

Data Set Documentation

I.	General Description	4
II.	Fixed-Width File Layout(s)	6
	Inpatient Discharge	6
	Outpatient Surgery (OPS) & Observation w/ Outpatient Surgery (OBS-OPS).....	7
	Emergency Department (ED) & Observation w/ Emergency Department (OBS-ED)	8
III.	Wlpop Relational Database Product.....	9
	Standard Layout - Data Tables	9
	Standard Layout - Data Support Tables.....	11
	Physician Enhanced Layout – Additional Table	14
	Revenue Enhanced Layout – Additional Table	14
IV.	Detailed Description of Data Elements	15
1.	Age in Years.....	15
2.	Infant Age Groups – Inpatient and Outpatient Surgery data only	15
3.	ZIP Code	15
4.	County/State Code	16
5.	Gender	16
6.	Length of Stay – Inpatient data only	16
7.	Year/Quarter.....	16
8.	Admission Type – Outpatient Surgery and Inpatient data only	16
9.	Admission Source – Inpatient and Emergency data only	17
	Source Codes For Non-Newborn Admissions.....	17
	Source Codes For Newborn Admissions.....	18
10.	Discharge Status – Inpatient and Emergency data only.....	19
11.	Total Charges.....	19
12.	Leave Days – Inpatient data only	20
13.	First Payer Identifier Group	20
14.	First Payer Category Group.....	20
15.	Second Payer Identifier Group	21
16.	Second Payer Category Group	21
17.	Principal Diagnosis Code	21

Data Set Documentation

18.	Other Diagnosis Codes (First through Eighth for fixed-width layout, all codes submitted for relational layout)	21
19.	'E' Code	22
20.	Principal Procedure Code – ICD-9-CM	22
21.	Other Procedure Codes – ICD-9-CM (First through Fifth for fixed-width layout, all codes submitted for relational layout).....	22
22.	Principal Procedure Code – CPT	23
23.	Other Procedure Codes – CPT (First through Fifth for fixed-width layout, all codes submitted for relational layout).....	23
24.	Pre-Procedure Days – Inpatient data only.....	23
25.	Attending Physician Specialty Code – Emergency data only	23
26.	Other (Procedure) Physician Specialty Code – Emergency data only	23
27.	Major Diagnostic Category (MDC) – Inpatient data only	24
28.	Diagnosis Related Group (DRG) – Inpatient data only.....	24
29.	Diagnosis Present at Admission – Inpatient data only	24
30.	Facility Identification Number	24
31.	Record Number (fixed-width layout only)	24
32.	First Payer Combined Code	25
33.	Second Payer Combined Code.....	26
34.	Second Other (Procedure) Physician Specialty Code – Emergency data only ...	26
35.	Bilateral Principal Procedure – CPT	27
36.	Bilateral Other Procedure – CPT (First through Fifth for fixed-width layout, all codes submitted for relational layout).....	27
37.	Record ID (relational layout only)	27
38.	Data ID (relational layout only)	27
39.	Start Date (relational layout only)	27
40.	End Date (relational layout only)	27
41.	OPS (relational layout only).....	27
42.	ER (relational layout only)	27
43.	OBS (relational layout only).....	28
44.	All Patient Refined Diagnosis Related Group (APR-DRG) (relational layout only)	28
45.	Severity of Illness (relational layout only)	28

Data Set Documentation

46.	Risk of Mortality (ROM) (relational layout only)	28
V.	Facility Identification Codes.....	29
	Inpatient and Emergency Department Data Submitters.....	29
	Freestanding Ambulatory Surgery Center Data Submitters	32
	Veteran Care Hospitals	33
	Facility Closings and Mergers	33
V.	County Codes	35
VI.	State Codes	35
VII.	County Assignments for Multi-County ZIP Codes	36
VIII.	Specialty Codes – Alpha Order.....	40
IX.	Specialty Codes – Numeric Order	42
X.	Payer Information Submitted by Facilities	45
XI.	Payer Identifier & Payer Category Group Code Criteria	46
XII.	Payer Combined Code Assignment.....	47
XIII.	Summary of All Codes – CodeSummary.xls	49

I. General Description

The data contained in the data sets were reported to WHA Information Center 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. Four types of data were 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-92 Item 4 or UB-04 Item 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 should be done by procedure date and outpatient surgery revenue codes that include one of the following: 036x, 0481, 049x, and 0750.
4. Observation Visit Data 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.

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). Freestanding Ambulatory Surgery Centers should 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.

The submitted data were edited for errors. 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 Patient Data Submission Manual, which also details facilities' reporting requirements. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-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.

CPT codes submitted in ED and AMB files were converted to ICD-9-CM procedure codes using the *2007 Procedure Conversion Files*, developed by Solucient (1st release – 01/01/2007 effective date). Effective with Q1 2007 data, all Outpatient records are required to submit CPT procedure codes (not ICD-9-CM procedure codes).

In the fixed width data sets; when a CPT code does not convert to an ICD-9-CM code, four 'X' characters (XXXX) were placed in the ICD field. There are six (6) CPT code fields (Principal CPT and five Other CPT fields) which contain the CPT codes that are originally submitted on the record. Each quarter, the list of CPT codes that translate to more than one ICD-9-CM code appears as part of the CPT2ICD Conversion Caveats document that accompanies this documentation. When only one CPT code is submitted and converts to two ICD procedure codes on a record, both ICD codes appear on the record on the data file. When more than one CPT code is submitted, and one or more CPT code(s) converts to two ICD codes on a record, only one ICD procedure code (ICD1) appears for each CPT code submitted.

In the relational data sets; when a CPT code does not convert to an ICD-9-CM code, four 'X' characters (XXXX) were placed in the ICD1 field. An unlimited number of CPT code fields (Principal and Additional) contain the CPT codes that are originally submitted on the record, while the ICD1 and ICD2 fields contain codes converted from the Solucient cross-walk.

The body of the documentation includes a file layout as well as a more detailed description of each data item available on the data file. Other sections contain a list of facility identification numbers, and county and state codes.