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WHA Information Center Data Set Documentation

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I. General Description

The data contained in the data sets were reported to WHA Information Center (WHAIC) pursuant to Chapter 153, Wis. Stats. That reported information contains patient demographic data, admission and discharge data, charge and payer data, and diagnostic and procedure data, among other data. Below are the data types reported:

1. **Inpatient Data (INP)** were reported by all of Wisconsin's acute care, non-federal hospitals, including General Medical/Surgical, Psychiatric, AODA, Rehabilitation, and State institutions pursuant to the above statutes.
    - Reportable hospital inpatient records were defined as ones with a UB-04 FL 4 "Type of Bill" codes 11x and 12x.
    - A record was submitted for each discharge.

2. **Emergency Department (ED) Data** were reported by all of Wisconsin's hospitals offering ED services pursuant to the above statutes.
    - Reportable emergency department visit records were selected by discharge date and revenue codes 0450, 0451, 0452, and 0459.

3. **Outpatient Surgery Data (OPS)** were reported by Wisconsin hospitals, affiliated ambulatory surgery centers, and freestanding ambulatory surgery centers pursuant to the above statutes.
    - Reportable hospital outpatient surgery records are reported by procedure date and outpatient surgery revenue codes that include one of the following: 036x, 0481, 049x, and 0750.

4. **Observation Visit Data (OBS)** were reported by Wisconsin hospitals pursuant to the above statutes. There are 3 different data sets available: Observation Visit Data ONLY (OBS), Observation Visit Data with Outpatient Surgery Data (OBS-OPS), and Observation Visit Data with OBS-ED data. OBS data set available in the relational format only.
    - Reportable observation visit data ONLY (OBS) should be selected by the "through" date in the statement covers period (UB Form locator 6B) that include OBS revenue codes 0760 and/or 0762 only (observation only data available in the Relational Data Format)
    - The OBS-OPS should be selected by the "through" date in the statement covers period (UB Form locator 6B) that include OBS revenue codes 0760 and/or 0762 and outpatient Surgery revenue codes that include one of the following: 036x, 0480, 0481, 049x, and 0750.
    - The OBS-ED should be selected by the "through" date in the statement covers period (UB Form locator 6B) that include OBS revenue codes 0760 and/or 0762 and Emergency Department Data that include one of the following ED revenue codes: 0450, 0451, 0452, and 0459.

5. **Other Hospital Outpatient (OHO) Data** were reported by Wisconsin hospitals also pursuant to the above statutes. Hospital outpatient departments are required to submit selected items or aggregations (e.g. repetitive services such as PT visits) of items on all outpatient visits, except hospital reference diagnostic services. The OHO data set does not include inpatient, emergency department, ambulatory surgery, or observation data as these are included in the above data sets.

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Hospital Outpatient records are submitted based on the Statement Covers Period. 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.

The OHO data set is provided in a relational format only. The reported information contains patient demographic data, charge and payer data, and diagnostic and procedure data, among other data elements.

Definitions of data elements reported to WHA Information Center are based on uniform billing forms, either the Center for Medicare and Medicaid Services (CMS) Form 1500 or Uniform Billing Form (UB-04). Freestanding Ambulatory Surgery Centers submit a record for each surgical case that occurs within a specific quarter. Each submitted record contained items or aggregations of items from the billing forms.

During the submission process, errors were identified, and facilities were responsible for correcting all invalid records. After successful submission of verified data, a summary profile of each facility's data was provided for facility review and reconciliation with internal records. This sometimes led to further corrections, deletion of duplicate records, or the submission of additional discharge records. The editing process is substantially described in the WHAIC Data Submission Manual, which also details facilities' reporting requirements. The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Manual, the CPT Coding Manual, the HCPCS Level II Coding Manual, and the UB-04 Manual contain some additional descriptions or specifications for particular items.

The data sets consist of either raw data items obtained directly from facilities or computed and derived items calculated from the raw data items or derived from another source. Raw data items that could identify a patient are not included in the data sets. Some elements are regrouped.

Effective with the Q1 2018 data submissions, WHAIC transitioned data collection formats to a modified 837 claims file format. In 2015, WI Act 287 the Wisconsin Health Care Data Modernization Act was passed. The Act removed outdated provisions in Chapter 153 and included an opportunity to bring data collection into greater alignment with the national ANSI 837 EDI Claim standard. This change presented WHAIC with a wide variety of opportunities to improve the data it currently receives, streamline how the data is collected, and expand the data elements it collects.

In data submissions prior to Q4 2015, CPT codes submitted in ED and OPS files were converted to ICD-9-CM procedure codes using the current Thomson Reuters *Procedure Conversion Files*. **Effective with Q4 2015 data, with the move to ICD-10, WHAIC will no longer provide the crosswalk of CPT procedure codes to ICD procedure codes.** The crosswalk product will no longer be available to WHAIC.

The CPT to ICD procedure code crosswalk fields will remain within the fixed-width and relational file layout, but the code values will be NULL. WHAIC did not want to change the file layout as much as it could.

