of inability to pay, we would expect to see the record with the charge, and a TOB that ends in zero – Non-payment / Zero Claim like 0850.	12/1/17
Record Submission	Should we submit records for rebills or late charges?	No, we allow non-payment/zero records, admit through discharge records, and records based on interim claims. No rebills, voids or corrected claims are allowed. We have no means to search and replace records that have already been submitted. And, the data users rely on the data to be accurate at the time it's released, therefore we do not release the data sets once it's been produced.	12/1/17
Record Submission	Should we continue to exclude swing bed/nursing home and hospice records from our data submission?	Yes, you must exclude those record types because they do not meet the definition of "hospital." The statute did not change regarding the definition of inpatient services; therefore, we cannot collect swing bed services in a nursing home or straight hospice records. However, this has been a tricky question – especially for CAH. Based on my research CAH use the 0181 to report patients that are in recovery from a hip or total knee and moved to a different location of the same hospital where they are still cared for on a daily basis and in the same hospital. In other words, it is okay to submit them provided the patient is in your facility as part of a transfer. We cannot accept patients in a SNF/nursing home patients, hospice, or other type of terminally ill / elderly in a Nursing home / Hospice environment.	12/1/17
Record Use	What does WHA do with our data?	The data collected from all WI hospital and surgery centers is available for public use data sets (record-level), we provide discharge data to the Consumer PricePoint website (facility charges) we support four annually released publications using the data from WIpop (Health Care Data Report and Quality Indicators Report). And, we partnered with WHA's Quality Department to assist with reporting various quality initiatives.	10/30/17
Reports	*How do I run a report?*	Log into WIpop, choose which facility you wish to run a report for and click Batch Review. On top right side in WIpop Production, click Batch/Reports. In that dropdown, you will see Create Report.  You will then be able to select the type of report, facility, quarter, and batch. Then click create report.  Descriptions of the reports will be listed on the right side on the	11/30/17

Required vs Situational	If the data element is marked as Situational, do I have to send it?	**Situational does not mean optional.** If an inpatient claim has an inpatient procedure on the claim, the inpatient procedure is required to be reported.	12/1/17
Roles	Where can I find more information about the roles in WIpop?	A description of the roles and responsibilities for WIpop are listed on our website and in WIpop above your listed of users. In short, the primary contact is responsible for over-seeing the quarterly data submission process to WIpop. A secondary contact gets most, but not all, of the data reports and serves as a back-up contact to the Primary. The WIpop user role is typically a vendor or individual that submits data or works edits.	10/30/17
S-Z			
Self-pay	Why do we have to report self-pay records?	WHAIC is contracted by the State of Wisconsin to collect all discharge data from hospitals and FASC. We want a complete representation of all patient data regardless of payer that provides greater value to the data users.	12/1/17
Self-pay	We are looking at the Pay Type/Pay ID errors and see that some of our accounts are self-pay. Are we supposed to be mapping the self-pay patient to a specific Plan ID/Type?	The code for self-pay is OTH-61. See Appendix 7.2 For self-pay, the Insurance Cert #: field may be left blank	
Self-pay	How should we report self-pay?	If you submit data electronically, use the 837I, 837R or 837P to create a record (fake claim) and submit the patient details along. You can specify "NULL" or just leave it blank.	12/1/17
Service Dates	Why am I getting an edit on the service dates if the revenue line items match what is in the statement from / to?	Typically, service date edits occur in the OPS data when the DOS falls outside of what WHAIC has deemed acceptable either before or after the principal procedure DOS. Service date more than 30 days before principal procedure date OR Service date more than 10 days after principal procedure date, AND no LT or RT modifier OR Service date more than 90 days after principal procedure date, AND has LT or RT modifier	08/18
Short Stay Edits	*Is there a reason we get edits on inpatient records that do not have inpatient revenue codes? We consider these short stays. We are billing part b for this claim – and the rev codes required in the INP billing edit are not something we can bill part b for an inpatient claim.*	WHAIC assigns the place of service for 837I and 837R files using the revenue codes on the claim. Inpatient revenue codes allowed are 0100-0189 or 0200 -0219. Part B is outpatient in a hospital like OBS care. Since WHAIC only uses the revenue codes and **not the TOB** to assign the POS, we cannot determine what should be INP or OP based on this information. The facility must either correct the records manually by updating the POS, Patient Type field, etc. Or, map those Part B records to an OBS rev code such as 0762 to allow WHAIC to properly assign them POS to OP.	08/2018 12/1/17
Source of Payment	*What pay ID and payer type number should I use for the Medicare Advantage?*	Medicare Advantage Plans are usually managed by a commercial or private insurance plan like an HMO. Since it is a contracted Medicare benefit, please code the record as MPC-09	~~12/1/17~~ 12/1/2022
Source of Payment	*Is all Medicaid the same as BadgerCare?*	No, there is a distinct difference. Although they share the same ID Card and some benefits are the same, Medicaid has stricter poverty levels and an asset test to determine one's qualifications. Source: WISCONSIN COALITION FOR ADVOCACY Source: Secs. 49.45-.47, Wis. Stats. Sec. 49.665, Wis. Stats. According to DHS: Medicaid = Elderly, Blind or Disabled	12/1/17

