



**Data Submitter Users Group
Teleconference Minutes
May 25, 2005**

Present: Kerry Burton, Elizabeth Cramer, Carla Gechas, Vicki Gorsuch, Rae Ann Gosser, Alice Haack, Melinda Hanchek, Renee Henkel, Cheryl Hoeth, Elaine Krause, Merilee Kullitz, Victoria Levett, LuAnn Matyas, Karen Miller, Carrie Potier, Joyce Potter, Becky Ruhnu-Gee, Cathy Sander, LaVonne Smith, Susan Summerfield, Lois Tetzke, Jonelle Villas, Theresa Wegener; Faye Wieser; Tom Wise, and Gary Wood

Staff Present: Julie Callies, Joe Kachelski, Debbie Rickelman, and Shannon Schumann

Order of Diagnoses and Procedures

WHA Information Center staff asked participants if they are reporting all diagnosis and procedure codes or a limited number. Some facilities are reporting all, some are reporting nine diagnoses and six procedures per the UB-92 specifications; and some did not know how many they are reporting. It was noted that if all diagnoses and procedures are not reported the DRG may not be correctly assigned for inpatient records.

Outpatient Surgery Services Billed with Repetitive Services

WHA Information Center staff referred to the additional information regarding repetitive services added to page 1-3 of the manual. The reference provides two options for reporting outpatient surgery services that occur during an episode of repetitive services. The manual states:

When one or more of the outpatient surgery revenue codes appears on a repetitive services record the record can be submitted in one of two ways:

- Submit the services related to revenue codes 036x, 0480, 0481, 049x, and 0750 as a separate record from the repetitive services. The outpatient surgery portion should be submitted as a place of service 1. The place of service for the repetitive services component should be based on the revenue codes for the remainder of the record.
- Combine the outpatient surgery services and the repetitive services on one record with a place of service 1 code, only if the surgery services are incidental to the repetitive services care (i.e. catheter placement during chemotherapy care).

The reason WHA Information Center prefers the services to be separated is due to the definition of outpatient surgery as outlined in the Wisconsin Statute 153 and the administrative rule that is an interpretation the statute. Some facility staff stated their billing systems do not allow for separating the outpatient surgery services from the repetitive services; therefore there are a considerable number of records with edits in the submitted files. The second option does not work well for some facilities because sometimes they bill unrelated services with repetitive services. Variation in billing repetitive services seems to be somewhat related to Medicare guidelines. Some facilities appear to be following CMS transmittal A-02-087. Others are following CMS transmittal 407. The Wlpop system works best with transmittal 407; however one facility received communication from a CMS staff person that transmittal 407 may be retracted because a number of facilities are having difficulty with the implementation. Debbie



Rickelman emailed the CMS staff person and asked for clarification but has not received a reply to date.

WHA Information Center staff will discuss the situation further and advise facility staff how to handle these records in the Wlpop data submission. *(An email was sent to all facility staff regarding this topic on Friday, May 27).*

ED Services Billed with Repetitive Services

Some facilities are submitting ED visits on the same record as repetitive services when the ED visit occurs during the billing period for repetitive services. This presents a problem with the definition of an ED visit as outlined in the statute and administrative rule. *(The email sent to facility staff on May 27 references ED visits as well.)*

Revenue Code 0480

Revenue code 0480 (general cardiology services) is included in place of service 1 (outpatient surgery services) in the Wlpop specifications. This was done because this revenue code can be used when billing cardiac catheterization and electrophysiological procedures, both of which are considered outpatient surgery. Revenue code 0480 may also be used to report echocardiography, which is usually not considered an outpatient surgery service. When facilities submit 0480 on a record without any other revenue codes from the place of service 1 category a principal procedure will not be required. If 0480 is submitted on the same record as another code from the place of service 1 category (036x, 0481, 049x, and 0750) the principal procedure, principal procedure date, and other physician 1 fields must be filled. After all data has been submitted WHA Information Center will identify the cases that were reported with 0480 and echocardiography codes and report them in the other hospital outpatient data set.