NOTE: Definitions of data elements reported to WHA Information Center are based on uniform billing forms, either the Center for Medicare and Medicaid Services (CMS) Form 1450, also known as Uniform Billing Form 92 (UB-92), Uniform Billing Form 04 (UB-04), or CMS Form 1500 (CMS-1500). Beginning with Q1 2010, WHAIC will no longer

provide reference to the UB-92. If you would like to obtain a crosswalk of the UB-92 to UB-04, please see: The National Uniform Billing Committee (NUBC) website at www.nubc.org.

Note: WHAIC assumed full responsibility for the collection, analysis and dissemination of health care information from hospitals and ambulatory surgery centers pursuant to s. 153, Stats., on July 1, 2004. Beginning with Q1 2010 data release, WHAIC will no longer provide reference to the BHI material. If you have questions, please contact the Information Center.

II. Fixed-Width File Layout(s)

File Layouts Using ICD-10

Inpatient Discharge

Column(s)	Length	Data Element
01-03	03	Age in Years
04	01	Infant Age Groups
05-09	05	ZIP Code
10-11	02	County/State Code
12	01	Gender
13-15	03	Length of Stay
16-18	03	Discharge Year and Quarter
19	01	Admission Type
20	01	Admission Source / Point of Origin
21-22	02	Discharge Status
23-34	12.2	Total Charges (explicit decimal)
35-37	03	Leave Days
38	01	First Payer Identifier Group
39	01	First Payer Category Group
40	01	Second Payer Identifier Group
41	01	Second Payer Category Group
42-48	07	Principal Diagnosis Code
49-55	07	First Other Diagnosis Code
56-62	07	Second Other Diagnosis Code
63-69	07	Third Other Diagnosis Code
70-76	07	Fourth Other Diagnosis Code
77-83	07	Fifth Other Diagnosis Code
84-90	07	Sixth Other Diagnosis Code
91-97	07	Seventh Other Diagnosis Code
98-104	07	Eighth Other Diagnosis Code
105-111	07	Ninth Other Diagnosis Code
112-118	07	Principal Procedure Code (ICD-10-CM Code)
119-125	07	First Other Procedure Code (ICD-10-CM Code)
126-132	07	Second Other Procedure Code (ICD-10-CM Code)
133-139	07	Third Other Procedure Code (ICD-10-CM Code)
140-146	07	Fourth Other Procedure Code (ICD-10-CM Code)
147-153	07	Fifth Other Procedure Code (ICD-10-CM Code)
154-156	03	Pre-Procedure Days
157-158	02	Major Diagnostic Category
159-161	03	Diagnosis Related Group ***(Q4 2012 – no longer provided; MS-DRGs are available)***
162-164	03	Hospital or FASC Identification Number
165-169	05	Record Number
170-176	07	Admitting Diagnosis/Reason for Visit
177-179	03	First Payer Combined Code
180-182	03	Second Payer Combined Code

Fixed-Width Layout(s)

Outpatient Surgery (OPS) & Observation w/ Outpatient Surgery (OBS-OPS)

Column(s)	Length	Data Element
01-03	03	Age in Years
04	01	Infant Age Groups
05-09	05	ZIP Code
10-11	02	County/State Code
12	01	Gender
13-15	03	Surgery Year and Quarter
16	01	Admission Type
17-28	12.2	Total Charges (explicit decimal)
29	01	First Payer Identifier Group
30	01	First Payer Category Group
31	01	Second Payer Identifier Group
32	01	Second Payer Category Group
33-39	07	Principal Diagnosis Code
40-46	07	First Other Diagnosis Code
47-53	07	Second Other Diagnosis Code
54-60	07	Third Other Diagnosis Code
61-67	07	Fourth Other Diagnosis Code
68-74	07	Fifth Other Diagnosis Code
75-81	07	Sixth Other Diagnosis Code
82-88	07	Seventh Other Diagnosis Code
89-95	07	Eighth Other Diagnosis Code
96-102	07	Ninth Other Diagnosis Code
103-109	07	Principal Procedure Code (ICD-10-CM Code)
110-116	07	First Other Procedure Code (ICD-10-CM Code)
117-123	07	Second Other Procedure Code (ICD-10-CM Code)
124-130	07	Third Other Procedure Code (ICD-10-CM Code)
131-137	07	Fourth Other Procedure Code (ICD-10-CM Code)
138-144	07	Fifth Other Procedure Code (ICD-10-CM Code)
145-149	05	Principal Procedure Code (CPT-4 Code)
150-154	05	First Other Procedure Code (CPT-4 Code)
155-159	05	Second Other Procedure Code (CPT-4 Code)
160-164	05	Third Other Procedure Code (CPT-4 Code)
165-169	05	Fourth Other Procedure Code (CPT-4 Code)
170-174	05	Fifth Other Procedure Code (CPT-4 Code)
175	01	Blank (*Previously Reportable Procedure Category*)
176	01	Blank (*Previously Number of Reportable Procedures*)
177-179	03	Hospital or FASC Identification Number
180-184	05	Record Number
185-187	03	First Payer Combined Code
188-190	03	Second Payer Combined Code
191	01	Bilateral Principal Procedure (**Y**es/**N**o)
192	01	Bilateral First Other Procedure (**Y**es/**N**o)

Outpatient Surgery (OPS) & Observation w/ Outpatient Surgery (OBS-OPS)