		BadgerCare = Families (parents, pregnant women, and children) Childless adults.	
Terminology	*I am confused on the terminology; can you explain what an EDI file is?*	This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. For purposes of the 837R reporting standard, providers of health care services may include entities such as physicians, hospitals, and other medical facilities, etc. required to provide claims information to meet regulatory requirements. **Sources** Accredited Standards Committee X12. ASC X12 Standard [Table Data] Data Interchange Standards Association, Inc., Falls Church, VA. http://www.x12.org/	12/1/17
Training	How do I receive training?	WHAIC offers annual face-to-face training in the fall, usually September. We also offer periodic WIpop 101 training that is a condensed version, but not a substitute for the in-person training. A bi-monthly newsletter is created when there is pertinent or necessary information to share with individuals involved in the data submission process.	10/30/17
Type of Bill	*Currently, our claims display the type of bill in CLM05-1 through 3. Will the WHA requirements expect the A to be absent, so that it just reads "131", or is it fine as shown:* *131 TOB Definition* *13 = means Hospital Outpatient* 1 = an admit through discharge claim	Certain bill types are designated for inpatient use while others are designated for outpatient reporting. The A is valid and need not be removed. In fact nothing needs to be removed from the 837 except patient names and Social Security numbers, as we cannot accept those. Our document is not a complete 837 spec, rather it is intended to point out the specific segments and elements that will be used for the WIpop data extraction. Everything else in the file will be ignored. **For the 837I and R** the Facility Code Qualifier is an A – Uniform Billing Claim Form Bill Type. **For the 837P** the Facility Code Qualifier is a B – Place of Service Codes for Professional or Dental services. CLM05 – 1 Facility Type Code Used by WHAIC CLM05 – 2 Facility Code Qualifier WHAIC Ignores Value CLM05 – 3 Claim Frequency Code Used by WHAIC	12/1/17
Type of Bill	The Type of Bill spec seems to reference a leading zero. This is not 5010 compliant.	The leading zero is not to be included on electronic transactions, but it is acceptable on the paper UB-04. There are some hospitals and ASCs that do direct data entry and for that reason it is fine to include it.	12/1/17
Type of Bill	Please clarify for ASCs – how does TOB work?	To clarify type of bill, on an 837P, the type of bill is set to 083 plus the value in CLM0503. In most cases that will be 1, so bill type will be 0831. ASCs can still use 0999 as a valid code in WIpop if doing direct data entry, but it would not be assigned from an 837 file.	
Type of Bill	In the 837 claim file - if we submit the last claim submitted in our datal, (which would be the most complete, correct claim) & the file comes to you with a TOB that ends in '7' like a 137 TOB, will the file be rejected, or will it be accepted with an edit?	If the patient control number is not a duplicate, the result would simply be an edit on the TOB field. We would not reject a file solely because of an invalid type of bill. Keep in mind we expect verification that the record would not be a duplicate of another record previously submitted and the TOB must be changed to a 131 in the WIpop file**.**	12/1/17
Type of Bill	*Are FASCs required to report type of bill?*	Yes, but the HCFA 1500 claim form does not require type of bill. See spec in section 5.5 for details.	11/28/17