Another use of revenue code 0480, that is inconsistent with the Wlpop logic, is its use when reporting CPR performed in the ED. This is a valid billing method when respiratory therapy staff performs the CPR, however if ED staff performs the CPR the appropriate revenue code is 0450. When revenue code 0480 is used on an ED record the software logic requires the place of service to be 1 which forces the record into the outpatient surgery file. The principal procedure field must be filled (with the CPT code for CPR) along with the principal procedure date and the other physician 1 field. The same methodology will be applied when reporting these cases in the data sets as will be applied for the echocardiography cases used with this revenue code. WHA Information Center will identify the cases where revenue code 0480 was performed in the ED and the record will be reported in the ED data set.

Medical Status Codes

Some facilities have difficulty identifying BadgerCare vs. Medicaid as the payer. Specific medical status codes designate the payer as BadgerCare. These medical status codes are available on the Medicaid on-line eligibility system. Page 5-7-1 of the Wlpop manual identifies which medical status codes indicate BadgerCare is the payer.

Records of Self-pay Patients

Records of self-pay patients must be included in the data submission as noted on pages 1-2 and 1-3 of the Wlpop manual. Even though there may not be a UB-92 or CMS 1500 generated, the data elements must be submitted in the required format.

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Ambulance Modifiers

Pick-up and destination modifiers will be allowed when used with the following HCPCS Level II codes for ambulance services: A0425-A0436 and Q3019-Q3020.

HIPPS Inpatient Rehab Facility Codes

Under the Inpatient Rehabilitation Facility PPS a five-digit HIPPS rate/CMG code (AXXYY-DXXYY) may be reported with revenue code 0024 in field 5 of the revenue record. This information is outlined on page 2-6 of the manual.

Units of Service

The units of service field should reflect the units rendered, not the units charged. The value must be greater than zero. Please see page 2-7 of the manual.

National Provider ID

Starting May 23, 2005, all health care providers can apply for their National Provider identifier (NPI). The NPI will replace health care provider identifiers in use today in standard health care transactions. All HIPAA-covered entities except small health plans must begin using the NPI on May 23, 2007. The Medicare program is not accepting the NPI in standard transactions yet. WHA Information Center is not accepting the NPI at this time due to the fact that a database with valid NPI numbers is not available at this time. For further information regarding the NPI process visit <https://nppes.cms.hhs.gov> or <http://cms.hhs.gov/medlearn/npi/npiviewlet.asp>.

Self-pay Patients vs. Research Grant

A question was raised regarding the appropriate payer type for services covered by a research grant. It was noted that payer type code 71 was added to the Wlpop manual (page 5-7-2) for this purpose.

Detail Edit Reports

A request was made that WHA Information Center provide edit reports by error type. Currently a report is not available that lists all records with an invalid provider ID. These requests will be referred to Tony Tosi, Director of Development.

Error Codes in Numeric Order

It was suggested that WHA Information Center published the error codes in numeric codes in addition to the current alphabetic list.

Principal Procedure for Outpatient Records

A question was raised regarding how to populate the principal procedure field for outpatient records when the field is not ICD-coded by health information coders.

Facilities have the option to fill the principal procedure field for outpatient surgery, ED and other hospital outpatient records with ICD or CPT/HCPCS Level II codes. The principal procedure field must be filled for outpatient surgery records. If a facility does not have a method for filling this field they may apply the recommended range of CPT/HCPCS Level II codes outlined on page 2-3. If one of these codes appears in the revenue record it may be entered in the principal procedure field. If more than one of these codes appears in the revenue record the facility will

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need to develop an internal procedure on how to designate the principal procedure code. Some facilities designate the code with the service line with the highest charge.

It was noted that CPT E&M codes should never be in the principal or additional procedure fields. An edit will be added to flag these cases when this occurs.

Validation Queries

Because of improved system edits there will be fewer validation queries with the Wlpop system. High and low charges, and lengths of stay greater than 3 days in the ED will continue to be reported. Facilities will be informed if additional queries are added.