Column(s)	Length	Data Element
193	01	Bilateral Second Other Procedure (**Y**es/**N**o)
194	01	Bilateral Third Other Procedure (**Y**es/**N**o)
195	01	Bilateral Fourth Other Procedure (**Y**es/**N**o)
196	01	Bilateral Fifth Other Procedure (**Y**es/**N**o)
197-203	07	Admitting Diagnosis/Reason for Visit

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Fixed-Width Layout(s)

Emergency Department (ED) & Observation w/ Emergency Department (OBS-ED)

Column(s)	Length	Data Element
01-03	03	Age in Years
04-08	05	ZIP Code
09-10	02	County/State Code
11	01	Gender
12-14	03	Discharge Year and Quarter
15	01	Admission Source / Point of Origin
16-17	02	Discharge Status
18-29	12.2	Total Charges (explicit decimal)
30	01	First Payer Identifier Group
31	01	First Payer Category Group
32	01	Second Payer Identifier Group
33	01	Second Payer Category Group
34-40	07	Principal Diagnosis Code
41-47	07	First Other Diagnosis Code
48-54	07	Second Other Diagnosis Code
55-61	07	Third Other Diagnosis Code
62-68	07	Fourth Other Diagnosis Code
69-75	07	Fifth Other Diagnosis Code
76-82	07	Sixth Other Diagnosis Code
83-89	07	Seventh Other Diagnosis Code
90-96	07	Eighth Other Diagnosis Code
97-103	07	Ninth Other Diagnosis Code ***(Effective with Q1 2013 Data Set)***
104-110	07	Principal Procedure Code (ICD-10-CM Code)
111-117	07	First Other Procedure Code (ICD-10-CM Code)
118-124	07	Second Other Procedure Code (ICD-10-CM Code)
125-131	07	Third Other Procedure Code (ICD-10-CM Code)
132-138	07	Fourth Other Procedure Code (ICD-10-CM Code)
139-145	07	Fifth Other Procedure Code (ICD-10-CM Code)
146-148	03	Hospital or FASC Identification Number
14-153	05	Record Number
154-160	07	Admitting Diagnosis/Reason for Visit
161-163	03	Attending Physician Specialty Code
164-166	03	Other (Procedure) Physician **1** Specialty Code
167-171	05	Principal Procedure Code (CPT-4 Code)
172-176	05	First Other Procedure Code (CPT-4 Code)
177-181	05	Second Other Procedure Code (CPT-4 Code)
182-186	05	Third Other Procedure Code (CPT-4 Code)
187-191	05	Fourth Other Procedure Code (CPT-4 Code)
192-196	05	Fifth Other Procedure Code (CPT-4 Code)
197-199	03	First Payer Combined Code
200-202	03	Second Payer Combined Code
203	01	Bilateral Principal Procedure (**Y**es/**N**o)
204	01	Bilateral First Other Procedure (**Y**es/**N**o)
205	01	Bilateral Second Other Procedure (**Y**es/**N**o)

Emergency Department (ED) & Observation w/ Emergency Department (OBS-ED)

Column(s)	Length	Data Element
206	01	Bilateral Third Other Procedure (**Y**es/**N**o)
207	01	Bilateral Fourth Other Procedure (**Y**es/**N**o)
208	01	Bilateral Fifth Other Procedure (**Y**es/**N**o)
209-211	03	**Second** Other (Procedure) Physician Specialty Code

III. WIpop Relational Data Set

Standard Layout – Data Tables

(Inpatient, Emergency Department, Outpatient Surgery and Observation)

tblDataType

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
DATA_ID	Data Type Identifier
OPS	Outpatient – Outpatient Surgery Record? **Y/N**
ER	Outpatient – Emergency Room Record? **Y/N**
OBS	Outpatient – Observation Record? **Y/N**
YYQ	Year & Quarter

tblDiagnosis

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
DX_ORDER	Diagnosis Order Code
DX_ICD	Diagnosis Code
DX_TYPE	Diagnosis Type Code
POA	Present on Admission Indicator ***(Added Q3 2013)***

tblDRG (*No longer provided in data sets – Q4 2012; MS-DRGs are available*)

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
MDC	Major Diagnostic Category
DRG	Diagnosis Related Group

tblMSDRG (*Added Q4 2007)*

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
MDC	Medicare Severity Diagnosis Related Group Major Diagnostic Category
DRG	Medicare Severity Diagnosis Related Group

tblPrimary

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
FACILITY_ID	Facility ID Number
AGE	Age in Years
NEWBORN	Infant Age Group
ZIP	ZIP Code
COUNTY	County/State Code
SEX	Sex
YYQ	Year & Quarter
LOS	Length of Stay
ATYPE	Admission Type