Type of Bill	We are an ASC what TOB should we use?	You can use either 0831 or 0999 - the statute requires a TOB to be used and the UB-04 manual has 083x (x= 0 for zero charge claim, 1 = service dates from / to, 7 = voided claim, etc.) as a code that is specific to ASC sites. Typically, it is not included on the 837P, but several of our hospitals own ASCs and use this. SO, you can either use this code or the default of 999. See the technical specification for programming this into the file.	
Validation	What am I supposed to do during the validation period?	Download the data from the Portal / Data Deliverables: 1) Review your summary profile report and validation reports; 2) Any data inconsistencies ± 25% should be investigated. 3) Run/request a census report or some type of report from internal departments to verify the total number of patients seen matches the number of records submitted. 4) If total records do not match, submit missing data, correct edits & request new reports. 5) To correct issues such as a duplicate procedure or inappropriate POA, open the batch, locate the record using the patient control number and update accordingly. 6) Verify batch has been marked complete and submit on-line affirmation statement.	10/30/17
Validation Reports	One of our validation team members asked if there were plans to get an account level report of what was being reported in each Patient Type (Inpatient, Outpatient Surgery, Emergency Department Visit, etc.). I did not see a current validation report that had this detail, do you know if this would be something that could be added as a reporting option?	We provide a summary profile report and a full profile report with the validation reports at the close of the quarter. The profile reports have detailed counts and charges for each data type. As for a validation report, that shows all data for all records would be to large and cumbersome for the average data user. If you are looking for patient control numbers, with a few other key fields, we refined the current inventory report such that the place of service and payer code appears on every line. In general, we take suggestions and report ideas under consideration. However, our goal is to remove and/ condense validation reports, so that they provide maximum info with minimum clutter.	
When WHAIC created	When was WHAIC and WIpop created?	WHA Information Center (WHAIC) is a wholly owned subsidiary of the **Wisconsin Hospital Association**. WHAIC was incorporated on October 1, 2003, and began collecting data in January 2004 under a contract with the Wisconsin Department of Administration.	
Zip-Code	What Zip Code should I use for a patient out of the country?	The field should be zero-filled ('00000') for persons with an address that does not include a valid United States ZIP code	
Zip-Code	Do I zero fill or leave the field blank when a ZIP code is unknown?	If the ZIP code is unknown, such as for homeless patients, this field should be left blank and Condition Code '17' should be used for inpatient and outpatient records.	
Technical Questions for those Creating 837 File			
837 Specification, Creating file	Your 837 Companion Guide & Technical Spec Manual is not a complete 837 file spec. It is missing some of the data elements. Where we can get a complete 837 spec requirements for WIPOP.	Our Manual is not intended to be a full 837 spec. Much like other state hospital associations or other data collection organization that collects discharge data, our documentation specifies only the 837 components that our parser will use for reference or have dedicated data fields in WIpop. The 837 file **needs to be a structurally correct 837, but the data not referenced in our guide will be ignored if supplied.** Since unused segments will be ignored, there is no need to strip all non-used components or populate with NULL. In short, you can submit all the data in the file, but unless it has a spot to populate in WIpop, or is necessary to process the file, the material will be discarded. You can purchase a full spec by going to the https://www.wedi.org/	12/1/17

