

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:

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

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:

- 1) the Admission Date (UB-04 FL 12) for Inpatient data, or
- 2) the Date of Principal Procedure (UB-04 FL 74 or CMS-1500 FL 24A) for Outpatient Surgery Center data and Observation with OPS data.

Code	Age Group
1	7 days or less
2	8 days through 28 days
3	29 days through 365 days
0	Over 1 year

- 3) 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:

1. The ZIP code has a residential population less than 1,000 per record type, or
2. The ZIP code appears on fewer than 30 discharges (Inpatient, Emergency Department, and Observation Visit 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.

- A. 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. Please see [Section VII](#).
- B. 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'.

See [Section V](#) for the full list of county codes. See [Section VI](#) for the full list of state codes. County and State codes and descriptions can be found in the relational data product data support table **tlkCounty**.

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 longer than 999 days were set to 999 days.

7. **Year/Quarter**

Indicates year and quarter (e.g., "041" for first quarter of 2004) 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 data, "from" date in statement period covers date is provided.

8. **Admission Type – Inpatient data only**

Indicates 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**.

Code	Priority	Definition
1	Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally the patient is admitted through the emergency room
2	Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally the patient was admitted to the first available and suitable accommodation

Code	Priority	Definition
3	Elective	An admission that could be delayed without substantial risk to the health of the individual. This means the patient's condition permitted adequate time to schedule the availability of a suitable accommodation
4	Newborn	A baby's first admission to this facility. Use of this code requires use of special Source of Admission Codes - see Element No. 9 (for data purposes, a baby born in, or en route to, the hospital is considered a newborn)
5	Trauma Center	Visit to a 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

9. Admission Source – Inpatient and Emergency data only

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**.

Source Codes for Non-Newborn Admissions

Code	Source	Definition
1	Non-healthcare point of origin	The patient was admitted to this facility. For outpatients, the patient presented to this facility for outpatient services. Updated language 7/1/10.
2	Clinic or Physician office	The patient was admitted to this facility. For outpatients, the patient presented to this facility for outpatient services. Updated language 7/1/10
3	Reserved for NUBC	
4	Transfer from a Hospital	The patient was admitted as a transfer from an acute care facility where he or she was an inpatient. For outpatients, a physician of another acute care facility referred the patient to this facility for outpatient or referenced diagnostic services
5	Transfer from a Skilled Nursing Facility	The patient was admitted from a skilled nursing facility where he or she was an inpatient. For outpatients, the patient was referred to this facility for outpatient or referenced diagnostic services by the skilled nursing facility where he or she is an inpatient
6	Transfer from another Health Care Facility	The patient was admitted as a transfer from a health care facility other than an acute care facility or skilled nursing facility. For outpatients, the patient was referred to this facility for outpatient or referenced diagnostic services by another health care facility where he or she is an inpatient
7	Emergency Room	The patient was admitted upon recommendation of an emergency room physician. For outpatients, the patient received services in this facility's emergency room. Discontinued: 7/1/10
8	Court/Law Enforcement	The patient was admitted upon direction of a court of law, upon the request of a law enforcement agency representative, or referral from a 51.42/51.437 or 46.23 county board. For outpatients, the patient was referred to this facility upon the

Code	Source	Definition
		direction of a court of law, or upon the request of a law enforcement agency representative
9	Information not Available	This code is invalid for Medicare outpatient services
A	Reserved for NUBC	
B	Reserved for NUBC	
C	Reserved for NUBC	
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer	The patient was admitted to this facility as a transfer from a hospital inpatient within this facility resulting in a separate claim to the payer. The admission source for the psych exempt unit record would be 'D'.
E	Transfer from Ambulatory Surgery Center	Patient was admitted to this facility as a transfer from an ambulatory surgery center.
F	Transfer from Hospice and is under a Hospice plan of care or enrolled in a hospice program	Patient was admitted to this facility as a transfer from a hospice.

Source Codes for Newborn Admissions

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

Code	Source	Definition
1	Reserved for NUBC	
2	Reserved for NUBC	
3	Reserved for NUBC	
4	Reserved for 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.
9	Reserved for NUBC	

10. Discharge Status – Inpatient and Emergency data only

Indicates 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**.

Code	Status
01	Discharged to home or self care (routine discharge)

Code	Status
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to a skilled nursing facility (SNF) with Medicare Certification in anticipation of covered skilled care.
04	Discharged/transferred to a facility that provides Custodial or Supportive care (i.e. an intermediate care facility (ICF))
05	Discharged/transferred to designated Cancer Center or Children's Hospital
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
08	Reserved for NUBC
09	Admitted as an inpatient to this hospital (used on Medicare outpatient claims only for services that begin greater than three days prior to an admission)
20	Expired
21	Discharges or Transfers to Court/Law Enforcement Q110
40-42	Expired Hospice – Removed Code options from data sets Q310
43	Discharged/transferred to a federal health care facility
50	Discharged to a Hospice-home
51	Discharged to Hospice-medical facility
61	Discharged/transferred to Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital.
63	Discharged/transferred to a Medicare certified long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital. CMS approved for use for Medicare patients.
70	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list.

11. Total Charges

All data are provided in explicit decimal format, i.e., xxxxxxxxxx.xx. Inpatient, Emergency Department data and Observation data was derived from UB-04 Field 47. Outpatient Surgery Center data was derived from, UB-04 FL 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 OBS-ED), 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 OBS-ED may represent ED and inpatient, ED and outpatient surgery, or Observation Visit data with ED 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**.

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**.

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
9	Unable to determine (payer identifier known but category not known)

15. **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.

16. **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.

17. **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, 9th Revision, Clinical Modification (ICD-9-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.