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FIELD	FIELD_DESCRIPTION
ASOURCE	Admission Source / Point of Origin
ASRCNWBRN	Admission Source – Newborn
DSTATUS	Discharge Status
LDAYS	Leave Days
TC	Total Charges
PAYIDGRP1	First Payer Identifier Group Code
PAYIDCAT1	First Payer Category Group Code
PAYCC1	First Payer Combined Code
PAYIDGRP2	Second Payer Identifier Group Code
PAYIDCAT2	Second Payer Category Group Code
PAYCC2	Second Payer Combined Code
PREDAYS	Pre-Procedure Days
BILLTYPE	Type of Bill
PROVIDER_ID	Facility NPI ***(Added Q4 2014)***
PBL_ID	Provider-Based Location Identifier ***(Added Q2 2015)***
RACE	Race ***(Added Q2 2016)***
RACE2	Additional Race ***(Added Q2 2016)***
ETHNICITY	Ethnicity ***(Added Q2 2016)***
BLKGRP	Census Block Group ***(Added Q1 2018)***

tblProcedure

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
PR_ORDER	Procedure Order Code
PR_CPT	Procedure Code – CPT-4
PR_MOD1	Procedure Modifier 1 Code
PR_MOD2	Procedure Modifier 2 Code
PR_MOD3	Procedure Modifier 3 Code ***(Added Q1 2008)***
PR_MOD4	Procedure Modifier 4 Code ***(Added Q1 2008)***
PR_ICD1	Procedure Code1 – ICD-10-CM
PR_ICD2	Procedure Code2 – ICD-10-CM
PR_TYPE	Procedure Type

tblRevenue

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
REV_CTR	Revenue Center Code
REV_TC	Revenue Center Total Charge

tblSpecialty

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
ATT_SPEC	Specialty Code of Attending Physician
OTH1_SPEC	Specialty Code of First Other (Procedure) Physician
OTH2_SPEC	Specialty Code of Second Other (Procedure) Physician

Standard Layout – Data Tables

(Other Hospital Outpatient Data)

tblDataType

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
DATA_ID	Data Type

tblDiagnosis

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
DX_ORDER	Diagnosis Order
DX_ICD	Diagnosis Code
DX_TYPE	Diagnosis Type Code

tblPrimary

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
FACILITY_ID	Facility ID Number
AGE	Age in Years
ZIP	ZIP Code
COUNTY	County/State Code
Sex	Gender
YYQ	Year & Quarter
TC	Total Charges
PAYIDGRP1	First Payer Identifier Group Code
PAYIDCAT1	First Payer Category Group Code
PAYCC1	First Payer Combined Code
PAYIDGRP2	Second Payer Identifier Group Code
PAYIDCAT2	Second Payer Category Group Code
PAYCC2	Second Payer Combined Code
BILLTYPE	Type of Bill
PROVIDER_ID	Facility NPI ***(Added Q4 2014)***
PBL_ID	Provider-Based Location Identifier ***(Added Q2 2015)***
RACE	Race ***(Added Q2 2016)***
RACE2	Additional Race ***(Added Q2 2016)***
ETHNICITY	Ethnicity ***(Added Q2 2016)***
BLKGRP	Census Block Group ***(Added Q1 2018)***

tblProcedure

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
PR_ORDER	Procedure
PR_TYPE	Procedure Type (Should be P or S)
PR_CPT	Procedure Code – CPT-4

FIELD	FIELD_DESCRIPTION
PR_MOD1	Procedure Modifier 1 Code
PR_MOD2	Procedure Modifier 2 Code
PR_MOD3	Procedure Modifier 3 Code
PR_MOD4	Procedure Modifier 4 Code

Standard Layout - Data Support Tables

tlkAdmitSource

FIELD	FIELD_DESCRIPTION
ASOURCE	Admission Source / Point of Origin
ASOURCE_DESC	Admission Source Description
START_DATE	Start Date of Admission Source
END_DATE	End Date of Admission Source

tlkAdmitSourceNewborn

FIELD	FIELD_DESCRIPTION
ASRCNWBN	Newborn Admission Source / Point of Origin
ASRCNWBRN_DESC	Newborn Admission Source Description
START_DATE	Start Date of Admission Source
END_DATE	End Date of Admission Source

tlkAdmitType

FIELD	FIELD_DESCRIPTION
ATYPE	Admission Type
ATYPE_DESC	Admission Type Description
START_DATE	Start Date of Admission Type
END_DATE	End Date of Admission Type

tlkAPR-DRG *(Available with APR-DRG data only)*

FIELD	FIELD_DESCRIPTION
APRDRG	All Patient Refined Diagnosis Related Group
APRDRG_DESC	All Patient Refined Diagnosis Related Group Description
START_DATE	Start Date of All Patient Refined Diagnosis Related Group
END_DATE	End Date of All Patient Refined Diagnosis Related Group

tlkBorder *(Added Q2 2010)*

FIELD	FIELD_DESCRIPTION
BORDER_COUNTY	Border States County Code
COUNTY_NAME	Border States County Name
COUNTY_NUM	County/State Code
STATE_ID	State Code
STATE	State Name