Address	The 2010BA loop address line 1 & 2 in the specs appear to pull on the same line. Is that correct or will address line 2 pull under address line 1?	We will only use N301 for our address. Technically you can provide a second address line in N302, but we will ignore that. Do not send two consecutive N3 segments.	
Case Sensitive	Does the data need to be programmed in upper or lower case?	No, the data is not case sensitive.	12/1/17
Creating File	How should we go about building or creating our 837 file?	Each facility should determine how to best supply your state data to WHAIC so that it matches your internal processes. Options might include: • Build the extract internally from mainframe system. • Build extract internally from claim (if this is the one used, the additional fields need to come from mainframe still) • Work with an EDI or Billing vendor or third party claims processor to build extract. Typically, a vendor will be used to create the 837 file.	12/1/17
Discharge Date Requirements	The WHAIC Discharge date requirements are a little different than what hospitals would submit on a *regular 837I file. Are we expected to do modifications to what is originally submitted on the claim to a payer?* .	Yes, there are modifications required in the spec out of necessity to meet the state statute requirements, historical data trending and the 837 requirements. We understand the 837 does not have a field specifically designated for Discharge Date. *In the HIPPA 837I Standard the field is Discharge HOUR (not Discharge DATE) where only the time of discharge is submitted in format HHMM and a qualifier in DTP02=TM.* To satisfy the WHAIC requirements, hospitals will have to modify this field to include the discharge date before the discharge hour in format CCYYMMDDHHMM. In general, we assume the Statement Through Date (loop 2300 DTP03) is also Discharge Date. M*odify the qualifier from TM to DT.*	12/1/17
File Translator, Software, Program	We are looking for a flat file conversion program to get to the 837 format. What are organizations with no programming resources doing to move forward with this change?	Each facility is responsible for determining the most cost effective, efficient way to deliver their data to us. We would encourage you to look for possible solutions from your billing provider or EMR vendor that are available for leverage to create your 837 file.	12/1/17
FTP	Are you allowing an FTP file delivery? You want us to use a manual web app to upload files. That would be our very last choice (we do not do that with anyone for financial/claim data).	We are a data collection entity our data base structure is much different than that of a payer. WIpop data is uploaded through a browser and has been for many years. We do not use an FTP site because of the difficulty in cloning and maintaining our WIpop user security to an FTP server equivalent, as well as collecting the file metadata for each upload.	12/1/17
HI and SV Segment	Should HCPCS pull to both the HI segment and the SV segment or should they only pull to the HI segment?	The coding guidelines require inpatient codes to be populated on a claim; accordingly, so that is what is referred to in the HI segments. The SV segments are the revenue line item details and those would always be populated for any OP record and include the revenue code and HCPCS/CPT codes.	
NPI	On pulling an Operating physician will you be looking to the HI segment or the SV segment for the surgical procedures?	We will be populating those fields based on the revenue codes in the SV segment. If a 0360 exist, then we will look for a procedure code to populate the principal and additional accordingly.	
NULL fields	There are several locations in the file that state to pull “NULL” but also mention blank. Should	It can be either. We put NULL because it is a required field and confused some folks.	