18. **Other Diagnosis Codes (First through Eighth 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. Up to 8 '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
R	Reason for Visit Diagnosis
P	Principal Diagnosis
S	Additional (Other) Diagnosis

19. **'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.

20. Principal Procedure Code – ICD-9-CM

Identifies the ICD-9-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. If the procedure code originally submitted was a CPT code, and it did not get translated during the conversion process, the field is filled with four 'X' characters (XXXX). Procedure codes that explicitly referenced induced termination of pregnancy were modified to eliminate distinctions between induced and spontaneous termination, as required by statute. WHA Information Center 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.

21. Other Procedure Codes – ICD-9-CM (First through Fifth for fixed-width layout, all codes submitted for relational layout)

Identifies the ICD-9-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). If the procedure code originally submitted was a CPT code, and it did not get translated during the conversion process, the field is filled with four 'X' characters (XXXX). Procedure codes that explicitly referenced induced termination of pregnancy were modified to eliminate distinctions between induced and spontaneous termination, as required by statute. WHA Information Center does not convert codes in this range since they are not codes that are specific to induced termination of pregnancy. Up to 5 'other' procedure 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.

22. Principal Procedure Code – CPT

Identifies the CPT code for the patient's Principal Procedure, if CPT code was submitted. 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. 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' for principal.

23. 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 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.

24. Pre-Procedure Days – Inpatient data only

The number of days between admission and the date of the principal procedure; calculated by subtracting the Admission Date from the Principal Procedure Date. Pre-procedure days exceeding 999 days were set to 999. 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.

25. Type of Bill (TOB) Relational Only

A code indicating the specific type of bill (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.

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

26. Attending Physician Specialty Code – Emergency data only

The code assigned by the Wisconsin Department of Regulation and Licensing representing the attending physician's primary specialty. A description of the Physician Specialty codes is listed in [Section VIII](#) in alphabetical order, and numeric order in [Section IX](#). Specialty codes and descriptions can be found in the relational data product data support table **tkSpecialty**.

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

The code assigned by the Wisconsin Department of Regulation and Licensing representing the other physician's primary specialty. A description of the Physician Specialty codes is listed in [Section VIII](#) in alphabetical order, and numeric order in [Section IX](#). Specialty codes and descriptions can be found in the relational data product data support table **tkSpecialty**.

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

Indicates Major Diagnostic Category, as computed by the DRG grouper program. As of Q1 10 WHA Information Center uses the DRG grouper marketed by Ingenix. 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 **tkMDC**.

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

Indicates Diagnosis Related Group, as computed by the DRG grouper program. As of Q1 10 WHA Information Center uses the DRG grouper marketed by Ingenix. 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**.

30. Admitting Diagnosis – Inpatient data only

The ICD-9-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.

31. Reason for Visit Diagnoses – Emergency and Observation data only

The ICD-9-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.

32. Facility Identification Number

A three-digit identification number assigned to each reporting unit. A list of Facility Identification Numbers and their corresponding facilities is presented in [Section IV](#). Facility openings, closings, and mergers, in addition to facility demographic information can be found in the relational data product data support table **tlkFacility**.

33. 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.

34. First Payer Combined Code

Identifies expected primary payer. 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**.

tlkPayCombinedCode

Code	Description
11	Medicare, Fee for Service
12	Medicare, HMO/PPO
14	Medicare, Unknown Type
21	Medicaid, Fee for Service
22	Medicaid, HMO/PPO
24	Medicaid, Unknown Type

Code	Description
25	Medicaid, Other State
33	CHAMPUS/CHAMPVA/TRICARE
41	WPS/Blue Cross/Workers Comp, Fee for Service
42	WPS/Blue Cross/Workers Comp, HMO/PPO
44	WPS/Blue Cross/Workers Comp, Unknown Type
61	BadgerCare, Fee for Service
62	BadgerCare, HMO/PPO
64	BadgerCare, Unknown Type
65	BadgerCare Expansion, Fee for Service (2010)
66	BadgerCare Expansion, HMO/PPO (2010)
68	BadgerCare Expansion, Unknown Type (2010)
71	Other Commercial or Private Insurance, Fee for Service
72	Other Commercial or Private Insurance, HMO/PPO
74	Other Commercial or Private Insurance, Unknown Type
81	Employer Self-Funded, Fee for Service
82	Employer Self-Funded, HMO/PPO
84	Employer Self-Funded, Unknown
91	Other Organization Self-Funded, Fee for Service
92	Other Organization Self-Funded, HMO/PPO
94	Other Organization Self-Funded, Unknown Type
101	Other Government, Fee for Service
102	Other Government; GAMP
111	HIRSP, Fee for Service
121	Self Pay, Fee for Service
122	Research Grant, Subsidized
131	Other or Unknown, Fee for Service
134	Other or Unknown, Unknown Type
NULL	Missing – Data Not Submitted – Second Payer only

35. **Second Payer Combined Code**

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 [\(31\) First Payer Combined Code](#). Second Payer Combined Code codes and descriptions can be found in the relational data product data support table **tlkPayCombinedCode**.

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

The code assigned by the Wisconsin Department of Regulation and Licensing representing the second other (procedure) physician's primary specialty. A description of the Physician Specialty codes is listed in [Section VIII](#) in alphabetical order, and numeric order in [Section IX](#). Specialty codes and descriptions can be found in the relational data product data support table **tlkSpecialty**.

37. **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.

38. 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.

39. 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.

40. 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 **tblkDataType**.

41. Start Date (relational layout only)

Date identified code was effective.

42. End Date (relational layout only)

Date identified code was no longer effective (delete date).

43. 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.

44. 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.

45. 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.

46. 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)

47. 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)

48. 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)