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tlkCounty

FIELD	FIELD_DESCRIPTION
COUNTY	County/State Code
COUNTY_DESC	County/State Code Description

tlkDataType

FIELD	FIELD_DESCRIPTION
DATA_ID	Data Type Identifier
DATA_DESC	Data Type Description

tlkDischargeStatus

FIELD	FIELD_DESCRIPTION
DSTATUS	Discharge Status
DSTATUS_DESC	Discharge Status Description
START_DATE	Start Date of Discharge Status
END_DATE	End Date of Discharge Status

tlkDRG

FIELD	FIELD_DESCRIPTION
DRG	Diagnosis Related Group
DRG_DESC	Diagnosis Related Group Description
START_DATE	Start Date of Diagnosis Related Group
END_DATE	End Date of Diagnosis Related Group

tlkDxType *(Added Q4 2007)*

FIELD	FIELD_DESCRIPTION
DX_TYPE	Diagnosis Type
DX_TYPE_DESC	Diagnosis Type Description

tlkEthnicity *(Added Q2 2016)*

FIELD	FIELD_DESCRIPTION
ETHNICITY	Ethnicity Category
ETHNICITY_DESC	Ethnicity Description

tlkFacility

FIELD	FIELD_DESCRIPTION
FACILITY_ID	Facility Identifier
FACILITY_NAME	Facility Name
FACILITY_ADDRESS1	Facility Street Address
FACILITY_ADDRESS2	Facility Street Address 2
FACILITY_CITY	Facility City
FACILITY_STATE	Facility State
FACILITY_ZIP	Facility ZIP Code
OPENED	Open Date of Facility
CLOSED	Close Date of Facility
COMBINE	Combine Date of Facility
COMBINE_TO	Facility Number Combined Into

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tlkMDC

FIELD	FIELD_DESCRIPTION
MDC	Major Diagnostic Category
MDC_DESC	Major Diagnostic Category Description
START_DATE	Start Date of Major Diagnostic Category
END_DATE	End Date of Major Diagnostic Category

tlkMSDRG *(Added Q4 2007)*

FIELD	FIELD_DESCRIPTION
DRG	MS DRG Value (Medicare Severity Diagnostic Related Group)
DRG_DESC	MS DRG Description
START_DATE	Start Date of MSDRG
END_DATE	End Date of MSDRG

tlkMSMDC

FIELD	FIELD_DESCRIPTION
MDC	Major Diagnostic Category
MDC_DESC	Major Diagnostic Category Description
START_DATE	Start Date of Major Diagnostic Category
END_DATE	End Date of Major Diagnostic Category

tlkNewborn (Infant Age Groups)

FIELD	FIELD_DESCRIPTION
NEWBORN	Infant Age Group
NEWBORN_DESC	Infant Age Group Description

tlkPayCategory

FIELD	FIELD_DESCRIPTION
PAYCAT	Payer Category Group
PAYCAT_DESC	Payer Category Group Description

tlkPayCombinedCode

FIELD	FIELD_DESCRIPTION
PAYCC	Payer Combined Code
PAYCC_DESC	Payer Combined Code Description
START_DATE	Start Date of Payer Combined Code
END_DATE	End Date of Payer Combined Code

tlkPayIdentifier

FIELD	FIELD_DESCRIPTION
PAYID	Payer Identifier Group
PAYID_DESC	Payer Identifier Group Description

tlkPOA *(Effective with Q3 2013)*

FIELD	FIELD_DESCRIPTION
POA	Present on Admission Indicator
POA_DESC	Present on Admission Description

tlkProviderID *(Effective with Q4 2014)*

FIELD	FIELD_DESCRIPTION
FACILITY_ID	Facility Identifier
NPI	Facility National Provider ID
NPI_DESC	Facility National Provider ID Description
PRIMARY_NPI	Indicator If Facility's Primary National Provider ID

tlkProviderBasedLocations *(Effective with Q2 2015)*

FIELD	FIELD_DESCRIPTION
FACILITY_ID	Facility Identifier
PBL_ID	Provider-Based Location Identifier
PBL_NAME	Provider-Based Location Name
ADDRESS1	Provider-Based Location Address 1
ADDRESS2	Provider-Based Location Address 2
CITY	Provider-Based Location City
STATE	Provider-Based Location State
ZIP	Provider-Based Location ZIP
MAIN_CAMPUS	Indicator if Provider-Based Location is on main campus
START_DATE	Provider-Based Location began submitting data
END_DATE	Provider-Based Location ended submitting data

tlkPrType *(Added Q4 2007)*

FIELD	FIELD_DESCRIPTION
PR_TYPE	Procedure Type
PR_TYPE_DESC	Procedure Type Description

tlkRace *(Added Q2 2016)*

FIELD	FIELD_DESCRIPTION
RACE	Race Category
RACE_DESC	Race Description

tlkRevenueCenter

FIELD	FIELD_DESCRIPTION
REV_CTR	Revenue Center Code
REV_CTR_DESC	Revenue Center Code Description
START_DATE	Start Date of Revenue Center
END_DATE	End Date of Revenue Center

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tlkRevenueCode

FIELD	FIELD_DESCRIPTION
REV_ID	Revenue Line Item Code
REV_DESC	Revenue Line Item Code Description
START_DATE	Start Date of Revenue Code
END_DATE	End Date of Revenue Code

tlkROM *(Available with APR-DRG data only)*

FIELD	FIELD_DESCRIPTION
ROM	Risk of Mortality Code
ROM_DESC	Risk of Mortality Code Description

tlkSeverity *(Available with APR-DRG data only)*

FIELD	FIELD_DESCRIPTION
SEVERITY	Severity of Illness Code
SEVERITY_DESC	Severity of Illness Code Description

tlkSpecialty

Effective 2017 Q1; Using AMA / NUCC Provider Taxonomy for Specialty Codes.