<table>
<tr><td></td><td>we pull the value NULL or can it pull blank in those fields?</td><td></td><td></td></tr>
<tr><td>Patient Relationships</td><td>Do we have to report the patient relationship to insured?</td><td>No, we do not require relationship identifiers in the data. If it is not in the spec, you do not have to report it.</td><td></td></tr>
<tr><td>Payer</td><td>We are building our Claims File, should we be using A99-09 or A99-9 when populating the payer mapping information?</td><td>The fields are set up to be three alpha/numeric fields for Payer ID and two-digit field for the Payer Type.
The correct mapping is to use A99 – 09.</td><td>12/1/17</td></tr>
<tr><td>Payer</td><td>For Loop 2000b SBR-03 it is built that if the payer is self- pay it is to produce a NULL, however the Policy or group number is not always collected, so when I load my file I have many edits because the Policy /Group number is blank.</td><td>That value can only be NULL on self-pays.
For all other payers, we need something in that field. Preferably some ID that links the patient to their insurance, so policy, group, subscriber number, etc. But if nothing like that is available, technically all we validate for is that the field is not blank.</td><td></td></tr>
<tr><td>Payer Codes</td><td>How often will WHAIC be adding new codes?
How will we know when a new code is added?</td><td>New Commercial Payer Codes "A" codes will be added annually. WHAIC staff will obtain documentation from OCI to verify new commercial payers in the marketplace.
WIpop users will be alerted of new payers added through the WHAIC Newsletter at least twice and then once again after they are effective.
New and existing Commercial Payers will be reviewed during the annual training and "New" codes will be highlighted with a distinct color and effective date.
Effective date for new codes will be the first quarter of the new year following notification.
In the meantime, before the code is "ACTIVE" use A99-09 to report new payers.</td><td></td></tr>
<tr><td>Physician Names</td><td>NM103, NM104 are the Physicians names in the 837 claim file however you do not have those fields listed and in the sample file you have ATTENDING listed, do you want the word ATTENDING in the file?</td><td>The specification we have outlined on our website only contains the loops and elements required to complete the WIpop data submission and file upload. Populate the field with whatever value you choose or leave it blank, we will ignore it all together during the processing of the file. As stated in the spec, what is important is the NPI numbers, code, and qualifiers. The words ATTENDING, OPERATING, etc. are simply there as illustrations to see how the field is laid out.
<table>
<tr><td colspan="5">LOOP ID 2310 (A – F) PROVIDER Information</td></tr>
<tr><td>2310A</td><td>NM101</td><td>Attending ID Code</td><td>S</td><td>71 =</td></tr>
<tr><td>2310A</td><td>NM108</td><td>Attending Provider ID Qualifier</td><td>S</td><td>XX =</td></tr>
<tr><td>2310A</td><td>NM109</td><td>Attending Provider ID NPI</td><td>S</td><td>Use</td></tr>
<tr><td>2310B</td><td>NM101</td><td>Operating Entity ID Code</td><td>S</td><td>72 =</td></tr>
<tr><td>2310B</td><td>NM108</td><td>Operating ID Code Qualifier</td><td>S</td><td>XX =</td></tr>
<tr><td>2310B</td><td>NM109</td><td>Operating Provider NPI Number</td><td>S</td><td>Use</td></tr>
<tr><td>2310C</td><td>NM101</td><td>Other Operating Code Qualifier</td><td>S</td><td>ZZ =</td></tr>
<tr><td>2310C</td><td>NM108</td><td>Other Operating ID Qualifier</td><td>S</td><td>XX =</td></tr>
<tr><td>2310C</td><td>NM109</td><td>Other Operating Provider NPI nbr</td><td>S</td><td>Use</td></tr>
</table></td><td>12/1/17</td></tr>
<tr><td>Recurring accounts</td><td>For Recurring accounts can those pull as one account once they are discharged or will they need to pull before being discharged? If they need to pull before discharged what</td><td>You can pull those either way. Populate the discharge status code with whatever is on the claim. We do not reject any of those anymore.</td><td></td></tr>
</table>

	Discharge Status code should pull?		
Reporting Guide and Question	How closely aligned to the HIPAA Institutional Claim 837 implementation guide 837I is the Health Care Service Data Reporting Guide 837R?	Very Close, especially the 5010 Versions of each guide. The Health Care Service Data Reporting (HCDR) Guide is a subset of the HIPAA Institutional implementation guide. The notable exception is the collection of some additional demographic data, such as the patient marital status, race, and ethnicity. It should also be noted that there is no business case for the collection of any coordination of benefits (COB) information in the HCDR, so that information is not supported in that guide.	
Testing			
Data Submission	If our new upload capability is completed by April 2018, is that adequate?	No, Q1 data is due May 15. All hospitals and ASC sites are required to send in test files during the 4th quarter to allow for time to work with your vendor or IT support to refine edits and issues as needed in a timely fashion prior to the Q1 due date.	12/1/17
Vendor Access	Can my vendor have access to WIpop to test the file?	Yes, you can authorize access to WIpop for your vendor to test your data on behalf of the facility. We may verify access with the primary contact to assure legitimacy.	12/1/17
Testing	If I pass testing, can I begin using the 837 file and format right way?	Testing is required prior to access to production. We evaluate the file as a whole, if it contains self-pay, value codes, occurrence codes and PBL data, if applicable.	12/1/17
Direct Data Entry	Do I have to test if we do direct data entry?	Yes, all facilities, regardless of mode of submission must submit files to the 837 test site in order to get access to the 837 production site. See the testing resource on our website.	12/1/17
Retesting/Software Updates or Program Changes	Do I have to retest after making software, system, or mapping changes?	Yes, any software, system or mapping changes can affect the data submission file or output of the data. To ensure successful data processing and minimal edits, we encourage all changes be tested using the 837 Test site and not the Production site.	12/1/17

