

## 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-92 Item 14, UB-04 Item 10 or CMS-1500 Item 3) to:

- 1) the Admission Date (UB-92 Item 17 or UB-04 Item 12) for Inpatient and Emergency Department data,
- 2) the Date of Principal Procedure (UB-92 Item 80, UB-04 Item 74 or CMS-1500 Item 24A-1) for Outpatient Surgery Center data, or
- 3) The “from” date in the statement covers period (UB-92 Item 6A or UB-04 Item 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-92 Item 14, UB-04 Item 14 or CMS-1500 Item 3) to:

- 1) the Admission Date (UB-92 Item 17 or UB-04 Item 12) for Inpatient data, or
- 2) the Date of Principal Procedure (UB-92 Item 80 , UB-04 Item 74or CMS-1500 Item 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-94 Item 6A or UB-04 Item 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-92 Item 13, UB-04 Item 9 or CMS-1500 Item 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-92 Item 15, UB-04 Item 44 or CMS-1500 Item 3).

Code	Sex
1	Male
2	Female
3	Unknown

#### 6. **Length of Stay – Inpatient data only**

Indicates number of days of inpatient stay. Calculated by determining the number of days between the Admission Date (UB-92 Item 17 or UB-04 Item 12) and the Discharge Date (UB-92 Item 6 or UB-04 Item 6) and subtracting the number of Leave Days (UB-92 Items 42 and 46, UB-04 Items 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 6A) 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 – Outpatient Surgery and Inpatient data only**

Indicates priority code of the admission (UB-92 Item 19 or UB-04 Item 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 born within the 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-92 Item 20 or UB-04 Item 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	Physician Referred	The patient was admitted to this facility upon the recommendation of his or her personal physician. For outpatients, a physician referred the patient for outpatient services, or the patient independently requested outpatient services (self-referral)
2	Clinic Referred	The patient was admitted to this facility upon recommendation of a facility's clinic physician. For outpatients, the patient was referred to this facility of outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician
3	HMO Referred	The patient was referred to this facility upon the recommendation of a health maintenance organization physician. For outpatients, a HMO physician referred the patient to this facility for outpatient or referenced diagnostic services
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
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

Code	Source	Definition
		referral from a 51.42/51.437 or 46.23 county board. For outpatients, the patient was referred to this facility upon the 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	Transfer from a Critical Access Hospital	The patient was admitted as a transfer from a critical access hospital where he or she was an inpatient
B	Transfer from Another Home Health Agency	The patient was admitted to this facility's home health agency, as a transfer from another home health agency
C	Readmission to Same Home Health Agency	The patient was readmitted to this facility's home health agency within the existing 60-day home health payment episode
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'. <b>Effective 04/01/2006</b>
E	Transfer from Ambulatory Surgery Center	Patient was admitted to this facility as a transfer from an ambulatory surgery center. <b>Effective 10/01/07</b>
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. <b>Effective 10/01/07</b>

### 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	Normal Newborn	A baby delivered without complications. <b>Discontinued 09/30/2007</b>
2	Premature Newborn	A baby delivered with time and/or weight factors qualifying it for premature status. <b>Discontinued 09/30/2007</b>
3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status. <b>Discontinued 09/30/2007</b>
4	Extramural Birth	A newborn baby delivered in a non-sterile environment
5	Born Inside this Hospital	A baby born inside this hospital. <b>Effective 10/01/2007</b>
6	Born Outside of this Hospital.	A baby born outside of this hospital. <b>Effective 10/01/2007</b>

- 9 Information not Available The facility does not have this information in its records. Invalid for Medicare outpatient services. **Discontinued 09/30/2007**

### 10. **Discharge Status – Inpatient and Emergency data only**

Indicates arrangement or event ending a patient's stay in the hospital or emergency room (UB-92 Item 22 or UB-04 Item 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)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to a skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution for inpatient care not defined elsewhere in this code list
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	Transferred or discharged to a home intravenous provider
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 (or did not recover - Christian Science Patient)
40	Expired at home; used only on Medicare and CHAMPUS claims for hospice care
41	Expired in a medical facility; used only on Medicare and CHAMPUS claims for hospice care
42	Expired – place unknown; used only on Medicare and CHAMPUS claims for hospice care
43	Discharged/transferred to a federal hospital
50	Discharged to a Hospice-home
51	Discharged to Hospice-medical facility
61	Discharged/transferred to Medicare approved swing bed
62	Discharged/transferred to another rehab facility
63	Discharged/transferred to a 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. <b>Effective 01/01/2006</b>
70	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list. <b>Effective 10/01/2007</b>

### 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-92 Items 42 and 47. Outpatient Surgery Center data was derived from UB-92-Item 47, UB-04 Item 47 or CMS-1500 Item 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. Derived from UB-92 Items 42 and 46. 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-92 Item 50(a), UB-04 Item 50(a) or CMS-1500 Item 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. BHI assigned only the identified 'Unknown' payers to Payer Identifier Group 6, and assigned the identified 'Other' payers to Payer Identifier Group 4. 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-92 Item 50(a), UB-04 Item 50(a) or CMS-1500 Item 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 (includes non-HMO Medicare or Medical Assistance). This category is assigned when none of the others are clearly defined
2	Alternative Health Care Insurance Plans (includes HMO, PPO, PPA, etc.)
3	CHAMPUS/CHAMPVA/TRICARE
4	Unable to determine (payer identifier known but category not known)

**15. Second Payer Identifier Group**

Identifies expected secondary payer. Developed from UB-92 Item 50(b), UB-04 Item 50(b) or CMS-1500 Item 1 – secondary payer identifier and category.