FIELD	FIELD_DESCRIPTION
SPECIALTY	Specialty Code
SPECIALTY_DESC	Specialty Code Description
START_DATE	Start Date of Specialty Code
END_DATE	End Date of Specialty Code

tlkTypeOfBill

FIELD	FIELD_DESCRIPTION
BILLTYPE	Bill Type
DESCRIPTION	Bill Type Description

Physician Enhanced Layout – Additional Data Table

tblPhysician

Effective 2017 Q1; Using AMA / NUCC Provider Taxonomy for Specialty Codes.

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
ATT_WI_LICENSE	Wisconsin License of Attending Physician
ATT_UPIN	UPIN of Physician
ATT_NPI	NPI of Physician
ATT_SPEC	Specialty Code of Attending Physician
ATT_NAME	Name of Physician
OTH1_WI_LICENSE	Wisconsin License of First Other (Procedure) Physician
OTH1_UPIN	UPIN of Physician
OTH1_NPI	NPI of Physician
OTH1_SPEC	Specialty Code of First Other (Procedure) Physician
OTH1_NAME	Name of Physician
OTH2_WI_LICENSE	Wisconsin License of Second Other (Procedure) Physician
OTH2_UPIN	UPIN of Physician
OTH2_NPI	NPI of Physician
OTH2_SPEC	Specialty Code of Second Other (Procedure) Physician
OTH2_NAME	Name of Physician

Revenue Enhanced Layout – Additional Data Table

tblRevenueDetail – Data Table

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
REV_CODE	Revenue Line Item Code
HCPCS_RATE	HCPCS / Rate Code
HCPCS_MOD1	HCPCS Modifier 1 Code
HCPCS_MOD2	HCPCS Modifier 2 Code
HCPCS_MOD3	HCPCS Modifier 3 Code ***(Added Q1 2008)***
HCPCS_MOD4	HCPCS Modifier 4 Code ***(Added Q1 2008)***
UNIT_SERV	Units of Service
REV_CHG	Revenue Line Item Charge

Border State County Enhanced Layout – Additional Data Table

This information identifies the county name of all non-Wisconsin residents treated in Wisconsin facilities.

tblBorder – Data Table *(Added Q2 2010)*

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
BORDER_COUNTY	Border States County Name
COUNTY_NUM	County/State Code
STATE_ID	State Code
STATE_NAME	State Name

APR-DRG Layout – Additional Table

tblAPR-DRG (A*vailable upon request and have a 3M APR-DRG software contract)*

FIELD	FIELD_DESCRIPTION
RECORD_ID	Unique Record Identifier
APRDRG	All Patient Refined Diagnosis Related Group
APRMDC	All Patient Refined Diagnosis Major Diagnostic Category
SEVERITY	Severity of Illness Code
ROM	Risk of Mortality Code

IV. Detailed Description of Data Elements

1. Age in Years

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

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

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

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

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

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

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

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

3. ZIP Code

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

Values are suppressed to protect patient confidentiality as follows:

A blank is entered if:

- The ZIP code has a residential population less than 1,000 per record type, or
- The ZIP code appears on fewer than 30 discharges (Inpatient, Emergency Department, Observation Visit and Other Hospital Outpatient data) or fewer than 30 outpatient surgeries in the current quarter.

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

4. County/State Code

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

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

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

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

5. Gender

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

Code	Gender
1	Male
2	Female
3	Unknown

6. Length of Stay – (Inpatient data only)

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

7. Year/Quarter

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

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

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

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

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

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

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

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

11. Total Charges

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

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

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

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

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

12. Leave Days – (Inpatient data only)

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

13. First Payer Identifier Group

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

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

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

14. First Payer Category Group

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

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

15. First Payer Combined Code

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

16. Second Payer Identifier Group

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

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

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

17. Second Payer Category Group

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

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

18. Second Payer Combined Code

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

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

19. Principal Diagnosis Code

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

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

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

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

21. 'E' Code

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

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

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

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

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

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

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

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

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

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

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

23. Admitting Diagnosis – (Inpatient data only)

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

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

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

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

25. Principal Procedure Code – ICD-10-CM

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

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

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

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

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

27. Principal Procedure Code – CPT

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

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

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

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

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

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

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

29. Bilateral Principal Procedure – CPT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37. Facility Identification Number

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

38. Record Number (fixed-width layout only)

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

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

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

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

40. Record ID (relational layout only)

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

41. Data ID (relational layout only)

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

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

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

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

2 – Emergency Department Visit

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

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

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

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

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

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

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

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

42. Start Date (relational layout only)

Date identified code was effective.

43. End Date (relational layout only)

Date identified code was no longer effective.

44. OPS (relational layout only)

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

45. ER (relational layout only)

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

46. OBS (relational layout only)

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

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

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

48. Severity of Illness (relational layout only)

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

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

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

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

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

51. Revenue Code (relational layout only)

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

52. HCPCS / Rate Code (relational layout only)

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

53. Units of Service (relational layout only)

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

54. Revenue Line Item Charge (relational layout only)

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

55. Provider ID (relational layout only)

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

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

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

57. Race (relational layout only)

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

58. Race 2 (relational layout only)

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

59. Ethnicity (relational layout only)

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

60. Census Block Group (relational layout only)

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

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

Block Group is assigned only for patient addresses in Wisconsin and its border states. It is not assigned for post office box addresses.