7.17 Changes to this document

The following version history is provided to easily identify updates between Companion Guide Versions. Each update is numbered. All corresponding areas of the document related to this update are also numbered.

Please check the WHAIC website at: WHA Information Center for the most recent version of this document and any supplemental resources.

Change Number	Date	Author of Change	Update includes
1	1/24/17	Cindy	Created date
2	3/2/17	Cindy	Posted Manual online
3	05/08/17	Jim	Updated Statement of intent with the 837 specification and that it is not intended to serve as an entire full specification.
3.1	5/08/17	Jim	Added NTE01 reporting option for 837R file users to report provider-based billing.
4	5/11/17	Cindy	Updated Special Character : and -
4.1	5/11/17	Cindy	Updated type of bill to remove leading zero. Submitter may use a leading zero, but it is not required.
4.2	5/11/17	Cindy	Added Interchange Control and Functional Group Specification as requested by developers.
4.3	5/11/17	Cindy	Updated Payer table to include more commercial payers.
5.1	06/14/17	Cindy	Updated TOB and Revenue Code table to remove special restrictions from data files.

Change Number	Date	Author of Change	Update includes
5.2	06/20/17	Cindy	Updated Payer Table – removed A35 - Care Wisconsin is a Medicaid/Medicare HMO
6.1	06/26/17	Cindy	Updated 837P to include POS field that will be mapped according to WHAIC POS hierarchy.
6.2	06/27/17	Cindy	
7.1	07/14/2017	Cindy	TOB update, Disclaimer, Reporting grid / format for payer clarification. FAQs
7.2	7/24/17	Cindy	Added new payer – Quartz Health Plan, Choice / Humana
8.1	8/09/17	Cindy	Prepared manual for printing
8.2	08/24/17	Cindy	Updated 837I crosswalk Rev Code exclusions: Added 019x as long as it is from an acute care or critical access hospital.
9.0	10/2/17	Cindy	Updated Facility List (Name Changes)
10	02/13/2018	Cindy	Removed Transplant Payer code from table
	3/20	Jim	Updated Black Box
	3/15	Cindy	Updated and streamlined manual. Added page numbers
	3/20	Cindy	Updated FAQ
11	07/2018	Cindy	Scheduled update: Edited and reorganized text throughout for clarity. Updated Facility List, Updated Edits, Support name updated.
12	10/2018	Cindy	Update logo, edits, FAQ, batch failure responses, revised specs to include more notes. Batch Failure updated with Removing duplicate process
13	11/2018	Cindy	Added New Appendix “Type of Admission” as 7.8 moving all others down one.
14	3/2019	Cindy	Updated Payer Table as per OCI guidance
15	7/2019	Cindy	Added new Appendix for Language 7.2.1
16	7/2019	Cindy	Added new Appendix for Claim Filing Indicator 7.3.1
17	7/2019	Cindy	Added new Appendix for Payer/NAIC 7.3.2
18	7/2019	Cindy	Added new four new fields to each of the 837 specifications: Language, Claim Filing Indicator, Payer / NAIC# and Payer Name. See June 2019 for more info.
19	7/2019	Cindy	Rearranged section 4 and 5 to better align with business rules vs. technical requirements and specifications.
20	7/2019	Cindy	Cleaned up multiple sections to read more clearly and address over use of words/phrases.
21	7/2019	Cindy	Added picture graphic to Section 3 – how to submit data in WIpop – “Go to Batch Review”
22	07/2019	Cindy	Updated Appendix to remove 0361 from POS 1 table and add it to POS 6.
23	07/2019	Cindy	Updated FAQ section to clarify and add new FAQ
24	12/2019	Jim	Added new Edit 1395 and 1396 – both apply to direct data entry to make sure that a principal also has a corresponding code in the revenue line item detail.
25	2/1/2020	Cindy	Updated Edit 1270 Type of Admission / Visit edit to include OPS, OBS and ED records.
	03/2020	Jim	Added new TOB edit 3186. Type of bill must match the record type. Edit 3186 will apply when either of these is true: • The record is inpatient and type of bill is not in the 110-121 range. • The record is outpatient and type of thill is in the 110-121 range.
	03/2020	Cindy	Revenue Code section updated and reviewed according to current UB-04 guidelines.
	03/2020	Cindy	Added new Hospital Services Policy Statement