For codes and descriptions see [\(13\) First Payer Identifier Group](#). BHI assigned Payer Identifier Group 6 (Other or Unknown) when a secondary payer was not reported. 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. BHI assigned only the identified 'Unknown' payers to Payer Identifier Group 6, and assigned the identified 'Other' payers to Payer Identifier Group 4. 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-92 Item 50(b), UB-04 Item 50 (b) or CMS-1500 Item 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**. BHI assigned Payer Category Group 1 (fee-for-service) when a secondary payer was not reported. 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—92 Item 67, UB-04 Item 67 or CMS-1500 Item 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 sex-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 sex-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	Primary Diagnosis
S	Secondary 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-92 Item 77, UB-04 Item 72 or CMS-1500 Item 21. An 'E' Code is accepted when used appropriately with codes outside the injury range. Effective with **Q307** data, only the primary E-Code diagnosis submitted by the facility will be included in the fixed width data set. 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-92 Item 80, UB-04 Item 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. BHI converted ICD-9-CM procedure codes 96.41-96.49 to a different code. 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-92 Item 81, UB-04 Item 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. BHI converted ICD-9-CM procedure codes 96.41-96.49 to a different code. 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 (UB-92 Item 44, UB-04 Item 44 or CMS-1500 Item 24D). 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 can be 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-92 Item 44, UB-04 Item 44 or CMS-1500 Item 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 (UB-92 Item 17 or UB-04 Item 12) from the Principal Procedure Date (UB-92 Item 80 or UB-04 Item 74). Pre-procedure days exceeding 999 days were set to 999. BHI entered a '.' in this field when there were no pre-procedure days. 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. 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 **tlkSpecialty**.

## **26. 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 **tlkSpecialty**.

**27. Major Diagnostic Category (MDC) – Inpatient data only**

Indicates Major Diagnostic Category, as computed by the DRG grouper program. WHA Information Center uses the DRG grouper marketed by Medstat. The version is changed for the fourth quarter of each year in synchronization with the yearly change in grouper versions. Version 5.24 was used for **3Q07** data. 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 **tlkMDC**.

**28. Diagnosis Related Group (DRG) – Inpatient data only**

Indicates Diagnosis Related Group, as computed by the DRG grouper program. WHA Information Center uses the DRG grouper marketed by Medstat. The version is changed for the fourth quarter of each year in synchronization with the yearly change in grouper versions. Version 5.24 was used for **3Q07** data. 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**.

**29. Admitting Diagnosis – Inpatient data only**

The ICD-9-CM Diagnosis Code (UB-92 Item 76 or UB-04 Item 69) provided at the time of admission as stated by the physician. Edit checks required fully specified codes, and age- and sex-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.

**29. Reason for Visit Diagnoses – Emergency and Observation data only**

The ICD-9-CM Diagnosis Code (UB-04 Item 70) provided as the reason for visit (up to three diagnoses) as stated by the physician. Edit checks required fully specified codes, and age- and sex-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 **3Q07** data, 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.

**30. 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**.

**31. 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 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.

**32. *First Payer Combined Code***

Identifies expected primary payer. Developed from UB-92 Item 50(a), UB-04 Item 50(a) or CMS-1500 Item 1 – primary payer identifier and category. This is a new, more descriptive first payer code added to the data sets as of **1Q 2004**. First Payer Combined Code 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
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
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 <u>Added 3Q05</u>
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

**33. Second Payer Combined Code**

Identifies expected secondary payer. Developed from UB-92 Item 50(b), UB-04 Item 50(b) or CMS-1500 Item 1 – secondary payer identifier and category. This is a new, more descriptive second payer code added to the data sets as of **1Q2004**.

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**.

**34. 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](#). This is an additional field as of **1Q 2005**. Specialty codes and descriptions can be found in the relational

data product data support table **tlkSpecialty**.

**35. 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'. This is an additional field as of **1Q 2005**. In the relational data product, actual modifier information (up to two 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.

**36. 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'. This is an additional field as of **1Q 2005**. In the relational data product, actual modifier information (up to two 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.

**37. 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.

**38. 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**.

**39. Start Date (relational layout only)**

Date identified code was effective.

**40. End Date (relational layout only)**

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

**41. 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.

**42. 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.

**43. 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.

**44. 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)

**45. 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)

**46. 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)