V. Facility Identification Codes[1]

This information can be found in the relational data product data support table **tlkFacility**. For a current list of facility information, please refer to Appendix 1 in the WIpop Data Submission Manual.

Veteran Care Hospitals

No patient record data is available for the following:

Code	City	Hospital Name
175	Tomah	*Veterans Affairs Medical Center*
176	Milwaukee	*Clement J. Zablocki VA Medical Center*
177	Madison	*Wm. S. Middleton Memorial VA Hospital*

Facility Closings and Mergers and New Facilities

*Due to facility closings and mergers, data has been combined from certain facilities and assigned a new facility identification number for purposes of analysis. Purchasers of data may find it useful to know the dates when such changes have occurred. Note: All facility closings and mergers prior to Q1 02 have been excluded from this table. For historical information prior to 2017, please contact WHA Information Center. Facility information can also be found in the relational data product data support table **tlkFacility**.

Date	Individual Facility ID Numbers	Combined Facility ID Number
Q1 17	415 – Waukesha Surgery Center d/b/a Lake County Surgery Center	New Facility
Q1 17	321 – Willow Creek Behavioral Health	New Facility
Q1 18	416 – Bellin Health Marinette Surgery Center	New Facility
Q2 18	418 – Milwaukee Surgical Suites, LLC	New Facility
Q2 18	419 – Midwest Nephrology Associates Surgery Center	New Facility
Q3 18	196 – Columbia Center Birth Hospital	Merged Data Submissions with Ascension Columbia St. Mary's Hospital Ozaukee (110)
Q3 18	207 – Marshfield Clinic	Merged Data Submissions with Marshfield Medical Center (069)
Q3 18	322 – Marshfield Medical Center – Eau Claire	New Facility
Q4 18	420 – Wisconsin Institute of Surgical Excellence, LLC	New Facility
Q4 18	421 – New Berlin Medical Services, LLC	New Facility

[1] Because of facility closings, mergers, and openings, all Facility Identification numbers may not appear in all quarters.

Date	Individual Facility ID Numbers	Combined Facility ID Number
Q1 19	203 – SurgiCenter of Racine	Closed
Q1 19	415 – Waukesha Surgery Center d/b/a Lake Country Surgery Center	Closed
Q1 19	422 – Southern Lakes Endoscopy	New Facility
Q2 19	181 – Post Acute Medical Specialty Hospital of Milwaukee	Closed
Q2 19	207 – Marshfield Clinic	Merged Data Submissions with Marshfield Medical Center (069)
Q2 19	242 – Marshfield Clinic – Eau Claire	Merged Data Submissions with Marshfield Medical Center – Eau Claire (322)
Q2 19	307 – LifeCare Hospitals of Milwaukee	Closed
Q2 19	423 – Drexel Town Square Surgery Center, LLC	New Facility
Q3 19	286 – Pain Centers of Wisconsin – Franklin, LLC	Closed Facility
Q3 19	424 – Aurora Surgery Center, LLC	New Facility
Q4 19	413 - BJOSC at Plover	New Facility
Q4 19	425 - Advanced Spine Center of Wisconsin, LLC	New Facility
Q2 20	269 – Aspirus Surgery Center	Data now submitted through Aspirus Stevens Point Hospital (324)
Q2 20	323 – Marshfield Medical Center – Minocqua	New Facility
Q2 20	324 – Aspirus Stevens Point Hospital	New Facility
Q2 20	405 – Pain Centers of Wisconsin – Stevens Point	Closed
Q3 20	208 – North Shore Surgical Center	Closed
Q3 20	222 – Menomonee Falls ASC	Temporarily Closed
Q3 20	251 – Wisconsin Health Center ASC	Closed
Q3 20	261 – SurgiCenter of Greater Madison	Closed
Q3 20	263 – Sheboygan Medical Center LLC	Closed
Q3 20	270 – Transformations Surgery Center, Inc	Closed Indefinitely
Q3 20	273 – Access Medical Center LLC	Closed
Q3 20	274 – United Medical Center	Closed