Change Number	Date	Author of Change	Update includes
26	08/2020	Cindy	Added New Point of Origin Code "G" – See Appendix 7.7
27	10/2020	Cindy	Updated Facility List with added sites
28	10/2020	Cindy	Corrected links to new Website and removed underlined words to not confuse reader which is a link and which is an emphasis.
29	02/2021	Cindy	Updated Payer table – see Appendix 7.3 for the change table.
30	02/2021	Cindy	Updated Coding Guidelines section. Removed the CPT/HCPCS code table. Data is pulled directly from the claim, therefore the person pulling the file has no inference in how that is decided.
31	03/2021	Cindy and Jim	Updated payer table to consolidate and condense mapping.
	04/2021	Cindy and Jim	Rolled out new Alert System to notify submitters and editors of potential issues with records. See section 2.1
	03/2021	Cindy and Jim	Updated Inventory report for ease of use and additional filtering for PBL, Batch Number, Race and Ethnicity.
	04/2021	Jim	Removed requirement to explain reason to reopen batch.
	04/2021	Jim	Updated Report explanations to include alerts for Error Summary Reports.
32	07/2021	Cindy	Added new section 7.9.1 Alerts
	07/2021	Cindy	Removed requirement to use password protected downloaded zip files for validation.
	07/2021	Cindy	Updated Edits with additional language and examples.
	07/2021	Cindy	Updated and cleaned up instructions in most sections for clarity.
33	12/2021	Cindy	Updated edit language and some of the terms in definition list.
34	1/2022	Cindy	Updated the payer mapping table – audited current payers against OCI and added the NAIC number to the table.
	01/2022	Cindy	Updated Section 2.1 – Data Parameters: Added the requirement for facilities to include Social Determinants of Health (SDOH) codes from the EMR or Claim to the file when coded.
	01/2022	Cindy	Updated Section 4.5 Revenue Codes
	01/2022	Cindy	Updates Section 7.6 WIpop Coding Guidelines for clarification principal procedures, newborn coding and SDOH.
35	04/2022	Justin	Created new edits for OTH-54 and OTH 31. See edit numbers 3770 – 3773
36	9/2022	Cindy	Effective Q322 *0760 – Specialty Services: General Classification – moved from POS 3 to Other Outpatient Place of Service 6.
	9/2022	Cindy	Added new facilities see Appendix 7.1
	9/2022	Cindy	Added link to NAIC and encouraging more facilities to use this as we could eventually create additional mapping options to define payers more accurately.
37	01/2023	Cindy	Payer Updates, technical spec -removed reference to new fields in 2019, removed red highlighting, updated outdated weblinks.
38	11/1/2023	Cindy / Justin	New WIpop System and Single Sign-on
			Removed references to a separate GUI/BlackBox program. The black box 837 File Handler is embedded in the WIpop app.
39	032024	Cindy	Updated all references to Medicare Advantage mapping to MPC-09
40	06/2024	Cindy	Updated Alerts and Report options.
41	11/2024	Cindy	Updated Race Codes to include MENA and Latino's. Updated Payer Table, gender and edits

Change Number	Date	Author of Change	Update includes
42	12/24	Cindy	Updated multiple sections to clean up language, updated Claim filing indicator, updated payer mapping codes and eliminated termed codes.

End