Date	Individual Facility ID Numbers	Combined Facility ID Number
Q3 20	285 – Pain Centers of Wisconsin – Green Bay, LLC	Closed
Q3 20	293 – Pain Centers of Wisconsin – Fox Point	Closed
Q3 20	295 – Pain Centers of Wisconsin – Kenosha	Closed
Q3 20	296 – Pain Centers of Wisconsin – Fort Atkinson	Closed
Q3 20	400 – Pain Centers of Wisconsin – Wausau	Closed
Q3 20	401 – Pain Centers of Wisconsin – Wauwatosa	Closed
Q3 20	402 – Pain Centers of Wisconsin – Beaver Dam	Closed
Q3 20	403 – Pain Centers of Wisconsin – West Bend	Closed
Q3 20	404 – Pain Centers of Wisconsin – Appleton	Closed
Q3 20	406 – Waukesha Pain Center, LLC	Closed
Q3 20	409 – Heart & Vascular Institute, LLC	Closed
Q3 20	410 – Pain Centers of Wisconsin – Sauk Prairie	Closed
Q3 20	411 – Pain Centers of Wisconsin – Oconto Falls	Closed
Q4 20	235 – Marshfield Clinic – Minocqua	Data now submitted through Marshfield Medical Center Minocqua (323)
Q4 20	325 – Froedtert Community Hospital – New Berlin	New Facility
Q4 20	326 – Froedtert Community Hospital – Pewaukee	New Facility
Q4 20	409 - Heart & Vascular Institute, LLC	Closed.
Q4 20	427 – BayCare Aurora Kaukauna Surgery Center	New Facility
Q4 20	428 – Aurora Pleasant Prairie Ambulatory Surgery Center	New Facility
Q1 21	429 – Kenosha Digestive Health Center	New Facility
Q2 21	426 – Ascension Wisconsin Surgery Center – Mount Pleasant	New Facility
Q2 21	430 – Orthopedic Surgery Center of the Fox Valley	New Facility
Q3 21	431 – North Shore Surgical Suites, LLC	New Facility
Q3 21	432 – Racine Digestive Health Center	New Facility
Q4 21	327 – Miramont Behavioral Health	New Facility

VI. State Codes

This information can also be found in the relational data product data support table **tlkCounty**.

Code	State
81	Illinois
82	Iowa
83	Michigan
84	Minnesota
98	Missing/Homeless
99	Other State or Country

VII. Payer Information Submitted by Facilities

Codes for the primary and secondary payers who are expected to pay the greater share for the inpatient stay, ambulatory surgery, or emergency department visit.

UB-04 FL 50(a) and 50(b); CMS-1500 FL 1

- This element has a field length of 5 characters and consists of two components – the payer identifier and the payer type. The primary payer is required, the secondary payer is required only if there is an additional payer. Compatibility between the Payer Identifier and the Payer Type components is checked.
- Payer Identifier has a field length of 3 characters and consists of the first three positions of the payer identification from the UB billing claim form. All Wisconsin Medical Assistance (Medicaid) patients must be coded as "T19", whether payer type is fee-for-service or HMO.

Code Structure for Payer Identifier

Code	Description
Ann	Commercial payer ***(Effective Q1 2018)***
MED/T18	Medicare
T19	Wisconsin Medical Assistance (Medicaid)
nnn	3-digit plan code or BCS for Blue Cross/Blue Shield ***(Obsolete Q1 2018)***
WPS	Non-Medicaid Wisconsin Physicians Service ***(Obsolete Q2 2014)***
CHA	CHAMPUS/CHAMPVA/TRICARE[2]
MAX	Badger Care Expansion (childless adults) ***(Effective Q1 2010)*** ***(Obsolete Q2 2014)***
BGR	BadgerCare (family coverage)
OTH	Payer not identified above

- Payer Type has a field length of 2 and constitutes the fourth and fifth positions of the payer code. Fee-for-service in all of the codes below is defined as whether the billing is fee-for-service and whether the insured is free to choose any provider to perform the needed service.
- Payer Type code depends on the Payer Identification code. A Payer Identification code of MED/T18, T19, nnn or BCS (Blue Cross/Blue Shield), WPS, CHA, BGR or MAX requires a Payer Type code of 01, 02, 03, or 09. However, these Payer Type codes can never be used with a Payer Identification code of OTH. For the appropriate Payer Type codes, see the following tables:
- Code structure for Payer Type for use with MED, T19, nnn (BC/BS), WPS, CHA, BGR or MAX

Code	Description
01	Fee-for-service, non-HMO Medicare, or non-HMO Medicaid
02	Alternative Health Care Insurance Plans (HMO, PPO)
03	CHAMPUS/CHAMPVA/TRICARE
09	Unable to determine insurance type[3].

[2] This must be used with Payer Type Code 03.

[3] To be used when it is unknown if the coverage is fee-for-service/non-HMO Medicare or HMO, PPO.

VIII. Summary of All Codes [4]

For a complete listing of the Code Summary, please refer to the Code Summary Lookup in the data set documentation folder or online via the WHA Information Center.

Tables: Further details in the tables can be found in the Appendix section of the WIpop Manual.

Admit Source Newborn	Appendix 7: Point of Origin for Admission
Admit Source NonNewborn	Appendix 7: Point of Origin for Admission
Admit Type	Appendix 7: Type of Admission
County	tlkCounty - Includes county code and county name
Discharge Status	Appendix 8: Patient Status
Facility City	Appendix 1: Facility Information
Facility Information (3 digit code and Name)	Appendix 1: Facility Information
Gender	tlkGender
Infant Age Groups	tlkNewborn
MDC	tlkMDC
MSDRG	tlkMSDRG
Payer Category Group	tlkPayCategory
Payer Combined Code	tlkPayCombinedCode
Payer Identifier Group	tlkPayIdentifier
Physician Specialty	tlkSpecialty
Border State County Codes	tlkBorder – identifies all counties within bordering states of WI, instead of using the out-of-state name.
County Assignments for Multi-County Zip Codes – WI	This table is available upon request
Type of Bill (not in code Summary table)	Appendix 4: Type of Bill
POA – Present on Admission Code	tlkPOA – applied to principal as well as all secondary diagnosis

[4] All information in this section can also be found in the relational data product in various data support tables.